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Executive Office of the President

Office of National Drug Control Policy

Office of Programs, Budget, Research & Evaluation

Performance Measures of Effectiveness: Status Report

January 1999

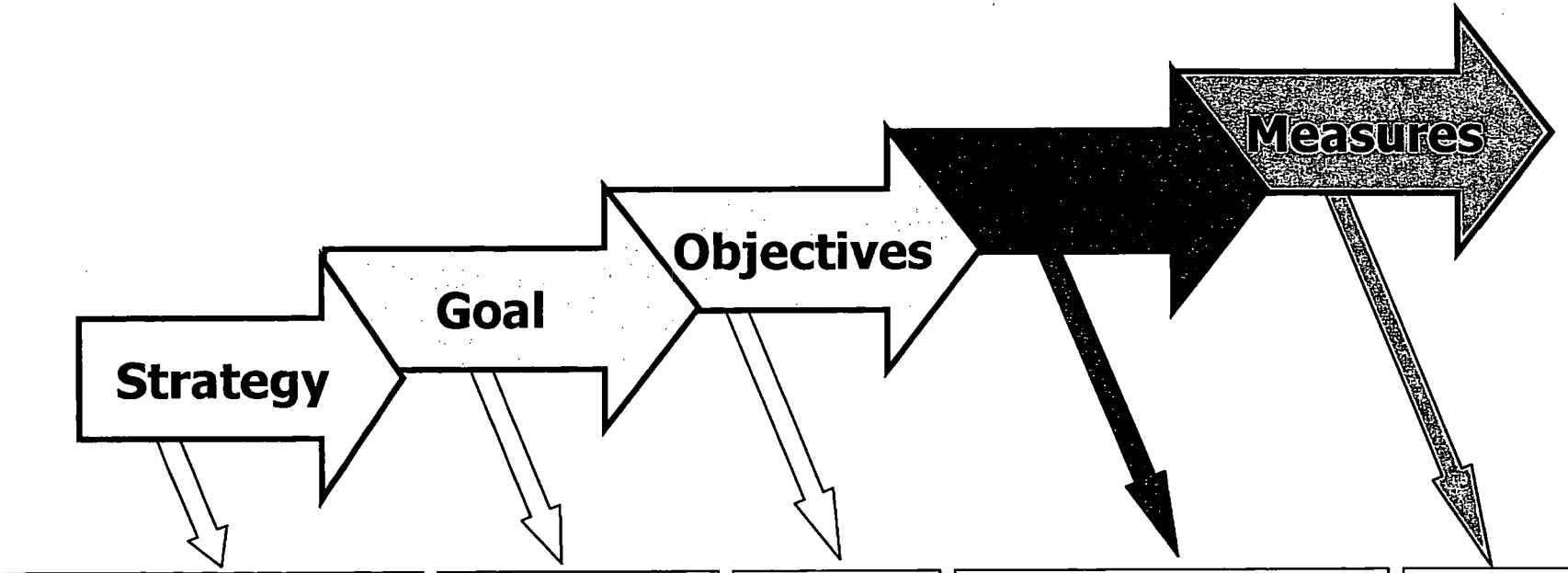
Status of Performance Measures of Effectiveness System

- PME System will not be built in a day -- up to three years.
- Accountability will not be immediate due to lags in data collection. Must identify budget linkages and define Federal and non-Federal roles in achieving outcomes.
- 1998: Interagency working groups met to develop:
  - *Glide Paths* for as many Targets as possible
  - *"Plans of action"* to achieve Targets
  - *Budget estimates by Strategy goals and objectives*
- 1999: Expanded effort to include other stakeholders

Congressional Requirements for PME

- ONDCP Reauthorization Act (P.L. 105-277) requires the Director ONDCP to submit to Congress no later than February 1 each year a PME System that --
  - develop performance objectives, measures, and targets for each Strategy Goal and Objective
  - revises performance objectives, measures, and targets to conform with drug control program agency budgets
  - identifies major programs and activities of drug control program agencies that support the goals and objectives of the Strategy
  - evaluates the implementation of the drug control program agency of program activities supporting the Strategy
  - monitors consistency between the drug-related goals and objectives of the drug control agencies and ensures that drug control agency goals and budgets support and are fully consistent with the Strategy
  - coordinates the development and implementation of national drug control data collection and reporting systems to support policy formulation and performance measurement

Performance Measurement Framework



The **Strategy** guides the development of executable, operational plans to achieve measurable goals and objectives. It should be long term in focus.

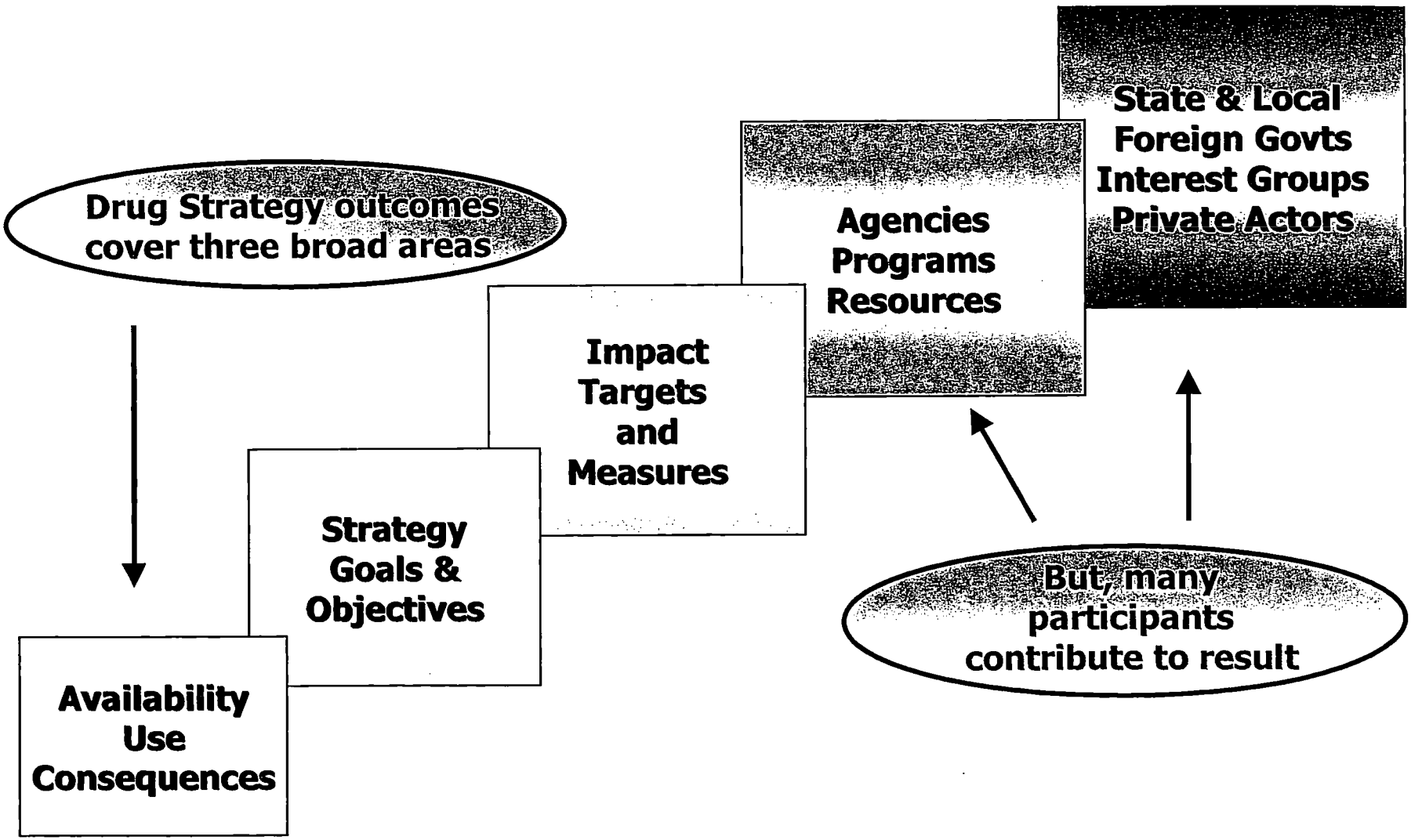
Goals define the major directives or directions of the Strategy.

Objectives define major lines of action to achieve each desired Goal.

Targets define desired end states with which to compare actual performance. Impact targets reflect progress toward the Strategy Goals; the remaining performance targets show progress toward the 32 Objectives.

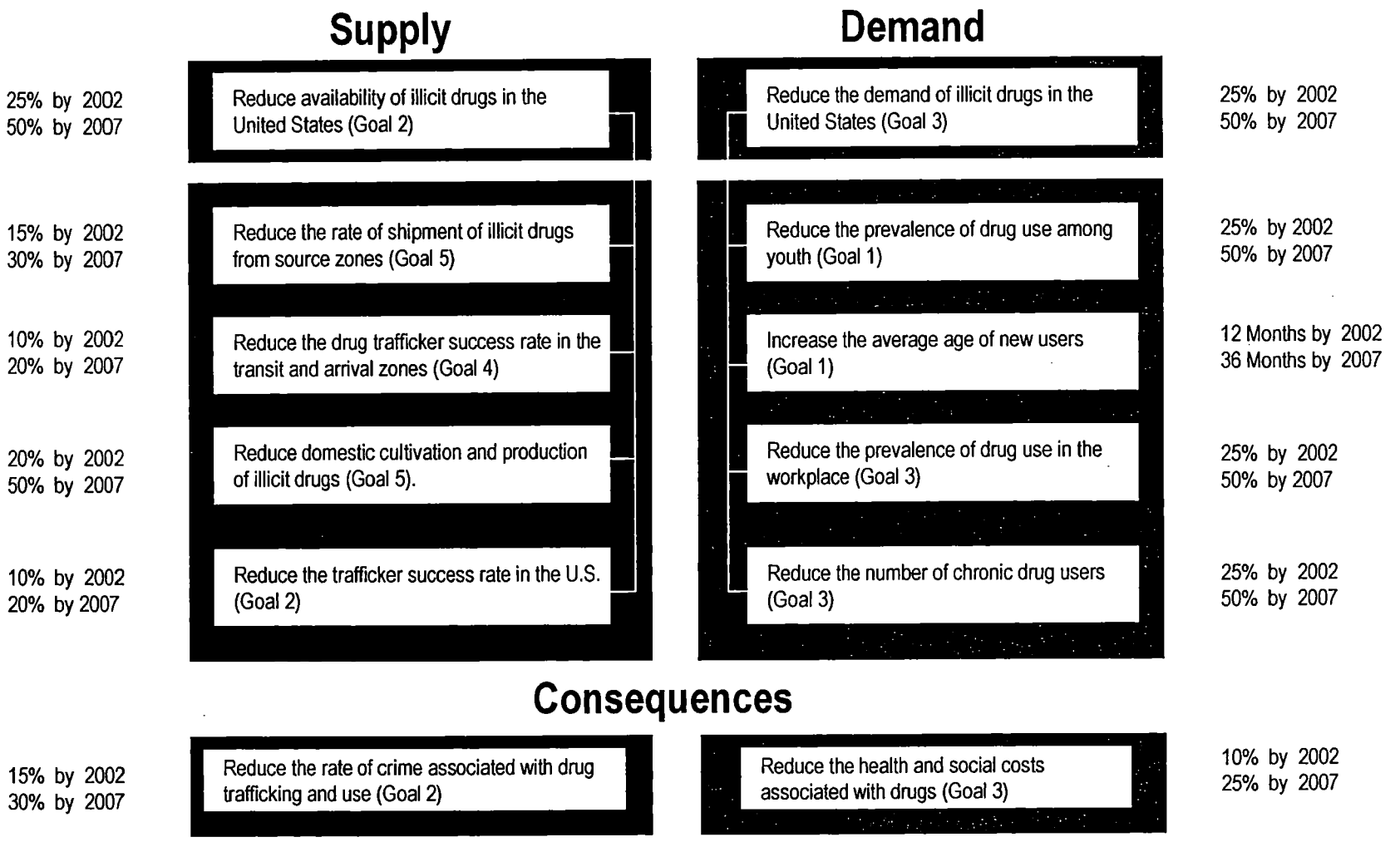
Measures are the data, variables, and events used to track progress toward targets.

PME System recognizes all program participants and links them to outcomes



12 Key Drug Strategy Impact Targets

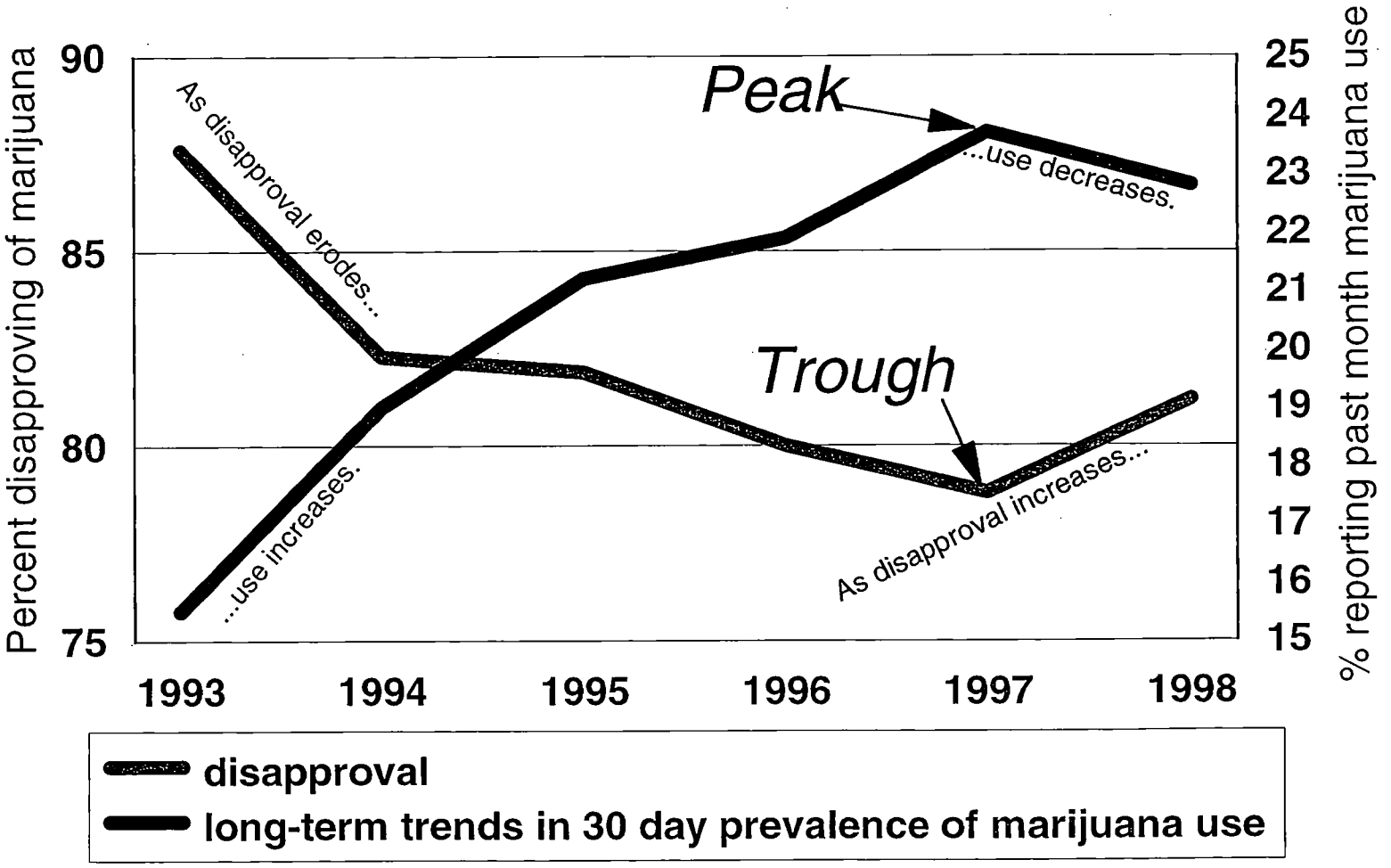
(82 other performance targets are not shown)



Performance Measurement seeks fundamental organizational change

- Measurement (data) to understand efficacy of strategy goals and objectives -- accountability
- Focus on endstates and outcomes, not just inputs or activities
- Reorientation of agencies' planning and budget process
- Drug programs rationalized in terms of their contribution to Strategy Goals & Objectives

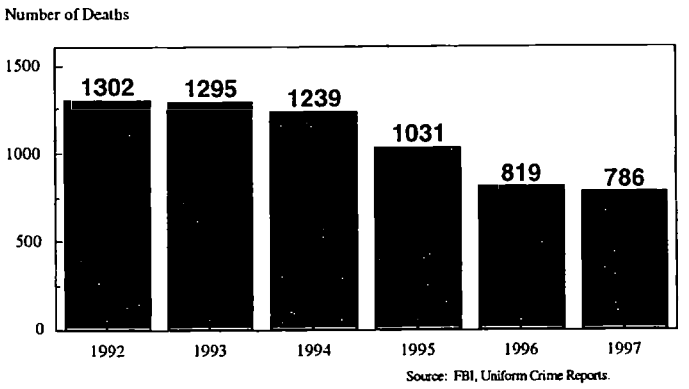
Youth attitudes determine youth marijuana use. The case of 12th graders.



Source: 1998 Monitoring the Future Study.

Drug related murders continue to decline.

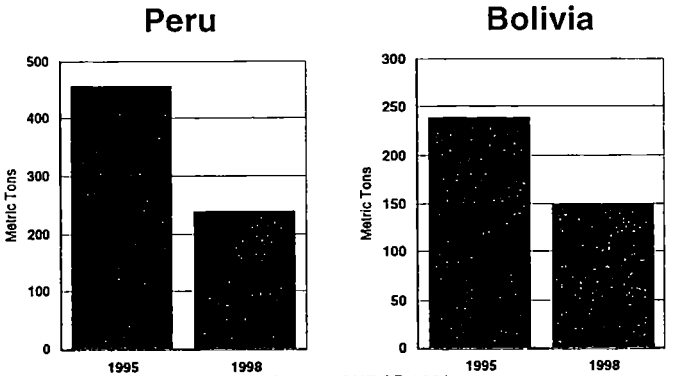
Murders related to narcotic drug laws.



Source: FBI, Uniform Crime Reports.

Cocaine Production in Peru and Bolivia has Declined Dramatically

1995 to 1998

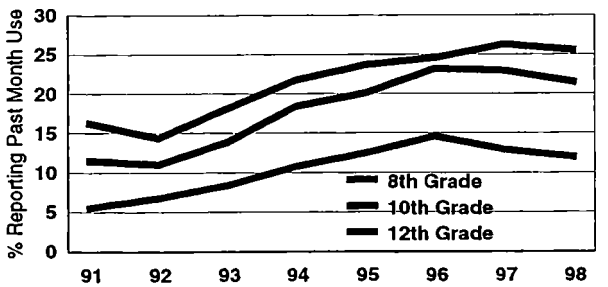


Source: ONDCP 1999

ONDCP: The Administration's Anti-Drug Policy is Working

Youth drug use has decreased.

Past month use of any illicit drug.



Source: 1998 Monitoring the Future Study.

Youth Anti-Drug Media Campaign

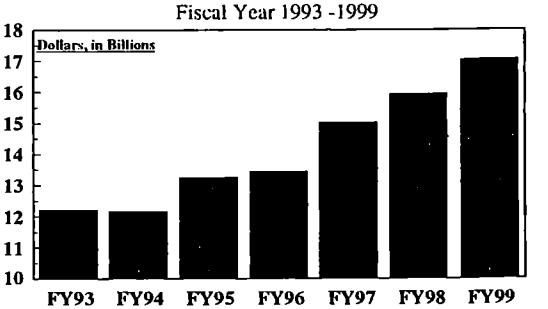
Exceeding Expectations

- Reach and Frequency:
  - GOAL -- 90% target audience 4/ a week
  - STATUS -- 95% target audience 7/ a week
- Calls to ONDCP for information --
  - Up 300% since campaign initiation
- Internet
  - Hits per month on campaign sites up over 2000 %

Source: ONDCP 1999

Federal Counterdrug Spending Has Increased.

Fiscal Year 1993 -1999

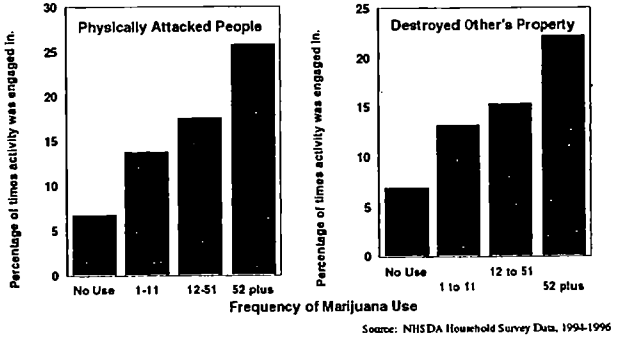


- Almost 40% Increase in Prevention
- 17% Increase in Treatment

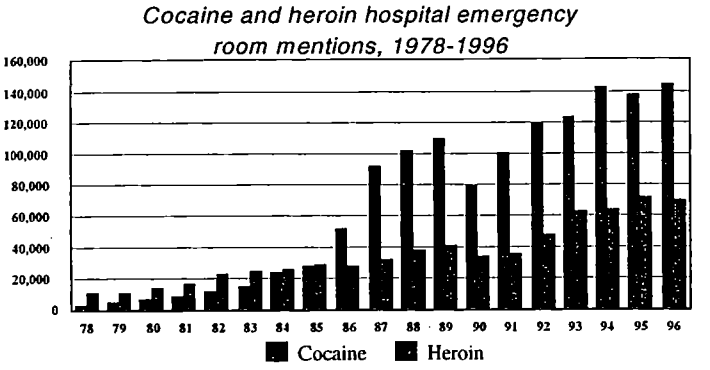
Source: OMB, 1999

ONDCP, 13 January 1999

Aggressive anti-social behavior is clearly linked to marijuana use

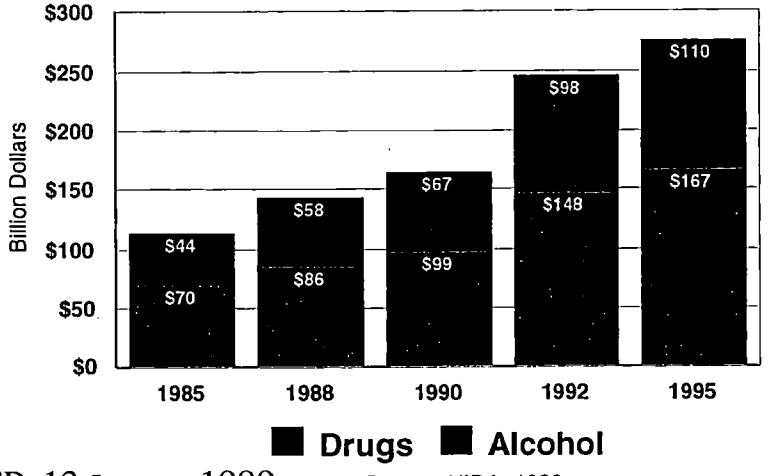


The Health Impact of Drug Abuse: 4.1 Million Addicts Getting Older and Sicker

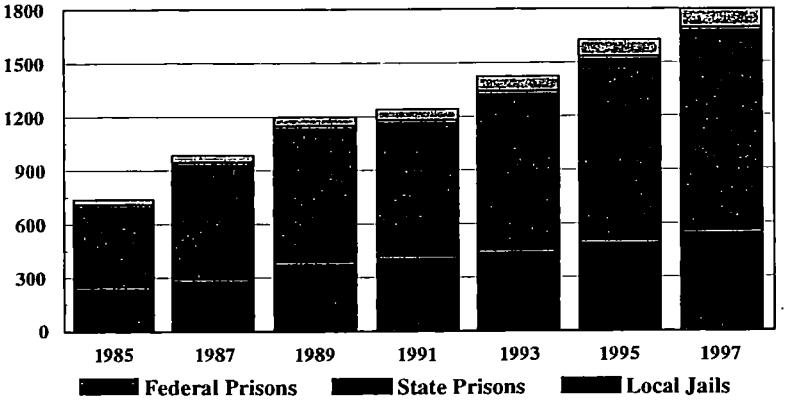


But We Still Have a Challenge.

The social costs of drug and alcohol abuse are increasing.



1.8 Million Americans are incarcerated: an all-time high.



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

THE NATIONAL DRUG CONTROL STRATEGY
PROGRESS REPORT

Educating Children, Preventing Drug Use -- The National Youth Media Campaign

- Campaign's aggressive goal was to reach 90% of target audiences 4 times per week, currently the Campaign is reaching 94% of target audience 7 times a week.
- Help calls to the Clearinghouse for anti-drug information are up 300% since the campaign's initiation.
- We see over 766,000 hits/month on the campaign's Internet sites; before the Campaign we averaged 33,000 hits/month.
- Media match of federal expenditures exceeds 100% -- more than dollar-for-dollar.

Securing America's Borders -- the Southwest Border

- The 2,000 mile border with Mexico is the world's busiest border; this open exchange greatly benefits both nations (1997, US merchandise exports to Mexico equal $71.4 billion).
- The Southwest border remains the primary entry point for drugs into the United States; recent federal efforts have produced only marginal gains.
- Improving anti-drug efforts at the border is vital to both reducing the availability of drugs in America and safeguarding our economic and political relationship with Mexico.

Closing the Treatment Gap -- Insurance Parity for Substance Abuse /MH

- For *de minimus* (0.2%) increase in the average insurance premium we can immediately make progress toward providing access to treatment to 4.1 million people up from 1.7 million.
- Initiative will pay for itself. For example, savings in incarceration costs: potentially up to 2.4 million addicted criminals will go into treatment and out of drugs/crime cycle at a possible savings of $260,000 per person.

Breaking the Cycle of Drugs and Crime -- Prisons and Drugs

- Prisoners who get treatment have 73% lower recidivism rate.
- Treatment is more cost effective than the average $125,000 -- 5 year prison term.
- Efforts to break cycle of drugs and crime will pay for themselves through reductions in prison costs, social costs associated with drugs and crime (over $110 billion per year), and through the money no longer wasted on purchase of drugs (over $57 billion per year).

Reducing the Population of Chronically Addicted

- One-quarter of all drug users (the chronically addicted), use upwards of two-thirds of all the illegal drugs consumed in America. This addict population also drives drug-related crime rates.
- Expanding their access to treatment programs (to include methadone and LAAM) will help addicts become drug-free, reduce crime, and substantially reduce America's demand for drugs.

Breaking the Sources of Supply -- Andean Ridge

- From 1994 to 1998, Peruvian coca cultivation down 56% from 108,600 hectares to 51,000 hectares.
- From 1994 to 1998, Bolivian coca cultivation down 28% from 48,100 hectares to 38,000 hectares.

Providing the Resources and Programs to Make a Difference -- Budget and Performance Measures

- Since 1995, the Administration's counter-drug budget has increased from $13.2 billion to $17.8 billion in 1999. We have invested an almost 40% increase in drug prevention and a 17% increase in drug treatment.
- The Administration's Performance Measures of Effectiveness System will provide greater accountability in our anti-drug programs, and ensure that the rate of current drug use drops below 3% -- which would be the lowest level in modern-day history.

Reducing Drug Abuse in America

An Overview of Demand Reduction Initiatives

January 1999

Foreword

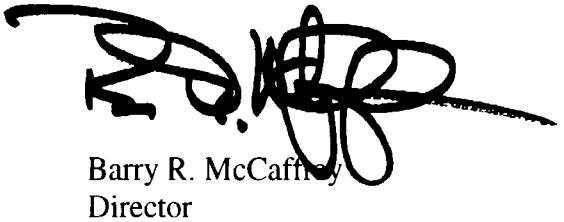
January 1999

Americans are united in their belief that the drug problem represents a serious threat to our country. The campaign to reduce drug abuse in America is a comprehensive, concerted effort by all levels of government -- federal, state, and local -- as well as non-governmental organizations, the private sector, and individual citizens. The 1999 federal drug control budget is a record $17.8 billion; of this, over 33 percent, or $5.9 billion, is spent on demand reduction efforts. This does not include spending by states, local communities, or private organizations. We have seen positive results from our combined efforts. Current drug use (that is use of an illicit drug in the previous month) among those 12 or older is now estimated at approximately 13.9 million Americans, or 6.4 percent of the population. This is a decline of over 50 percent since 1979 when 14.1 percent of Americans were current drug users.

Our goal is to cut today's drug use in half -- to 3.1 percent of the population -- by the year 2007. We need to bring down the level of drug abuse. Moreover, drug abuse is costly to Americans. In financial terms, drug abuse costs approximately $110 billion annually. More serious than that, however, is the cost of drug use to the societal underpinnings of our country. Drug abuse fuels crime, fills our emergency rooms, means lost productivity to businesses, and lost futures to teens.

The *National Drug Control Strategy* is a ten-year plan for reducing drug use in America. The *Strategy* proposes international, interdiction, and law enforcement efforts to reduce the availability of drugs in the United States. But primary among its goals is reducing the demand for drugs. Research has shown that those addicted to drugs impose greater health costs upon society and are responsible for more of our crime. Demand reduction's approach is to treat and rehabilitate the addicted, convince the occasional user to stop using, and prevent non-uses from ever starting.

Education, prevention, and treatment are the components of demand reduction. This booklet highlights the major federal, demand reduction programs and initiatives now underway which will help bring drug use to historic new lows. These initiatives and programs are not the only demand reduction efforts in the United States. The solution calls for a coordinated, nationwide effort that incorporates every level of government, neighborhood organization, and community structure. Demand reduction is everyone's business. Together, we can have an impact on the future of America



Barry R. McCaffrey
Director

Table of Contents

I. Changing Patterns of Drug Use in America

A. Two Decades of Progress

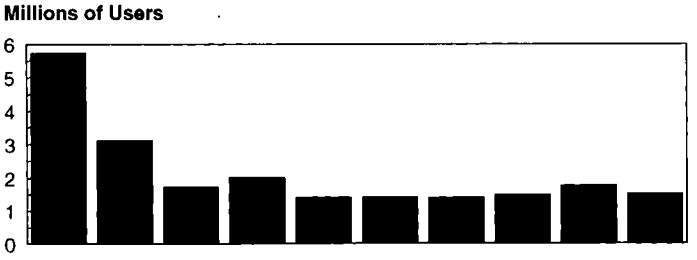
During the late 1970s through the mid-1980s, the United States experienced an unprecedented epidemic of illegal drug use. In 1979, twenty-five million Americans —14.1 percent of the population aged 12 and over and the highest level ever recorded — had used an illegal drug at least once in the month prior to being surveyed. Last year, the *National Household Survey on Drug Abuse* (NHSDA) estimated that about 13.9 million Americans, or 6.4 percent of the population, had used illegal drugs. Since 1979, the number of Americans who use illegal drugs has dropped by nearly 50 percent, and the percentage of the population using drugs has fallen by a remarkable 57 percent. Few other chronic societal problems have been reduced by a comparable magnitude. (Figure 1)

Despite this dramatic drop, 34.8 percent of Americans twelve and older have used an illegal drug in their lifetime; of these, more than 90 percent used either marijuana or hashish, and approximately 30 percent tried cocaine. Fortunately, sixty-one million Americans who once used illegal drugs have now rejected them.

B. Teen Drug Use Stable for Second Consecutive Year

After five years of increase, drug use by American teens has remained steady—or has decreased—for two consecutive years. According to the 1998 University of Michigan *Monitoring the Future* Survey (MTF), nearly all categories of drug use by eighth, tenth, and twelfth graders have either declined or remained unchanged for the second consecutive year. This follows five years of significantly rising drug use during the period 1992 through 1996.

Current use of cocaine is down significantly



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

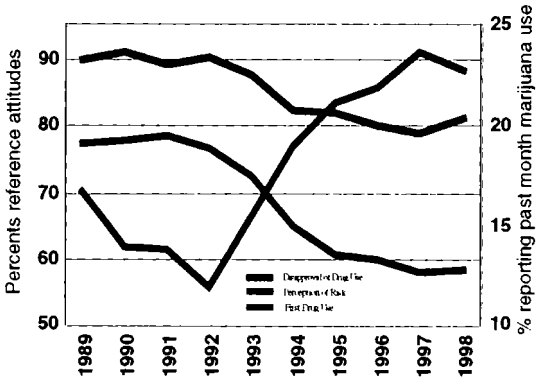
Fig 1 Source. 1997 National Household Survey on Drug Abuse

From 1992 through 1996 illegal drug use increased substantially, particularly for marijuana but also for such drugs as cocaine and heroin. For example, marijuana use by eighth graders nearly tripled. In addition, the

period in which teen drug use was increasing was preceded by erosion of anti-drug attitudes among youth. Both the perceived harmfulness of regular illicit drug use as well as the perceived social disapproval of drug use fell significantly among all categories of youth. (Fig 2)

Youth Attitudes and Their Effect on Marijuana Use

Drug use among 12th graders can be linked to changes in attitudes about risk and social acceptability.



Source: 1998 Monitoring the Future Study. Fig 2

The results of the 1997 and 1998 MTF surveys give cause for optimism that teens are beginning to heed the prevention message. For example, past-year drug use by tenth graders fell from 38.5 percent to 35 percent, while the percentage of eighth graders who viewed marijuana use as risky increased. Despite these promising signs, the levels of teen drug use remain far too high, and attitudes toward illicit drugs still far too lax. Aggressive prevention efforts over the next decade should continue to bring these levels down.

C. Chronic Drug Use Remains a Serious Public Health and Law Enforcement Problem

Researchers estimate the number of chronic cocaine users at 3.6 million and heroin users at 810,000. Yet, estimates of the number of chronic users — that is, those who use drugs heavily — are imprecise because many individuals who are deeply involved in drugs are difficult to locate for interviews. For example, the *Household Survey* does not survey transients who do not reside in shelters, nor those incarcerated in prisons or jails. 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, tuberculosis, HIV/AIDS and other sexually transmitted diseases. Without a reasonable 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. 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.

common means of administration, particularly for low-purity heroin. However, the increasing availability of high-purity heroin has made snorting and smoking more common, thereby lowering inhibitions to use. Among lifetime heroin users, the proportion who had ever smoked, sniffed, or snorted heroin increased from 55 percent in 1994 to 63 percent in 1995, and 82 percent in 1996.

The growing use of heroin by young people is an alarming recent trend. (Fig 3)

Heroin initiation rates have risen dramatically since 1992

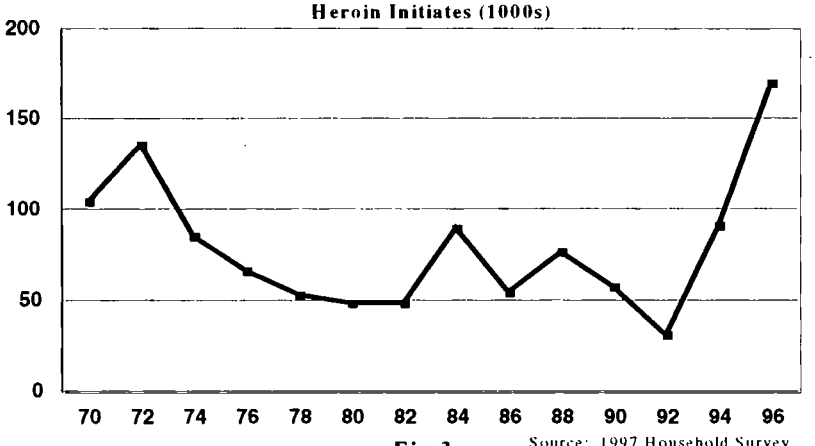


Fig 3 Source: 1997 Household Survey

D. Emerging Illegal Drug Threats

Cocaine and marijuana have long been America's most frequent drugs of abuse. In recent years, however, other substances have become increasingly serious threats to Americans, including young Americans. Among these emerging threats are heroin and methamphetamine.

1. Heroin

Studies estimate that there are 810,000 chronic users of heroin (defined as those who use heroin 51 or more day per year) in the United States. Injection remains the most

According to the *Monitoring the Future* study, while still low, the rates of heroin use among teenagers rose in eighth, tenth, and twelfth grades during the 1990s. For example, for twelfth graders, the prevalence increased from 0.9 percent in 1991 to 2.0 percent in 1998 and this increase was highly statistically significant. The 1997 *NHSDA* found that the mean age of initiation declined from 26.2 years in 1988 to 18.1 in 1996. Communities throughout the country are experiencing the results of increased heroin abuse. Plano, Texas, 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.

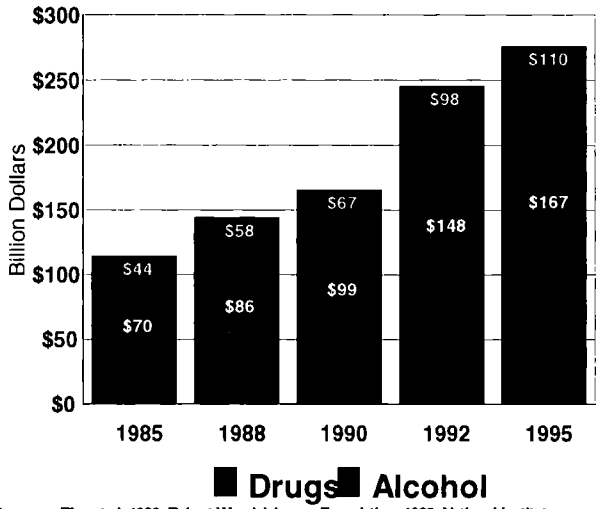
2. Methamphetamine

The 1997 *NHSDA* estimated that 5.3 million Americans (2.5 percent of the population) tried methamphetamine in their lifetime, up insignificantly from 1994, when 1.8 percent of the population had ever used methamphetamine. The National Institute of Justice's (NIJ) 1997 Arrestee Drug Abuse Monitoring (ADAM) Annual Report on Adult and Juvenile Arrestees (which regularly tests arrestees for drug use in twenty-three metropolitan areas) reports that methamphetamine use continues to be more common in the west, southwest, and midwest United States than in the rest of the nation. Between 1992 and 1994, positive rates for methamphetamine among adult arrestees rose steadily in eight cities (Dallas, Denver, Los Angeles, Omaha, Phoenix, Portland, San Diego, and San Jose), reaching as high as 44 percent in San Diego and 25 percent in Phoenix in 1994. While the rates fell significantly for the next two years — to 30 percent in San Diego and 12 percent in Phoenix — 1997 data shows that methamphetamine use has returned close to 1994 levels.

E. Drug Use Continues to Take a Toll on American Society

Illegal drugs cost our society approximately 110 billion dollars each year, (Fig 4) according to the National Institute on Drug Abuse (NIDA) and the National Institute on Alcoholism and Alcohol Abuse (NIAAA). Estimates of these costs have risen steadily since 1985, despite decreases in the number of Americans who use illegal drugs. Accidents, crime, domestic violence, illness, lost opportunity, and reduced productivity are the direct consequences of substance abuse. Drug and alcohol 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

The Economic Costs relating to alcohol and drug abuse are increasing, adding up to $377 billion in 1995



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

Fig 4

criminal justice, health, and social-service systems.

F. 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. DAWN reported that drug-related episodes increased by 25 percent between the first half of 1992 and the first half of 1997, from 214,600 to 269,000. There was a seven- percent increase between the first half of 1996 and the first half of 1997.

During this same time, the number of total drug episodes increased among those aged 18-25 (11%) and 35 and over (10%). The most frequently recorded reason for a drug-related emergency room visit in the first half of 1997 was overdose, which comprised 49 percent of all episodes. Cocaine-related emergency room episodes 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, yet 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. (Figure 5)

Methamphetamine/speed-related visits to emergency rooms increased steadily between the first half of 1988 and the first half of 1991 fell by 57 percent during the first half of 1996, but are rising again. According to DAWN statistics, they increased 100 percent between the first half of 1996 and the first half of 1997, from 4,200 to 8,400.

Cocaine and Heroin episodes -- generally, the longterm consequences of chronic drug use -- create serious problems for hospital Emergency Departments

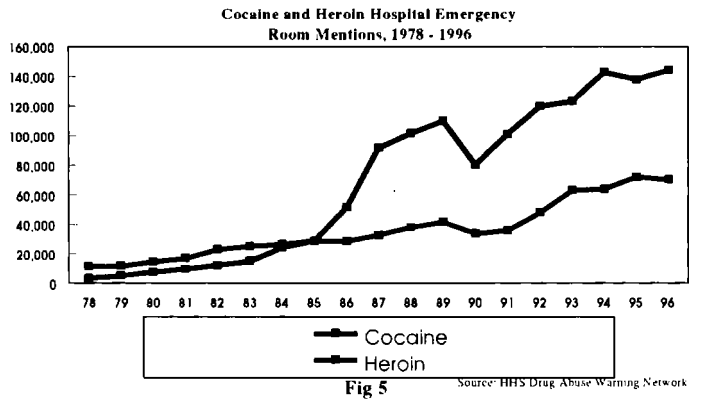


Fig 5 Source: HHS Drug Abuse Warning Network

G. Drug Abuse Affects Business Productivity

According to the 1997 *NHSDA*, 6.7 million current illegal drug users were employed full-time; this number represents 6.5% of full-time workers aged 18 and older. 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; according to a

SAMHSA study released in 1997, *An Analysis of Worker Drug Use and Workplace Policies and Programs*, 12.1 percent did so compared to 6.1 percent of drug-free workers. Illegal drug users get fired more frequently (4.6 percent were terminated within the past year compared to 1.4 percent of non-users). Drug users also switch jobs more frequently; 32.1 percent worked for three or more employers in the past year, compared to 17.9 percent of drug-free workers. One quarter of drug users left a job voluntarily in the past year.

H. Drug Use Closely Linked to Crime and Violence

Crime in general continues to decline in the U.S. The FBI's 1997 *Preliminary Uniform Crime Reports* notes that serious crime has continued its downward trend as indicated by a 4 percent decline from 1996 figures, the sixth consecutive annual decrease in reported crime. Yet arrests for drug-law violations are at record highs. More than 1.5 million Americans were arrested for drug-law violations in 1996. 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.

Research conducted at the Arrestee Drug Abuse Monitoring Program (ADAM) program shows consistently that between one-half and three quarters of all arrestees that were tested in 35 cities around the country have drugs in their system at the time of arrest. About a fifth of all arrestees test positive for more than one drug. About half of those charged with violent crimes or income-generating crimes such as robbery, burglary or theft test positive for more than one drug. Therefore, it is clear that this population is deeply involved in drug use. According to a study in Baltimore, the drug users coming through the court system are highly dependent upon illegal substances as measured by traditional addiction severity instruments

Although the ADAM program found little change in overall drug use among arrestees between 1996 and 1997, these data do not reflect changing patterns of drug use such as an increase in the use of methamphetamine, and the decrease in use of cocaine and marijuana. Cocaine/crack use seems to be declining in most cities, although individual cities have experienced epidemics. Opiate use is more often seen in older arrestees; the exceptions to this are New Orleans, Philadelphia, and St. Louis. Marijuana use, however, is disproportionately concentrated among youthful arrestees.

II. Demand Reduction Goals, Objectives and Target Measurement

A. Demand Reduction – Cornerstone of the U.S. Response

The *National Drug Control Strategy* proposes a ten-year conceptual framework to reduce illegal drug use and availability 50 percent by the year 2007. If the goal is achieved, just three percent of the household Population aged twelve and over would use illegal drugs. This level would be the lowest recorded drug-use rate in American history. Drug related health, economic, social, and criminal costs would also be reduced commensurately. In order to achieve these goals, the *Strategy* call for a comprehensive, balanced approach to the drug problem that involves prevention, treatment, research, law enforcement, protection of our borders, and international cooperation.

But among these approaches, Demand Reduction is the key. The U.S. recognizes that it will never be able to interdict all drugs coming across our borders. Even if we could, substantial amounts of drugs – for example, marijuana and methamphetamine – could still be produced domestically. Nor can we ever arrest our way out of the drug problem. Continuing and expanding demand reduction programs, as well as promoting increased participation by the private sector, are paramount objectives of the *National Drug Control Strategy.*

National Drug Control Strategy
Five Goals

1: Edcuate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.
2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.
3: Reduce health and social costs to the public of illegal drugs.
4: Shield America's air, land and sea frontiers from the drug threat.
5: Break foreign and domestic sources of supply.

Fig 6

B. Foundations of Strategic Goals and Objectives

The *National Drug Control Strategy* outlines five goals (see Figure 6) and thirty-two objectives. These establish a framework for all national demand and supply reduction drug-control agencies. These goals and objectives are intended to orient a national effort that will reduce illegal drug use and availability by 50 percent over the next ten years. It must be stressed that the *Strategy* is

a comprehensive, balanced approach that focuses on shrinking America's demand for drugs, through treatment and prevention, and attacking the supply of drugs through law enforcement and international cooperation. 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; international cooperation to confront drug cultivation, production, trafficking, and use; and research to provide a foundation based on science.

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.

Performance Measurement Framework

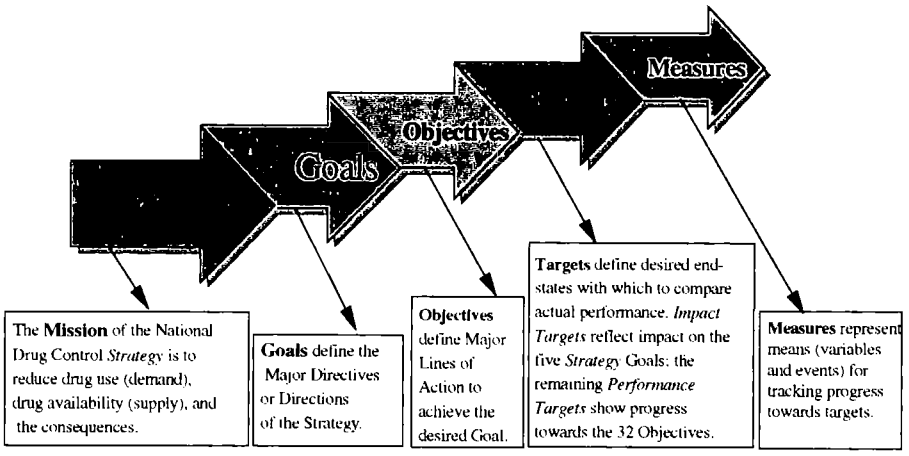


Fig 7

C. Demand Reduction Goals, Objectives and Rationale

Demand reduction is integral to three of the five goals: Goal 1, Goal 2, and Goal 3. Associated with each of these Goals are a number of objectives, targets, and measures. The relationship is shown in *Figure 7* and the following section outlines the objectives for each demand reduction goal.

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 illegal drugs, including 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 federally 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 other drug prevention programs and policies that are evaluated, 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 partnerships with the media, entertainment industry, and professional sports organizations to avoid the glamorization, condoning, or normalization of illegal drugs and the use of alcohol and tobacco by youth.

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

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

Rationale: Drug policy should be based on science, not ideology. We 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: Drug prevention must be research-based. Prevention programs must also take into account the constantly evolving drug situation, risk factors students face, and community-specific problems.

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 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 offenders arrested each year have substance abuse problems, and significant percentages are chronic substance abusers. 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 for inmates 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 adult drug users are employed. Workplace policies and programs, such as drug testing and Employee Assistance Programs that include prevention, intervention, and referral to treatment can reduce drug use.

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

Rationale: Many community-based 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.

D. Principles of U.S. Demand Reduction Effort

Once viewed as essentially a moral problem or character defect, drug use is now more accurately considered a complex behavioral problem with personal, social, and biological underpinnings. Some individuals are at greater risk of drug related problems than are others. Thus, implementing prevention strategies requires awareness of factors that place individuals at increased risk and, conversely, factors that protect individuals from such risk. Similarly, drug treatment and rehabilitation strategies must address factors that foster or hinder entry into, and successful completion of, drug treatment.

America's drug demand reduction strategy takes into account:

- Scientific advances in our understanding of education, prevention, and treatment, which must be reflected in practice;
- Recent setbacks in youth attitudes toward and use of drugs, especially marijuana;
- Pro-use messages sent to our young people by well-organized drug legalization efforts, the media, and other manifestations of popular culture;
- The cost and service reduction pressures inherent in managed health care approaches being adopted by private employers and public programs, which threaten the effectiveness, stability, and continuity of prevention, early intervention, and treatment programs; and
- The shifting of resource allocation decisions and program accountability from the federal to the state and local level.

1. Prevention

Progress in prevention will require significant, long-term change in youth attitudes toward drug use. Such a change in attitudes will depend in large part on a consistent "no use" message from American society, together with predictable negative consequences for use and affirmation of the benefits of abstinence.

Principles. Prevention programs must work at all levels, but especially where they can do the most immediate good -- at the local level. Local leaders must be given the tools to implement and manage effective programs.

- Prevention must be incorporated into the institutions that are closest to our children and our families. It must start with the informed leadership of parents and remain constant and consistent.
- Numerous scientific investigations have established the fact that families play *the most important role* in determining how young people handled the temptations to use alcohol, cigarettes, and illegal drugs. If families are to succeed in preventing substance abuse by children, many parents and children need to develop new behaviors and skills.
- Interrelated, family-focused prevention programs should be conducted in schools, health clinics, faith communities, workplaces, and communities.
- No one approach or program is the answer, but each is part of the answer. Individual programs should be structured to complement one another. They should be viewed and judged in terms of their contribution to the overall, cumulative results in the community.
- Individual programs should be required to incorporate the established results of research and evaluation and held accountable for producing results.
- targeting all forms of drug use, including underage alcohol and tobacco use.
- matching activities to the nature of the problem in the community.
- beginning early in young peoples' lives and continuing with developmentally appropriate interventions.

- providing long-term, intensive efforts for children most at risk, with special attention to appropriate booster sessions during critical life transitions (e.g., middle school to high school).

- reflecting a sensitivity to the specific needs of gender, and particular ages and ethnic and cultural groups.

- assessing and strengthening social norms against drug use.

- imparting drug resistance skills, critical thinking skills, social competency skills, and the needed communication skills to explain and reinforce personal anti-drug commitments.

- maintaining a family focus, with significant parent involvement.

For example, school-based programs must: instill strong social norms against drugs, evoke a commitment to avoid drugs, provide solid drug resistance skills, provide self-management and social skills, recruit peer leaders to work with teachers, and involve parents in a strong leadership role with their children.

The federal government is uniquely equipped to help states, local governments, and communities gather and disseminate information on effective family, school, health provider, faith community, workplace, and community prevention approaches. Provision of information on proven effective approaches, and support for its application must be our highest, short-term, domestic priority. Federal government provision of information about state-of-the-art approaches to prevention is also critical, and must be continuous in response to new research findings.

Treatment Reduces Drug Use

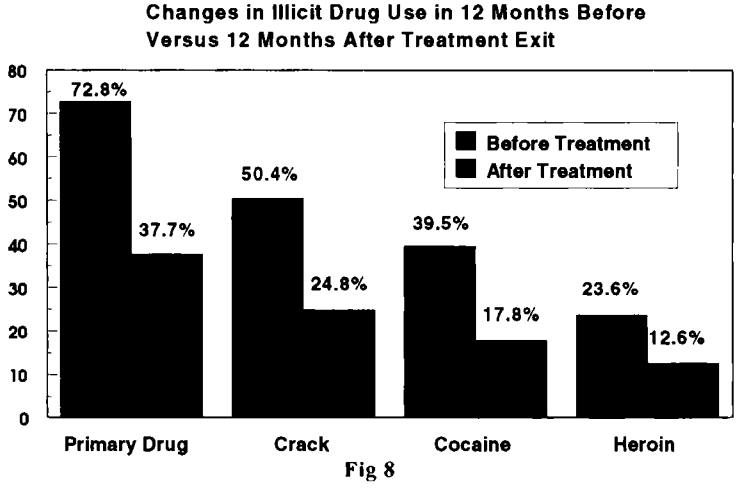


Fig 8

2. Treatment and Rehabilitation Services

Reducing the numbers of addicted persons is also essential to reducing drug demand. While intervention and treatment are

important first steps in accomplishing this goal, many addicts also will require rehabilitation services if they are to achieve stable abstinence and recovery.

Drug addiction is a chronic relapsing condition involving a long-term change in brain chemistry. Drug seeking and using behavior also trains the brain. Addicts are not simply sick people. Rather they are sick people who engage in a web of behaviors that exacts a toll on the health and safety of all society's institutions, starting with the family. Many drug users cannot, and sometimes do not want to, control their behavior. They may resist efforts to bring their actions in line with the requirements of society.

Only the most structured interventions can get chronic users and addicts into treatment, keep them in treatment, provide the supervision and support required to start them on recovery, and enable them to maintain their recovery over the long term. It is progressively more apparent that long-term progress in reducing and managing this population requires a rehabilitation approach that: confronts and exposes thinking errors and the addictive lifestyle, provides for values and character development, matches specific services to specific needs, and continues needed services for a significant period of time.

Intensive (often residential) drug treatment or therapy is essential for many addicts but may be of reasonably short duration. The services that prepare the addict for recovery and support continuing recovery, while much less expensive, are of much longer duration.

- Vocational skills, social survival skills, relapse prevention skills, social supervision and support, medication -- most of these will be necessary to some extent, and for a long period of time, to allow the continuation of the process that begins with intensive treatment.

- During this transitional, or "aftercare," period self-help groups, social model programs, faith-based programs, and other nonprofessional groups can offer the structure, sanctions, and support that are so critically needed.

Principles. Given the chronic relapsing nature of addiction, the consequences of addictive behavior for the individual, the family and society, and given the condition of existing service systems, our efforts to rehabilitate and assist people with addictive disorders are governed by the following principles:

- We must take full advantage of any opportunity to get addicts into a formal treatment and rehabilitation program.

  - The criminal justice system offers an immediate opportunity to engage significant numbers in treatment and long term rehabilitation;

  - The child welfare system offers a similar opportunity — most drug dependent mothers can be motivated and helped to act in the interest of their children. Since the children who are involved in the child welfare system are also at high risk for substance abuse, such involvement also offers an opportunity to prevent future substance abuse by providing these children with needed therapeutic and supportive services.

- Existing criminal justice and child welfare systems of treatment and rehabilitation should be expanded and

systematic support and referral systems should be developed for workplaces and health care service settings.

- All treatment programs should employ a comprehensive assessment instrument at the point of intake, and to update that assessment periodically during the course of treatment and recovery. Programs should assess progress and respond to lack of progress.

- All treatment programs should develop a formal, long-term rehabilitation plan, in accordance with the results of the assessment; and review and revise it in accordance with periodic assessments. This should include the initial intensive therapy and pharmacology and the longer-term recovery plan.

- All formal treatment interventions should include specific, realistic relapse prevention training and compliance motivation training, during the initial course of treatment and as a continuing part of recovery.

- Consequences for non-compliance should be established clearly; they should be graduated and employed swiftly and fairly.

- Treatment programs should be held accountable for results in light of the relative difficulty of the population they serve, as determined by the initial, comprehensive assessment.

- A supervision and support person or organization should be designated for each person who completes the initial stage of treatment, to manage and supervise and ensure continuing compliance with the recovery plan.

The federal government plays a leadership role in assisting the states to establish systems of rehabilitation. Federal treatment programs, such as those in the Department of Veterans Affairs and the Federal Bureau of Prisons, can lead by example. Grant-in-aid programs, supported by the Departments of Health and Human Services and Justice, provide explicit guidance and assistance to states and localities.

3. Focus on the Criminal Justice System

The nexus between drug use and the criminal justice system is clear. As Arrestee Drug Abuse Monitoring (ADAM) statistics show, between one half and three quarters of all arrestees tested in the 35 ADAM cities have drugs in their systems at the time of their arrest. Not only are these arrestees deeply involved in drugs, many are severely addicted, and few have ever been in treatment. Furthermore, frequent drug users who are involved in the criminal justice system are responsible for consuming a significant portion of the illegal drugs consumed in this country.

Reducing drug use among the criminal justice population not only contributes significantly to the overall goal of reducing drug use by half by 2007, it also goes a long way to reducing crime in America. The treatment needs of the population under control of the criminal justice system should be based on four principles:

- *Treatment works.* Not all treatment works equally well for all populations, and relapse is to be expected. However, we are striving to be more accurate in matching treatment to drug users, and hope to differentiate treatment settings that are appropriate for juveniles, for

poly-drug users, for those with co-occurring substance abuse and mental disorders, and for different, and for different cultural and ethnic groups. Scarce treatment resources have to be allocated according to the best match between participant and provider, based on scientific evidence of effectiveness and solid diagnostic profiles of clients.

- *Coerced Treatment Works.* Addiction is a brain disease, but one that often results in criminal behavior. Treatment of addiction requires management of behavior, and the criminal justice system can provide "incentives" for an addict to change behavior, such as rewards and sanctions. It should be noted that coercion also includes the threat of losing a job or a relationship.

- *Length of time in treatment is correlated with success.* Drug use for individuals who participated in either long-term residential or outpatient treatment programs showed reductions in both criminal activity and drug use, especially those who had been in treatment for at least 90 days. Research also shows that the presence of criminal justice supervision increased the likelihood that the individual would stay beyond the 90-day mark.

- *Post-release supervision is an essential ingredient to successful prison-based treatment.* Results of an evaluation of Delaware's Key-Crest Program, those prisoners who participated in a transitional work release program after in-prison drug treatment were more than twice as likely to remain drug free, and were one-third more likely to remain arrest free eighteen months after release.

E. Providing Greater Accountability: Performance Measures of Effectiveness (PME) System

The pursuit of Strategy Goals and their associated Objectives is expected to yield measurable outputs and outcomes designated as "performance targets." The Administration's *National Drug Control Strategy* PME system recognizes that performance measures must (1) assess the *Strategy's* overall impact on drug use, availability, and consequences, and (2) assess the effectiveness of specific federal, state, local and private sector programs and activities that constitute the national drug control effort. Measures are the means for tracking progress toward the targets. Ultimately, data for the measures will be provided by the federal, state, and local drug control agencies.

The Impact Targets, designed to reduce drug use, availability, and drug use consequences, establish desirable outcomes or end-states by defining where the nation should aspire to be, a decade from now. Five Impact Targets are provided for demand reduction efforts and two are provided for reducing the adverse health and crime consequences of drug use. These aggressive targets are intended to motivate federal, state, local, foreign, and private partners in drug control to reduce supply and demand to levels that are realistically achievable in the future.

1. Demand Reduction

In the area of ***total demand reduction***, we propose *a 25 percent reduction by 2002 in the overall rate of illegal drug use in the United States below that of the 1996 base year. By 2007, the target is a 50 percent*

reduction in the rate of overall drug use below that of the 1996 base year. In 1996, the current (i.e., past month) rate of drug use across the United States was 6.1 percent. The targeted 50 percent reduction would yield a nation-wide drug use rate of 3.1 percent by 2007. The 3.1 percent rate would be the lowest verified rate since the federal government began systematically tracking such data. This ambitious undertaking is contingent on a long-term commitment by federal, state, local, foreign, and private partners in drug control to achieve the Goals and Objectives of the Strategy.

The Impact Target for overall drug use requires success in the following three key areas: drug use by our nation's youth; drug use in the workplace; and drug use by chronic drug users.

- Focus on Youth: Two Impact Targets are related to current (past month) youth drug use. The intent is to delay the onset of drug use, as measured by the mean age of drug use. *By 2002, increase the average age of first-time drug use by 12 months from the average age of first-time use in the 1996 base year. By 2007, increase the average age of first-time drug use by 36 months from that in the 1996 base year.* To illustrate the value of reducing first-time drug use, consider the mean age for first- time use of marijuana (16.7 years). If a youth approaches the age of 20 without having tried drugs, the chances of becoming a drug user are much lower. Delaying the initial use of drugs such as marijuana by 36 months would, in turn, set the mean age of initial use at a high enough level to allow a larger percentage of the population to approach the "20 and older safety- zone." The PME system will use average age of first-time use of marijuana as a proxy measure to track progress toward the target of delaying the onset of drug use. Achieving this ambitious target would clearly demonstrate the nation's progress toward shutting down the pipeline of youth drug use.

  The Strategy also must have an impact on overall youth drug use prevalence. *By 2002, reduce the prevalence of past month use of illegal drugs and alcohol among youth by 20 percent as measured against that in the 1996 base year and by 2007, reduce the prevalence by 50 percent as compared to that in 1996.* To measure progress toward this target, we propose to use information collected annually in the National Household Survey on Drug Abuse on current use of any illegal drugs by youth aged 12-17. In 1996, the prevalence of drug use in the 12-17 age group was 9.0 percent. A 50 percent reduction from the 1996 base year incidence rate moves toward a targeted use rate in 2007 of 4.5 percent. Achieving this critical Impact Target by 2007 would mean that the nation would have the lowest rate of drug use among those aged 12-17 since record keeping on youth drug use began.

- Focus on the Workplace: Approximately 74 percent of drug users are employed. Targeting the workplace with drug prevention and education programs will reduce overall drug use and protect the health, safety, and productivity of the American worker. *By 2002, reduce the prevalence of drug use in the workplace by 25 percent compared with that in the 1996 base year and by 2007, reduce prevalence by 50 percent compared with that in 1996.* This target focuses on users who are not necessarily chronic drug users. The workplace offers an

opportunity to reach these users. In 1996, the total full-time workforce population was 99 million with a current drug use rate of 6.2 percent or approximately 6.1 million drug users. The rates were 8.6 percent for those employed part-time and 12.5 percent for those actively seeking work. To measure progress toward this target, we propose to use the National Household Survey on Drug Abuse, which reports current use of any illegal drugs for those employed full-time or part-time or who are actively seeking work. When the 1996 rates are reduced by half, drug use among those who are employed full-time will drop to 3.1 percent, a reduction of three million drug users. The rates for those employed part-time or unemployed will drop to 4.3 percent and 6.3 percent, respectively. Achieving these targets will substantially enhance productivity and safety in the workplace.

- Focus on Chronic Drug Use: Chronic drug users consume the vast majority of available drugs in the United States. Unless their demand is substantially reduced, drug traffickers will continue to enjoy a long-term, stable market in which to provide their products. While supplying these users, suppliers will entice others to begin using drugs. If the nation's demand for drugs is to be broken, chronic drug users must be targeted aggressively. *By 2002, reduce the number of chronic drug users by 20 percent compared with that in the 1996 base year and by 2007, reduce the number of chronic drug users by 50 percent compared with that in 1996.* The Department of Health and Human Services (HHS) estimates that there are at least 3.6 million chronic drug users who could benefit from drug treatment. Though this estimate is subject to revision as newer and better modeling techniques are developed, meeting this Impact Target within 10 years would reduce the number of chronic drug users to 1.8 million by 2007. A decline of this magnitude in the number of chronic drug users would result in a significant reduction in the overall demand for drugs. In addition, these users place the greatest burden on society in the form of health and social costs.

2. Drug Use Consequences

In the area of drug use ***consequences***, we aim to reduce the substantial damaging health and social costs stemming from drug use, including those from drug-related crime. These costs are estimated to be $110 billion annually with a large share being crime-related. We target two principal areas to reduce the health and social costs of drug use: crime and violence and health costs.

- Focus on Crime and Violence: Reducing drug use, especially chronic drug use, can do much to reduce drug-related crime. Drug-related crime is not limited to highly publicized violent crimes. Drug use also spawns many other types of crime including corruption, prostitution, domestic violence, money laundering, forgery and counterfeiting, embezzlement, and weapons violations. Domestic law enforcement must aggressively target traffickers to mitigate the violence that surrounds the drug trade and decrease the entire range of drug-related crime. *We propose by 2002, to reduce by 15 percent the rate of crime and violent acts associated with drug trafficking and drug abuse, as compared with the 1996 base year, and by 2007, to reduce drug-related crime and violence*

by 30 percent, as compared with the base year. In 1996, the rate of arrests for drug law violations was 594 per 100,000. Reducing this rate by 30 percent over 10 years to 416 per 100,000 arrests will significantly increase the safety of our nation's streets.

- Focus on Health: Drug users engage in high-risk behaviors making them and their associates susceptible to a range of infectious diseases such as tuberculosis (TB), HIV/AIDS, and hepatitis. Drug use also contributes to birth defects and infant mortality, undermines workplace safety, and leads to premature death. *We propose by 2002, to reduce health and social costs attributable to illegal drug trafficking and use by 10 percent, as expressed in constant dollars, as compared to the 1996 base year, and by 2007, to reduce such costs by 25 percent as compared to the base year.* To illustrate the implication of this Impact Target, consider the following example: According to the Centers for Disease Control and Prevention, 1,919 cases of TB reported in 1996 were related to drug use (11.5 percent of all cases reported). Achieving the Impact Target would reduce this figure to 1,727 in 2002 and to 1,439 in 2007.

F. Federal Government Commitment to Demand Reduction

Many of the approximately fifty federal agencies involved in the drug control effort are engaged in demand reduction programs. These include the Department of Health and Human Services, the Department of Transportation, the Department of Justice, the Department of the Treasury, the Department of Education, the Department of Labor, the Department of Housing and Urban Development, the Department of Veterans Affairs, the Department of the Interior, the Department of Defense, and numerous sub-cabinet agencies, such as the Small Business Administration.

The President's FY 1999 budget sought $5.9 billion for demand reduction programs and related research, the largest percentage increase in the drug budget. Since 1986, support for demand reduction has increased nearly seven-fold. As a percentage of the overall federal drug budget, demand reduction has increased from 30 percent in 1986 to 34 percent in FY 1999.

Included are federal resources targeted to state and local governments and private organizations that provide demand reduction and supply reduction programs in our nation's communities. Approximately one-quarter of the federal government's drug control resources are for grants-in-aid or other forms of assistance to state and local governments and private entities, where they complement local resources for drug control programming.

G. Private Sector Involvement Critical to Demand Reduction Effort

The *National Drug Control Strategy* recognizes that the federal government is not the sole financier of the national anti-drug effort. A national-level strategy requires a national-level effort. To achieve the *Strategy*'s Goals, responsibility must be shared among all levels of government and the private sector — federal, state, local and private entities. These entities, involved in our national drug control effort, must join

together to reduce drug abuse if the *Strategy*'s Goals are to be achieved.

By providing management objectives, The *National Drug Control Strategy* provides a framework by which communication between the federal government and its partners in drug control can be improved. It remains the federal government's objective to ensure that resources provided to our partners have few strings attached so that our partners have maximum flexibility in determining how best to use federal funds in achieving *Strategy* Goals and Objectives. At the same time, the requirement for increased accountability and improved performance means that partners must work cooperatively with federal agencies.

III. United States Efforts to Reduce Demand for Drugs

A. Prevention

1. National Youth Anti-Drug Media Campaign

Changing Youth Attitudes and Behavior: Beginning in 1998, ONDCP launched a 5-year, two billion dollar multi-media campaign, designed to change the attitudes of young people toward illegal drug use, as well as educate parents and other adults about their roles in preventing drug use. In fiscal year 1998 the Congress appropriated $195 million to begin the campaign and has continued the program with a $185 million appropriation in FY 1999. From its initial test phase in twelve American cities, the campaign grew into a full-fledged national campaign in July.

A targeted, high impact, paid media campaign emphasizing advertising -- at both the national and local levels -- is the most cost effective, quickest means of changing drug use behavior through changes in adolescent perceptions of the danger and social disapproval of drugs. It is also the most cost-effective means of reaching baby-boomer parents who may be ambivalent about sending strong anti-drug messages to their children. Although public service messages (PSAs) are part of this campaign, it is impossible to reach the specific audiences at the times and with the frequencies that are required to move drug use attitudes with PSAs alone. The entertainment industry, Internet, and corporate participation and corporate involvement components of their campaigns will support and enhance the impact of advertising. Messages and other activities are linked to existing anti-drug efforts at the community level where possible.

National Youth Anti-Drug Media Campaign

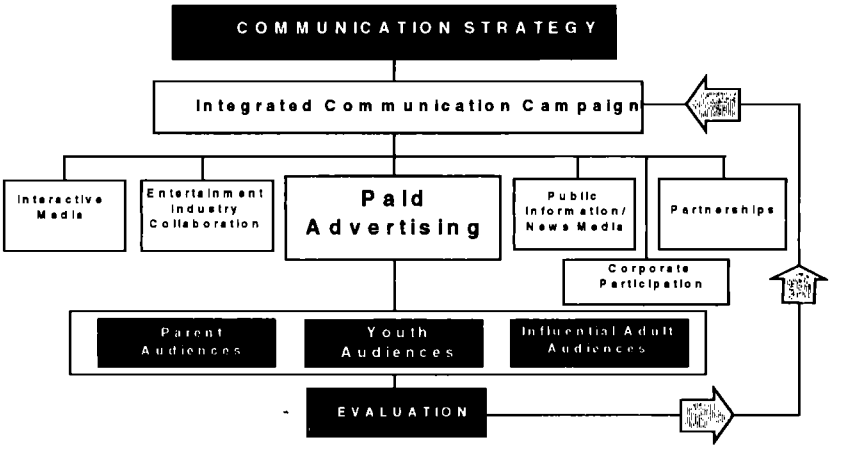


Fig 9

The objectives of ONDCP's campaign are aggressive. Although research indicates that it will take two to three years to achieve measurable changes in youth attitudes and behavior, an ONDCP study of the results of the 12-city test phase of the campaign focused on initial changes in parent and

youth awareness of anti-drug messages. Findings resulting from qualitative data, collected through site visits at 12 target and 12 comparison sites at baseline and about 12 weeks after the Campaign was introduced, show that parents are eager to learn more about how to educate their children about the dangers of drug use, and that youth in the target sites have seen and heard the Campaign ads.

- 12 weeks into the Campaign, youth in target sites had 3 times greater awareness of anti-drug ads than did comparison site youth.

- Parents in the target sites reported that the anti-drug ads provided valuable information about the drug problem, including how to obtain more information and the importance of educating their children about the dangers of drug use.

- Most parents in the target sites reported that the anti-drug ads had stimulated discussion between them and their children about drugs.

- During the Campaign, 3.7 times more of the target audiences in the target sites were exposed to anti-drug ads than in the pre-Campaign period; this demonstrates that the use of paid advertising and the pro bono match requirement has increased the frequency of youth and parent exposure to anti-drug ads.

- 12 weeks into the Campaign, the number of anti-drug ads appearing in the target sites increased an average of 123 percent. Cities with greatest increases included: Washington, DC (279 percent increase), Houston (246 percent increase), and San Diego (224 percent increase).

Since the campaign expanded in July 1998 to national coverage, the following demonstrated the popularity of the campaign and attested to its ability to mobilize important media groups.

- **Message frequency and reach:** The campaign goal of four message exposures per week seen by 90 percent of the teen audience is being met. For African American teens the rate is 4.3 messages per week and 92 percent of the target audience. When matching contributions from the media are factored in the frequency and reach for the general population is 6.8 per week by 95 percent; for African Americans it is 7.7 per week by 95 percent.

- **Unprecedented matching contributions by media outlets:** An additional 107 percent in public service time and contributions from national and local media has been generated in areas where ads were purchased, more than doubling the benefit derived from public funds.

- **Outstanding creative support from networks:** Network television has been particularly responsive and is becoming more sensitive to depiction of youth drug use issues in their series. Over 20 network episodes, including major series, have been developed and broadcast. Six broadcast and cable networks have produced their own public service messages using the top stars in their programs.

- **Parent requests for information up 88 percent:** Although only 10 percent of current ads show toll free numbers, contacts to the National Clearinghouse

for Alcohol and Drug Abuse (NCADI) are sharply higher and will continue to increase further when new ads, which will contain contact numbers,air in early 1999.

- **Ads being developed in 11 languages:** This campaign represents the federal government's largest ethnic and minority communications effort. When Spanish language ads first aired in late August 1998, Hispanic callers to NCADI jumped from an average of 3-4 per day to 40 per hour.

- **Web site "hits":** ONDCP's drug prevention web site for youth and parents launched July 9, 1998, now has an average of 177,000 "hits" per month, and the site is still in its testing phase.

2. Mobilizing Community Anti-Drug Coalitions

The community-based anti-drug movement in this country is strong, with more than 4,300 coalitions already organized. These coalitions are significant partners for local, state, and federal agencies working to reduce drug use, especially among young people. Coalitions typically include schools, businesses, law enforcement agencies, social service organizations, faith communities, medical groups, local and county government, and youth groups. Coalitions develop plans and programs to coordinate anti-drug efforts for the benefit of communities. In many locations, integrating efforts have created comprehensive prevention infrastructures that reduced drug use and its consequences. Such groups have the ability to mobilize community resources; inspire collective action; synchronize complementary prevention, treatment, and enforcement; and engender community pride.

The Drug-Free Communities Program: Congress enacted the Drug-Free Communities Act of 1997 to provide modest grants to community anti-drug coalitions. $20 million is authorized for FY 1999, $30 million for FY 2000, $40 million for FY 2001 and $43.5 million for FY 2002. The program is designed to strengthen community-based coalition efforts to reduce youth substance abuse by bringing together family, school, the faith community, civic and business groups, the law enforcement and criminal justice systems, and the medical community. This systems approach to the reduction of substance abuse is a research-based strategy that has had positive results in many communities.

In October 1998 the President appointed an 11 member Advisory Commission on Drug-Free Communities to advise, consult with, and make recommendations to the ONDCP Director concerning activities carried out under the program The Justice Department's Office of Juvenile Justice and Delinquency Prevention (OJJDP) administers the program through interagency agreements with the Office of National Drug Control Policy (ONDCP). The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) is providing training and technical assistance through the Centers for the Application of Prevention Technologies (CAPTs). Additionally, OJJDP is conducting an evaluation of the Drug-Free Communities Support Program, which will determine whether the two major goals of strengthening community coalitions and reducing substance use among youth have been reached.

In 1998, building upon the existing coalition movement, the first grants were awarded to 93 coalitions in 46 states. In 1999 ONDCP and OJJDP will jointly solicit a second round of program applications from communities nationwide to strengthen existing coalitions and expand their number across the nation.

3. Drug-Free Schools and School Coordinator Programs

Prevention in Schools: As the number of "at-risk" children increases in our country over the next five years, resources must be made available to expand school-based drug prevention programs to keep pace with those increases. The Department of Education's Safe and Drug-Free Schools Program (SDFSP) is the only federal drug prevention program intended to reach all school-age children. It provides funds for virtually every school district to support drug and violence-prevention programs and to assist in creating and maintaining safe learning environments. It represents a major investment in our youth and is funded at a level of $531 million in FY 1999 with $441 million for formula grants and $90 million for national programs. Overall, the program has focused on ensuring that SDFSP fund recipients (governors, state education agencies, local education agencies, and community groups) adopt programs, policies, and practices that are based on research and evaluation. In 1998, the Department of Education implemented Principles of Effectiveness for the program. These Principles will help grantees use program funds more effectively. These Principles of Effectiveness state that a SDFSP grant recipient must:

- Base its programs on a thorough assessment of objective data about the drug and violence problems in the schools and communities served;
- With the assistance of a local or regional advisory council, establish a set of measurable goals and objectives and design its programs to meet them;
- Design and implement its programs based on research or evaluation that provides evidence that the programs prevent or reduce drug use, violence, or disruptive behavior among youth; and
- Evaluate its programs periodically to assess progress towards achieving its goals and objectives, and use its evaluation results to refine, improve, and strengthen its programs and refine its goals and objectives as appropriate.

The Department of Education is also developing an Expert Review Panel to help identify promising or exemplary drug and violence prevention programs.

In October, 1998 President Clinton announced his plan for the re-authorization of the Safe and Drug-Free School Program to provide more effective prevention programs for the reduction of drugs and violence in schools, more accountability for results, and better targeting to those schools that need the most assistance. These changes include:

- Increasing funding for effective plans and strengthening accountability. Under the proposal, federal funds will provide support to school districts with demonstrated need and a commitment to adopt a rigorous, comprehensive approach to drug and violence reduction and prevention.

- Creating incentives to develop comprehensive and results-oriented plans. Districts will be expected to use relevant drug and violence data to develop a comprehensive plan -- in consultation with parents, teachers, students, law enforcement officials, mental health providers and other members of the community -- to do the following:

- Adopt and enforce, clear and fair discipline policies, such as zero tolerance policies for guns and drugs, and parent notification and involvement.

- Provide effective anti-drug and violence prevention programs, including programs that teach responsible decision-making, mentoring, mediation, or other activities aimed at changing behaviors. Funded activities must demonstrate effectiveness in helping to create a drug-free and safe learning environment.

- Collect data and report to the public the results by providing annual report cards on the number and type of school-related drug and/or violence incidents.

- Assess and intervene for troubled youth through procedures to identify students for evaluation and counseling; training for teachers and staff; and providing linkages between district officials, mental health, and other community professionals where appropriate.

- Connect to after-school activities for youth to extend the school day and/or develop links to other after-school programming, and help provide children with meaningful connections to responsible adults in the community.

- Develop plans for crisis management, such as drug overdoses. The plan must also address assistance for victims, contacts with parents, law enforcement, counseling, and communication wit the media.

School Coordinator Program: In FY 1999, the Congress provided $35 million to launch the Administration's School Coordinator Program. This program will support the hiring of drug prevention coordinators in middle schools across the country to help improve the quality and effectiveness of drug prevention programs. Drug prevention coordinators will be responsible for developing, conducting and analyzing assessments of their school's drug problems; identifying promising research-based drug prevention programs to address those problems; assisting teachers, coaches, counselors and other school officials in adopting and implementing those programs; working with the community to ensure that the needs of students are linked with available community resources; and identifying alternative funding sources for drug prevention initiatives. The drug program coordinators will assist parents, youth, and school officials to identify community resources and to strengthen the role of parents in school settings. This program will also require coordinators to provide feedback to state educational agencies on programs that have proven to be successful in reducing drug use among school-aged youth.

Post-secondary Education: Illegal drug use and the abuse of alcohol and tobacco also are serious problems on our college and university campuses. In the 1997/1998 academic year, several students died as a direct result of binge drinking, and many

more were admitted to hospitals for treatment of alcohol-related injuries and alcohol poisoning. In 1998, the Department of Education has led efforts to identify those programs and activities that have been successful in reducing alcohol and drug use on college campuses. The Department of Education also provides funding and technical assistance to a limited number of colleges and universities so they can adopt those programs that have been identified as successful.

4. Parenting and Mentoring Initiative

Research by the National Institute on Drug Abuse (NIDA) and the Center on Addiction and Substance Abuse at Columbia indicates that if parents would simply talk to their children regularly about the dangers of illicit drugs, alcohol, and tobacco, drug use among youth could be substantially reduced. Data suggests that parents can be the most powerful influence on youth, and we know that children who do not receive adequate supervision and attention are the most likely to engage in anti-social and risky behaviors, including drug use and drug trafficking.

Likewise, effective drug prevention programs require strategies which provide youth with role models and life skills that help to reduce the likelihood of the initiation of alcohol and drug use. This has been demonstrated through studies which reflect the powerful impact a concerned and caring adult can have on a young person's life. For example, a Big Brothers/Big Sisters study of mentoring programs has shown a 46 percent reduction in the initiation of drug use and a 27 percent reduction in the initiation of alcohol use.

Family-Centered Approaches to Keeping Children Drug-Free: A systematic review of current research on the family's role in reducing substance abuse among youth has established that families play *the most important role* in determining how young people handle the temptations to use alcohol, cigarettes, and illegal drugs. The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention has produced a compilation of the family-centered approaches which have been proven effective for specific populations. Second in its Prevention Enhancement Protocol System (PEPS), the *Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches* publication includes three specific documents: a comprehensive reference guide; a practitioner's guide; and a community guide.

Raising Awareness of Parents and Mentors: The *1998 National Drug Control Strategy* has as its first goal to "Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco." Objective 5 of this goal seeks to "support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modeling behavior to be emulated by young people." Through an interagency agreement with ONDCP, the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, is implementing a number of efforts to organize, train, motivate, and raise the awareness of parents and adult mentors to assist them to help children and youth remain drug-free.

Your Time - Their Future: This campaign was developed by the Substance Abuse and

Mental Health Services Administration as part of the Department of Health and Human Services Youth Substance Abuse Prevention Initiative. Your Time - Their Future highlights the importance of structured positive activities, such as playing sports, collecting stamps, or playing a musical instrument, in helping youth resist alcohol, tobacco, and illicit drugs. The Campaign encourages adults to become involved in volunteering, mentoring, and other efforts that help young people ages 7-14 participate in positive activities that build life skills, self-discipline and competence. The four informational guides contained within this Campaign are:

- Positive Activities - A Campaign for Youth
- Get Involved in Someone's Future - A Guide to Volunteering With Young People
- Your Time - Their Future: Membership-Based Groups Provide Positive Activities
- Your Time - Their Future: Positive Activities Promote a Productive Workforce

A pilot evaluation study will be conducted to track the Your Time - Their Future Campaign. The purpose of the study is two-fold. Process evaluation will document the implementation of Campaign materials and messages. Outcome evaluation will determine whether there was an increase in public awareness about, knowledge of, and willingness to participate in positive skill-building activities.

"Parenting IS Prevention" Program (PIPP): Under an interagency agreement with the Office of National Drug Control Policy and other federal partners, CSAP has worked to strengthen and mobilize existing anti-drug programs to assist parents and other caregivers to help children and youth remain drug free. Training and technical assistance to motivate and mobilize communities are underway, with more than 200 representatives of large, medium and small-sized communities already trained. In addition to training/technical assistance, PIPP maintains an information referral service, an interactive PIPP website (http://www.emory.edu/NFIA/PIPP/) and works closely with the media to feature messages that promote parent-focused youth substance abuse prevention efforts.

5. Youth Drug Prevention Research (NIDA)

National Initiative on Drug Abuse Prevention Research: NIDA-supported science research has made significant strides in the past year to further our understanding of drug abuse prevention. The total NIDA funded research portfolio represents a major investment in health research. For FY 1999, NIDA is funded at $634 million, almost one quarter of all Department of Health and Human Services drug-related funding.

Several of these studies illustrate the importance of the collaboration between research-based prevention programs, communities, and families in protecting the future of our youth. The Midwestern Prevention Project in Indianapolis evaluated the effects of a multi-component community-based drug abuse prevention program on 3400 students from 57 junior high schools. Study results showed that participation in the

prevention program significantly decreased drug use among users of tobacco, alcohol, and marijuana. The study counters a commonly held belief that primary prevention works only with non-users or occasional users. Parents and families play the major role in drug abuse prevention, however. A study on parental and family risk factors for substance use by inner-city African-American children and adolescents confirmed expectations that positive parental and family characteristics protect children and adolescents against future drug use risk by enhancing negative drug attitudes. Another study enrolled parents in a drug abuse prevention education program and found that participation in the program not only increased communication about drug abuse issues but also increased proactive communications and decreased negative interactions in general between those parents and their children.

NIDA has published the first research-based guide to preventing young people from using drugs. The guide, "Preventing Drug Use Among Children and Adolescents: A Research-Based Guide," is organized around 14 prevention principles distilled from research on effective prevention techniques and notes that every dollar spent for effective prevention programs can save $4 to $5 in the costs of treatment and counseling.

6. Improving State Planning for Prevention

Despite increases in funding for drug control programs over the past decade, the incidence and prevalence of youth drug use has increased. Prevention programs must be responsive to local needs, but also must support proven prevention methods in order to be effective. SAMHSA/CSAP's State Incentive Grant (SIG) programs help states to implement such programs. These competitive grants support science-based prevention by requiring each grantee state to direct 85 percent of the grant award to community-based substance abuse prevention. The SIG program serves as an incentive for Governors to leverage and/or redirect prevention funding streams and develop and implement comprehensive plans for a more strategic allocation of prevention funds. FY 1999 funding, requested in the President's budget, totaled $65.7 million for 21 Incentive Grants.

7. Civic Alliance: Prevention Through Service

On November 15-18, 1997, the Substance Abuse and Mental Health Services Administration hosted a conference launching the ONDCP *Civic Alliance: Prevention Through Service* initiative. This meeting was attended by more than 45 national and international civic and service organizations and provided a range of education, training, and networking opportunities addressing all aspects of drug abuse prevention, with a focus on outreach to youth, their parents, and other care givers through parenting and mentoring efforts.

Highlighting the meeting's training function was a media literacy training session for youth. The meeting also included round table discussions and sessions by leading federal partners on the latest developments in drug abuse prevention, including the physiology of addiction and the National Youth Anti-Drug Media Campaign. Training on community and volunteer mobilization was provided, with a focus on parenting and mentoring.

Thirty-three national civic and service organizations, representing more than 55 million volunteers, signed the *Prevention Through Service Alliance Resolution Agreement.* At the signing, ONDCP Director Barry R. McCaffrey praised the organizations for their promise to volunteer one million hours. He emphasized the importance community groups, which he characterized as "the heart and soul of America," had in reaching out to youth. On April 28, 1998, with the encouragement of Vice President Gore, an additional five groups joined the original 33 national organizations joined as signatories so that the Alliance now includes 38 groups representing over 62 million members.

ONDCP and SAMHSA, as well as the other federal prevention partners, continue to provide support in terms of training opportunities, resource and programmatic materials, and other assistance as needed to the Alliance as it implements its action plans and recruits new Alliance members.

8. Reducing Youth Use of Tobacco and Alcohol and Marijuana

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. This includes limiting youth access 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. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and SAMHSA/CSAP are examining possible causal relationships between exposure to alcohol advertising and alcohol consumption among youth. The National Highway Traffic Safety Administration (NHTSA) and the Office of Juvenile Justice and Delinquency Programs (OJJDP) are addressing alcohol and drug-related crashes among young people in support of the President's "Youth, Drugs, and Driving" initiative. NHTSA is providing law enforcement, prosecutors, and judges with training and education for detecting, arresting, and imposing sanctions on 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 working to increase 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 conducted 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, is 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 Clinton 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.

HHS Secretary's Initiative on Youth Substance Abuse Prevention: This initiative, created under the leadership of HHS Secretary Donna Shalala, is guided by the first goal of the President's 1998 *National Drug Control Strategy*. That goal is to "educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco." There are three major components: 1) Leverage and Mobilize Resources; 2) Raise Public Awareness and Counter Pro-Use Messages; 3) Measure Outcomes. Projects under these headings are conducted in collaboration with other Federal agencies, States, communities, and private partnerships.

Reality Check: To address the dramatic increase in marijuana use by youth, the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention has developed a nationwide effort to prevent and reduce the growing problems associated with marijuana use among 9 to 14 year-olds. The Campaign addresses the issues of perception and use of marijuana at the community level. Efforts have been made to change community attitudes/practices, to develop credible and effective education programs, and to galvanize support for changing community norms regarding the use of marijuana. To date, the Campaign has placed lighted posters in more than 300 malls throughout the country and 200 regional grocery and department stores.

9. Youth Athletic Initiative Against Drugs

In June of 1998, ONDCP launched the "Athletic Initiative Against Drugs." The purpose of the initiative is twofold: first, to mobilize the athletic world to educate children about the dangers of drugs and provide them with positive opportunities to keep them away from drugs; second, to ensure that the message the athletic world sends our children about drugs is a positive one -- "If you use, you lose. Be a winner."

Mobilize the Athletic World: The first National Coachathon Against Drugs week was held in 1998. Coaches were asked to spend ten minutes or more, at least once during the week, talking about the dangers of drugs to their players and students. With DOJ, ONDCP has published and mailed out 100,000 *Coaches Playbooks Against Drugs* to coaches across the nation. Events took place all week all across the nation. The kickoff was held with Major League Soccer at their championship in Los Angeles. The anchor event was a basketball clinic in D.C. with leading college coaches.

Public Service Announcements (PSAs) in Stadiums: In the Initiative's first year, 17 major league baseball teams showed anti-drug PSA spots on their "jumbotrons" during the season. NFL teams are now showing PSAs. ONDCP is developing a program with the NHL to show PSAs at all games.

NCAA National Youth Sports Program: Working with Department of Housing and Urban Development (HUD), ONDCP secured additional anti-drug money for this NCAA youth education program, which provides a sports summer camp, tied with anti-drug and pro-learning courses, to over 68,000 at-risk kids across the nation.

Coaching and Youth Programs: ONDCP is working with organizations (e.g., Boys and Girls Clubs) and corporations (e.g., Nike) to help them incorporate anti-drug education into their coach and youth training programs.

Get Drugs Out of Sports: ONDCP has launched a public and private diplomacy effort to ensure that this round of NBA bargaining addresses the problem of drugs in the sport. ONDCP's efforts helped the International Olympic Commission (IOC) to enact a new prohibition on marijuana. ONDCP is participating in the IOC's current effort to strengthen its anti-doping program. In addition to addressing the performance enhancing drug issue, the goal is to make the Olympics drug-free (including non-performance enhancers, such as Ecstasy). ONDCP is working in cooperation with the USOC leadership to help our Olympic program strengthen its domestic anti-doping program.

10. National Guard Drug Demand Reduction Program

The National Guard is uniquely qualified to provide support to the efforts of the community-based anti-drug organizations. Located in over 3,200 communities in all 54 states and territories and working in combination with over 3,900 coalitions, the Guard has provided, since 1989, vital support to a wide variety of demand reduction missions by providing resources and personnel who serve as facilitators, trainers, speakers, mentors, planners, volunteers, and role models. These citizen-soldiers serve on over 2,500 local, state, and national coalitions whose only mission is the prevention of substance abuse.

The National Guard Drug Demand Reduction Program, in partnership with communities, coalitions and organizations, reaches millions of young people in the country to help educate and motivate them to reject illegal drugs. In FY1998, the National Guard spent over $12.5 million to support over 8,600 missions reaching over 11.7 million people. These missions support parents, community coalitions, and law enforcement agencies serving youth prevention programs aimed at youth between the ages of 5-18.

The Guard supports the "Red Ribbon Campaign;" Junior ROTC programs; Adopt-A-School programs; National Youth Sports Program camps; Boys and Girls Clubs; Kids and Cops program; Drug Abuse Resistance Education (DARE); Drug Education For Youth (DEFY); Big Brothers/Big Sisters program; Youth Academies; and Police Athletic League programs.

B. Treatment

1. Close the Public System Treatment Gap

Although treatment services are available to more people today than ever before, ONDCP and SAMHSA recognize that treatment need has expanded more rapidly than the service system designed to meet that need. Nationwide, there continues to be a great need for additional capacity for effective drug treatment. The largest problem in treatment (the "gap") revolves around three issues: accessibility, affordability, and availability. These three issues effect both private and public funding. The efforts of this initiative focus on the federal responsibilities in relation to closing the public system treatment gap. Drug treatment overall is funded in FY 1999 at over $3 billion. The *National Drug Control Strategy* also addresses private sector treatment issues through its efforts to ensure parity for substance abuse treatment.

Block Grants to States: For FY 1999, the Substance Abuse Prevention and Treatment (SAPT) Block Grant is funded at over $1.6 billion, an increase of $275 million over FY 1998. Of this increase, $185 million will be used for the provision of substance abuse treatment services that will reduce the public system treatment gap. Additional requests include funding for the SAPT Block Grant and the Targeted Capacity Expansion Program. The Substance Abuse Block Grant provides funding to states and has been a cornerstone of federal efforts to close the public system treatment gap.

Targeted Capacity Expansion Program: This program differs from the block grant in that all of its funds are directed toward providing treatment services. In addition, the Targeted Capacity Expansion program makes awards directly to states, localities, and service providers based on their ability to demonstrate an emerging or existing need for expanded treatment services.

Parity for Substance Abuse: The Office of National Drug Control Policy (ONDCP) supports the concept of parity --health insurance coverage for the treatment of drug dependence that is essentially similar to the coverage for treatment of other medical and health problems. The *National Drug Control Strategy's* goal of reducing drug use by 50 percent in the next ten years can only be accomplished with a significant expansion of capacity to treat chronic drug users. Parity offers an immediate opportunity to expand capacity. ONDCP has developed a position paper and is working with the Federal drug control agencies to establish parity as Federal policy.

2. Expansion of Treatment in the Criminal Justice System

At midyear 1997, more than 1.7 million U.S. residents were incarcerated. Of this amount, 99,175 inmates were in federal prisons and the remainder in state and local prisons. Since FY 1990, prisoners sentenced for drug offenses constituted the single largest group of federal inmates--approximately 60 percent. (Note: Similar statistics do not presently exist for state facilities. However, the Bureau of Justice Statistics' census of state and federal correction facilities showed that an estimated 23 percent of state prisoners were serving time for a drug-related offense.) From 1990 to 1996 the increase of nearly 24,000 drug offenders accounted for 72 percent of the total growth in federal inmate population. This population is expected to exceed 168,400 by 2004. By 2004, if current trends continue, over 104,400 inmates will be serving time for drug offenses. As the *National Drug Control Strategy* states "our nation has an obligation to assist all who are in the criminal justice system to become and remain drug-free." In order to break the cycle of drug abuse and its consequences, all drug-abusing inmates must have access to effective drug treatment programs. This initiative seeks to build upon established drug treatment programs targeted toward the criminal justice system. The Federal Bureau of Prisons (BOP) provides drug treatment to all eligible inmates, prior to their release from Bureau custody. The number of institutions offering residential treatment has grown from 32 to 42 since FY 1994. In FY 1997, nearly 31,000 inmates participated in Bureau treatment programs (education, 12,960; non-residential, 4,733; residential, 7,895; community transition, 5,315). This program is funded at over $26 million.

Provide Drug Testing and Intervention Programs: Research has shown that when drug testing is combined with effective interventions, such as meaningful, graduated sanctions, drug use can be curtailed within the criminal justice population. Further, recent studies demonstrate that drug-dependent individuals who receive comprehensive treatment decrease their drug use, decrease their criminal behavior, increase their employment, improve their social and interpersonal functioning, and improve their physical health. Moreover, when compared to substance abusers who voluntarily enter treatment, those coerced into treatment through the criminal justice system are just as likely to succeed. Since the majority of drug users are processed through some part of the criminal justice system during their drug-use careers, it makes sense to consider that system for intervention. The Administration's proposal for this program would provide drug testing and intervention programs to non-incarcerated populations. (Note: Incarcerated populations would receive drug treatment services under the Criminal Justice Treatment Priority through Office of Justice Program's (OJP) Residential Substance Abuse Treatment Program and the Federal Bureau of Prisons' Residential Treatment Program.) The President's Drug Testing Program for Federal Probationers is funded at $4.7 million in the federal courts.

Drug Courts: The criminal justice system often fails to subject nonviolent, substance-abusing adult and juvenile offenders to intervention measures that provide the sanctions and services necessary to change their deviant behaviors. Many of these individuals repeatedly cycle through our courts, corrections, and probation systems. Title V of the Violent Crime Control and Law Enforcement Act of 1994 authorizes the Attorney General to make grants to states and local units of government to establish drug courts. Statistics collected by recently established drug courts show a significant reduction in recidivism among drug court program graduates. This program seeks to provide alternatives to incarceration through using the coercive power of the court to force abstinence and alter behavior. A combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs are used to teach

Treatment Reduces Crime

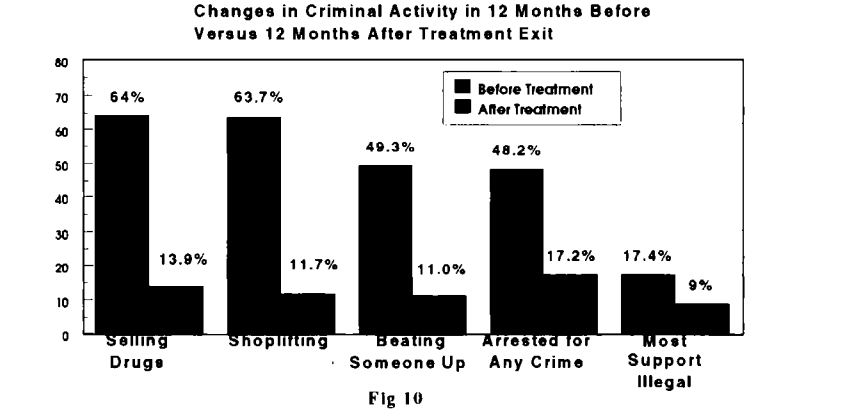


Fig 10

responsibility and to transition offenders back into the community.

The Department of Justice provides $40 million in grants to localities for Drug Courts. This initiative expands the Drug Court program to more sites, expands both national and local evaluations of drug courts, as well as builds the state and local capacity to incorporate drug courts into established court management systems. It includes the following components: 1) development of state level technical assistance and training capacity; 2) provision of drug court management information system development assistance; 3) national-scope evaluations, with 1-2 year follow-up periods, of 20 to 30 sites to examine which aspects of drug courts produce the best outcomes; 4) provision of assistance to local drug courts so that local evaluations are of high quality; 5) double the current number of drug courts; and 6) target as wide a range of defendants who are eligible for release as possible. The results of this demonstration will assist in the modification or development of future criminal justice drug control programs.

Breaking-The-Cycle (BTC): BTC combines the coercive power of the criminal justice system with research-based treatment for populations under supervision of the criminal justice system. BTC activities include a range of drug testing options, as appropriate, and the use of relapse prevention and control measures such as graduated sanctions to bring about behavioral change.

On November 10, 1998, ONDCP and NIJ announced the three jurisdictions selected to participate with Birmingham, Alabama in the BTC initiative. Jacksonville, Florida and Tacoma, Washington, will introduce BTC into their adult criminal justice systems. Eugene, Oregon will implement the initiative in its juvenile justice system. Each jurisdiction received a multi-year, multi-million dollar grant, as well as extensive technical assistance and other support coordinated by the National Institute of Justice.

BTC programs include: drug testing; individual and group counseling; academic and vocational instruction; and training. This initiative will increase the capacity of the criminal justice system to refer addicts and heavy drug users to treatment and rehabilitation and monitor their progress.

Although Congress provided no funding in the FY 1999 budget to expand BTC further, they included a provision that would allow up to ten percent of funds going to states for prison construction (up to $50 million) to be used for drug testing and treatment during and after incarceration. Related initiatives expand the Bureau of Prisons residential drug treatment program, continue support for prison Residential Substance Abuse Treatment at the level of $63 million for Department of Justice grants to states, and expand the Arrestee Drug Abuse Monitoring System (ADAM).

3. Treatment Research Development and Evaluation

National Institute on Drug Abuse (NIDA): Recent intramural and extramural research in the area of pharmacotherapies and behavioral therapies for the treatment of the dependence on and abuse of cocaine/crack, marijuana, opiates, and stimulants, including methamphetamine, has shown great promise. 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.

Medications for Cocaine Dependence: Researchers at NIDA have discovered compounds that can block the effects of cocaine without interfering with the normal mood-modulating effects of dopamine. NIDA studies have led to the discovery of receptors in the brain which act as re-uptake transporters for dopamine, a chemical that causes pleasure responses in the brain, much like cocaine. Also, research has found that there are multiple dopamine receptors that respond differently to various compounds. For example, one type of dopamine receptor, D1, suppresses drug seeking behavior and relapse, where as activation of the D2, triggers drug-seeking behavior. These findings have been used for clinical studies. Using equipment such as the positron emission tomography (PET), to identify brain regions that are particularly responsive to cocaine associated-stimuli, researchers have been able to identify brain activity associated with drug craving. This could help lead to the development of treatments that might prevent or reduce craving.

The conclusion of animal studies published in August 1998 in the journal *Synapse* showed that the epilepsy drug gamma'vinyl-GABA, or GVG, blocked cocaine's effect in the brains of primates, including the process that causes "high" feelings in humans. The GVG research was sponsored by the Department of Energy's Office of Energy Research and the National Institute of Mental Health with the involvement of NIDA.

Methadone and Other Opioid Agonists: The use of methadone and, more recently, other opioid agonists such as bupernorphine is widely accepted in drug treatment. Methadone treatment, along with counseling and other interventions, has been used successfully to treat heroin addictions. Approximately 115,000 Americans are able to lead stable lives as a result of methadone treatment received at the more than 900 methadone treatment programs. The *Drug Abuse Treatment Outcome Study (DATOS),* conducted by NIDA, found that among participants in outpatient methadone treatment, weekly heroin use decreased 69 percent, illegal activity decreased 52 percent, and full time work increased by 24 percent.

Unfortunately, regulatory barriers limit methadone availability and therefore methadone treatment capacity. To correct this problem, regulatory oversight is undergoing extensive reform. A pilot test of accreditation for methadone treatment

programs is underway. If this test proves successful the current regulatory approach will be replaced by an accreditation system. In this system, programs will be subjected to clinically based performance standards that emphasize comprehensive treatment. The accreditation system being developed is consistent with recommendations from recent reviews conducted by the National Academy of Sciences, NIDA, and the General Accounting Office (GAO).

Behavioral Treatment Initiative: Behavioral therapies remain the only available effective treatment approaches to many drug problems, including cocaine addiction, where viable medications do not yet exist. Behavioral interventions are needed, even when pharmacological treatments are being used. An explosion of knowledge in the basic behavioral science field is ready to be translated into new behavioral therapies. NIDA is encouraging research to develop and establish the efficacy of promising behavioral therapies, to determine how and why a particular behavioral intervention is effective; to develop and test behavioral interventions to reduce AIDS risk behaviors, and to disseminate efficacious behavioral interventions to practitioners in the field. More specifically, NIDA's behavioral research initiative will focus on therapies for adolescent drug use, addressing drug addiction treatment as HIV risk reduction, and determining the transportability of behavioral therapies to the community.

National Drug Treatment Clinical Trials Network: Over the past decade, NIDA-supported scientists have made tremendous progress in developing new and improved pharmacological and behavioral treatments for drug addiction. However, most of these newer treatments are not widely used in practice, in large part because they have been studied only in relatively short-term and small-scale studies conducted in academic settings on stringently selected patient populations. To reverse this trend and to dramatically improve treatment throughout this country, NIDA is establishing a National Drug Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, controlled multi-site Stage III and Stage IV treatment studies in community settings using broadly diverse patient populations. The National Drug Treatment Clinical Trials Network will enable rapid, concurrent testing of a wide range of promising science-based behavioral therapies, medications, and their combined use, across a range of patient populations, treatment settings, and community environments nationwide. Science-based behavioral therapies that are in queue for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and new, manualized approaches to individual and group drug counseling. Medications to be studied include naltrexone, LAAM, buprenorphine for heroin addiction, and those currently being developed by NIDA for cocaine.

Center for Substance Abuse Treatment (SAMHSA/CSAT) : 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, NIDA and SAMHSA/CSAT have focused on treatment in national conferences on marijuana,

methamphetamine, heroin, cocaine and crack. Additional conferences on treatment modalities and treatment in the criminal-justice system were held during the spring of 1998. SAMHSA/CSAT continues to develop Treatment Improvement Protocols (TIPS), which provide research-based guidance for a wide range of programs. SAMHSA/CSAT also supports thirteen university-based Addiction Technology Transfer Centers, which cover forty states and Puerto Rico. These centers train substance-abuse counselors and other health, social service, and criminal-justice professionals. In addition, SAMHSA/CSAT have several programs in their portfolios that are intended to move research into the field and establish an epidemiological measurement system.

4. Reduce Infectious Disease Among Injecting Drug Users

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." The prevalence of HIV infection in Injecting Drug Users (IDUs) and their sexual partners and children is high in the United States, and is on the rise in many other parts of the world as well. Not only is the AIDS/HIV epidemic a problem in this country, the reemergence of tuberculosis (TB) is also something which should be taken notice of when working on programs for injecting drug users. These populations, especially drug users who are dually infected with HIV and TB and who congregate in poorly ventilated areas, are suspected to be the source of TB infection for non-HIV infected crack smokers. This epidemic has continued to grow, especially among women on welfare. Many times, these women have infected their children, further adding to the medical costs borne out by society. Both hepatitis B and hepatitis-C continue to be an infectious disease problem associated with drug abuse.

Interventions for HIV/AIDS: The National Institute on Drug Abuse (NIDA) is continuing research programs on the enhancement and further development of behavioral therapies focusing on AIDS risk reduction. NIDA research has determined specific factors that should be present in intervention programs aimed at reducing the spread of HIV, especially among youth. It will identify the most effective types of interventions appropriate for different groups and communities, as well as the effect of abused drugs on the progression of AIDS. Drug abuse prevention and treatment significantly reduce drug use, improve social and psychological functioning, decease related criminality and violence, and reduce the spread of AIDS, TB and other diseases.

SAMHSA continues to support early intervention services for HIV through the Substance Abuse Prevention and Treatment (SAPT) Block Grant in 38 States. In addition SAMHSA is developing a strategic plan to address HIV/AIDS with an emphasis on minority communities. Planned activities include funding the National Minority AIDS Council (NMAC) for $100,000 to define the gaps in HIV/AIDS activities and substance abuse treatment and prevention and mental health services for women in minority communities. A cooperative project, among the CDC; the National Association of State and Territorial AIDS Directors (NASTAD); and the National Association of State Alcohol and Drug Abuse Directors

(NASADAD), has been started to define the barriers to collaboration of state and local HIV and substance abuse and mental health programs in minority communities. In addition, SAMHSA/CSAT targets funds to support comprehensive treatment for women and their children, substance abuse treatment programs that include an HIV component for men and youth, and prevention and substance abuse prevention services for African American and Hispanic youths.

The Centers for Disease Control (CDC) provides funding for AIDS drug counseling and drug-related HIV prevention activities. The Substance Abuse and Mental Health Services Administration (SAMHSA) also provides HIV/AIDS activities in support of this initiative. The program studies the efficacy, outcomes, recidivism, and HIV risk behaviors (needle use and sex) among injecting drug users.

5. Training for Substance Abuse 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. In addition, SAMHSA/CSAT published a Treatment Improvement Protocol: *A Guide to Substance Abuse Services for Primary Care Clinicians.*

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. *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice,* a SAMHSA/CSAT publication, will help provide criteria with which to certify practitioners.

Educational Materials for Substance Abuse Professionals: This initiative is intended to develop educational materials for substance abuse professionals using information such as SAMHSA's Laboratory Certification Program Standards and other national professional, accreditation, and certification organizations materials. It also provides the resources necessary to develop performance and educational materials for substance abuse professionals. Funding will also be used to conduct training for substance abuse prevention and treatment professionals, and for employee assistance professionals employed by programs receiving federal funds.

C. Workforce Demand Reduction

The *Strategy* encourages public and private-sector employers, including eight million small businesses, to initiate comprehensive drug-free workplace programs. 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 nation'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. These agencies represent about 1.8 million employees -- the vast majority of the federal civilian workforce.

Testing of Transportation Employees: The Omnibus Transportation Employees Testing Act of 1991 requires the Department of Transportation (DOT) to prescribe regulations that require drug testing of over eight million safety-sensitive employees in the United States who work in businesses that fall under federal mandatory testing regulations in the aviation, motor carrier, rail, transit, pipeline, and maritime industries. Consequently, DOT oversees the nation's largest workplace drug-testing program. DOT requires workers in safety-sensitive positions who test positive for drugs to be referred to substance abuse professionals before returning to work. If the employee is in need of assistance with his/her substance abuse problem, the employee must receive treatment or appropriate help before resuming duties. This program -- which also requires drug testing for operators of commercial motor vehicles from Canada and Mexico -- has become a model for non-regulated employers throughout the United States and 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 programs.

Small Business Drug-Free Workplace Initiatives: Most small and medium-sized businesses in America have no drug-free workplace programs in place. According to the *National Household Survey*, 69% of current illicit drug users are employed full-time. An additional 17% are employed part-time. The dramatic reduction in substance abuse in the military and other workforce settings is an effort that must be replicated in the small business civilian workforce.

In cooperation with state and local agencies, the Department of Labor (DOL) and the Department of Health and Human Services' Center for Substance Abuse Prevention (SAMHSA/CSAP's) assist small and medium-sized companies to implement drug-free workplace programs. These programs may include policy formulation, prevention education, supervisory training, drug testing and access to employee assistance programs. DOL'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 Information Database. SAMHSA/CSAP's Helpline provides business callers with free technical assistance and guidance in developing and evaluating programs and policies that address substance abuse in the workplace. Many of the over 1000 telephone calls or Internet inquiries received every month from small businesses seek expert assistance about best practices.

Beginning in FY 1999, a new small business initiative, administered by the Small Business Administration and funded initially

at $4 million, will provide for continuation and expansion of model drug-free workplace programs. This program is authorized by the Drug-Free Workplace Act of 1998.

Employment Training Programs: The Department of Labor funds a variety of employment training programs for both dislocated and low-income adults, and at-risk, disadvantaged youth. Under newly enacted authorizing legislation, these programs will include more comprehensive assessments of program participants' service needs. For youth participants, program components must include tutoring, study skills training, instruction leading to completion of secondary school, occupational skills training, adult mentoring, work experience, leadership training, and supportive services. Youth will receive follow-up services for at least one year, and will also receive comprehensive guidance and counseling which, by the determination of local workforce investment boards, may include drug and alcohol counseling and referral, as necessary.

Drug-Testing for Military Readiness: The Department of Defense (DoD) drug-testing program is a military readiness program to deter and detect drug abuse by military personnel, thereby ensuring the military fitness, readiness, mission performance, and safety of the individual and military unit. The program focuses on drug testing and anti-drug education.

Drug use reported by military personnel has declined steadily

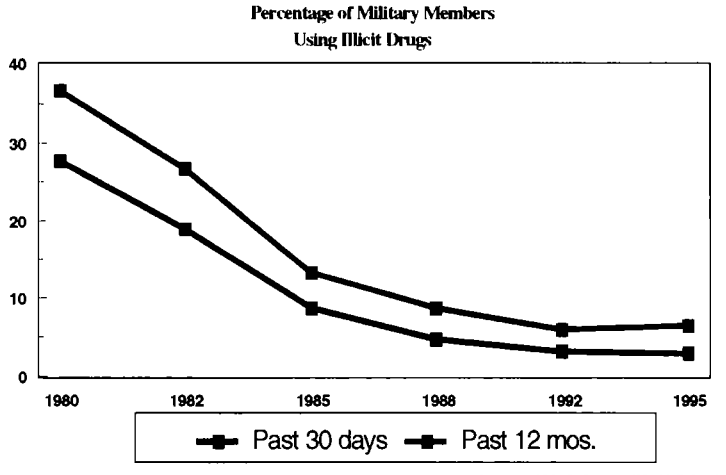


Fig 11 Source: 1995 DoD Survey of Health Related Behaviors Among Military Personnel

The DoD drug-testing program was begun during the Vietnam War era to counter rising drug abuse. The program was initiated to identify returning veterans in need of treatment and rehabilitation. In 1980, the aircraft carrier *Nimitz* suffered significant casualties, loss of life, and property damage during aircraft recovery operations. Drug presence was detected in several of the casualties of this incident. As a result, the Department began a concerted effort to deter and detect drug abuse by military personnel

The program has been highly successful. In fiscal year (FY) 1998, total drug positive testing rates for illicit drugs averaged 0.64%

for active duty military personnel. The Triennial Worldwide Survey of Health Related Behaviors Among Military Personnel reported self-admitted drug abuse, within the past 30 days, of less than 3%. This is a 90% reduction in self-admitted drug abuse since 1980. In FY 1998, approximately 2.5 million active duty military personnel were tested for drug abuse, or nearly two random tests per active duty military member per year. The cost of this program approximated $55 million in fiscal year 1998 including the cost of collection, testing, anti drug education and training, and rehabilitation and treatment. Fiscal year 1999 expenses are anticipated to be approximately $54 million. Drug abuse by military personnel continues to decline on an annual basis. The Military Services implemented several new initiatives to further reduce drug abuse:

- Beginning in FY 1998, a software package that will randomize the frequency of urine collections was distributed to the Services. The objective is to improve the unpredictability of when a testing event will occur. It is believed that increasing the risk of detection will deter drug abuse.

- The Navy, Marine Corps, and Air Force have begun drug testing at both the military processing center and at the recruit training center. The purpose is to prevent the entry of individuals with drug dependency into military service.

- To deter abuse of designer amphetamine drugs, the military drug testing program requires that all specimens that screen positive for amphetamines be analyzed in confirmation testing for the presence of the designer drugs MDA, MDMA and MDEA.

The United States Coast Guard has a similar drug-testing program. In FY1998, the Coast Guard tested about 65 percent of its personnel and 100 percent of its new accessions. The program has been very successful. The total positive testing rates for illicit drugs averaged 0.57 percent for combined active duty and selected reserve personnel. The FY1998 cost for this program was approximately $400 thousand, including the cost of collection, testing, anti-drug education and training.

D. Addressing Emerging Drug Threats

1. Domestic Heroin Initiatives

An estimated 810,000 Americans are chronic users of heroin. Between the first half of 1988 and the first half of 1997, heroin medical emergency mentions increased 99 percent from 18,100 to 36,000 mentions. As noted in the July 1997 National Narcotics Intelligence Consumers Committee Report "heroin remained readily available to addicts in all major metropolitan areas throughout 1996." The same report notes that "stable wholesale process per kilogram and high retail-level purities indicated increasing supplies."

Heroin Addiction Can Be Treated:
Methadone treatment, along with counseling and other interventions, is being used successfully to treat heroin addiction. Methadone is an agonist agent for opiates. In other words, methadone operates by occupying the brain receptor sites that are affected by heroin and blocks the craving attendant to addiction. Approximately 115,000 Americans are able to lead stable

lives as a result of methadone treatment received at the more than 900 methadone treatment programs.

Yet many of the nation's 810,000 heroin addicts do not have access to methadone treatment or any other effective form of drug abuse treatment. Methadone treatment is not available in Idaho, Mississippi, Montana, North Dakota, New Hampshire, South Dakota, Vermont, and West Virginia. The laws governing methadone treatment, the Controlled Substances Act (CSA) and Narcotic Addict Treatment Act (NATA), date from the 1970s and pre-date research breakthroughs on the nature of addiction. These laws arbitrarily limit the expansion of treatment capacity.

SAMHSA/CSAT is developing an accreditation system for methadone treatment. Regulatory oversight responsibility will be transferred from the FDA to SAMHSA/CSAT. The current regulatory approach will be replaced by an accreditation system. In this system, programs will be subjected to clinically based performance standards that emphasize comprehensive treatment. Law enforcement (anti-diversion) responsibilities will remain with the DEA.

Increased Public Awareness: Efforts are also underway to increase public awareness of the dangers of heroin use, especially among youth. The National Anti-Drug Youth Media Campaign is showing heroin messages on prime-time television, as well as in newspapers, magazines and other media. Areas of the country in which heroin use is growing are receiving concentrated exposure to anti-heroin programming.

2. Countering the Methamphetamine Threat

Methamphetamine: Over the past few years methamphetamine trafficking and abuse in the United States have steadily increased. According to the 1997 National Household Survey, an estimated 5.3 million people (2.5 percent of the population) tried methamphetamine in their lifetime. The estimate has increased significantly since 1994, when 1.8 percent of population had ever used methamphetamine. In the past, methamphetamine was largely produced and supplied by outlaw motorcycle gangs. More recently, however, organized crime poly-drug trafficking groups are dominating the wholesale trafficking in the United States. These large organized groups have developed large-scale laboratories — both in Mexico and the United States — that are capable of producing large quantities of methamphetamine.

The Attorney General and the Director of ONDCP are co-chairs of a Federal Task Force on Methamphetamine. In the past year, the Demand Reduction component has met twice, and is reviewing all federal programs relating to education, prevention and treatment as they apply to methamphetamine.

Funding to implement the demand component of the National Methamphetamine Strategy is included in the Department of Health and Human Services drug control budget. Specifically, the National Institutes on Drug Abuse annually spends approximately $20 million in research to understand the epidemiology of methamphetamine use, its mechanism of action and effects on brain functions,

behavioral consequences, and treatment and prevention implications and approaches. Furthermore, the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, allocates funding to investigate the treatment paradigms that may prove effective to treat addiction to methamphetamine.

3. Increasing Awareness of Inhalant Abuse

Inhalants are a chemically diverse group of products commonly found in every household. Although they are not illicit substances, they are often the first substances abused. Inhalants are legal, easily obtained, commercial products found in most homes. They include such products as glue, paint, typewriter correction fluid, felt tip markers, gasoline, and many others. When these products are inhaled, however, the consequences can be deadly. Death can occur the first time one sniffs, or the tenth, or the hundredth. Damage can occur to the liver, kidneys, and bone marrow, even irreversible brain damage. According to the *National Household Survey on Drug Abuse*, there were an estimated 805,000 new inhalant users in 1996, up from 382,000 in 1991. Approximately 20 percent of adolescents nationwide have used inhalants in their lifetime.

In order to raise public awareness of inhalants, the ONDCP Director has made a video in conjunction with SC Johnson Corporation and Deloris Jordan, mother of pro-basketball star Michael Jordan, that has been sent to educators and parents groups around the country warning them of the dangers of inhalant abuse.

E. Building International Cooperation in Demand Reduction

Drug abuse is a serious international problem requiring multi-disciplinary prevention. The United States supports demand reduction efforts by the United Nations International Drug Control Programs, the European Union, the Inter-American Drug Abuse Control Commission of the Organization of American States, and other multilateral institutions.

Expansion of Multilateral Cooperation: The United States expanded multilateral cooperation through participation in summits on drug abuse issues in Central and South America and through collaboration with CARICOM nations, OAS/CICAD, UNDCP, and the European Commission. For example, the United States participated in the United Nations General Assembly Special Session on Drugs in June. At that meeting, member states agreed that reducing demand for drugs is a key element of the global drug control strategy, and drafted the first international agreement to counter drug abuse.

The United States hosted anti-drug leaders from 23 nations at the Caribbean Regional Drug Control Conference (CRDCC) in Miami, Florida, from October 12-14. That conference fulfilled commitments made at the *Caribbean/US Summit* in Bridgetown, Barbados that was held on May 10, 1997, and responded to the document adopted there, the *Bridgetown Declaration of Principles.* In the spirit of partnership and mutual respect, that document pledged to strengthen cooperation in responding to the challenges of the coming millennium and noted the provision of technical assistance

and information exchange on demand reduction and supply reduction issues by the United States. Attendees at the CRDCC conference included participants from the Caribbean, observers from Latin America and Europe, and officials from law enforcement, criminal justice, drug prevention and treatment communities. The conference focused on regional cooperation with anti-drug officials, and assessed and promoted further narcotics cooperation between the US and Caribbean countries.

Development of a Hemispheric Anti-Drug Alliance: The U.S. has continued to play a prominent role in establishing a unified hemispheric alliance that incorporates a global and multi-disciplinary perspective. The alliance will strengthen and promote citizen participation, disseminate information on the deleterious effects of drug use support and strengthen organizational capacity, and create and support a multi disciplinary team of experts to assist participating countries in their demand reduction efforts. In April 1998, the President and other heads of state participated in the Second Summit of the Americas, which was held in Chile. Participants agreed to further meetings in order to forge an alliance against drugs and apply the Hemispheric Anti-Drug Strategy. Formal negotiations were begun in May, when OAS/CICAD was charged with establishing a procedure for multilateral cooperation to prevent and combat all aspects of the drug problem and related crimes based on the principles of sovereignty, territorial integrity of states, and shared responsibility, with a comprehensive and balanced approach.

U.S.-Mexico Bi-National Alliance/Conference: In May 1997, President Clinton and President Zedillo signed the Joint Alliance Against Drugs. The alliance formed between the two countries is expressed in the form of a 16-point framework for a U.S.-Mexico Common Drug Control Strategy. Alliance Point 1 seeks to "reduce the demand for illicit drugs through the intensification of anti-drug information and educational efforts, particularly those directed at young people, and through rehabilitative programs". At present, work is underway to develop performance measures of effectiveness to evaluate Alliance Point 1.

In March 1998, the first U.S.-Mexico Bi-National Demand Reduction Conference was held in El Paso, Texas. More than 300 experts in drug prevention, treatment, and research, as well as government officials, educators and other community leaders from both sides of the border met for two and a half days to address the root causes of the drug problem. During the conference, participants from both countries developed explicit strategies in eight areas to reduce the demand for drugs: research cooperation and the exchange of technical information; public information and awareness; community participation; youth; special populations; the workplace; HIV/AIDS; and violence and drug-related problems. Teams of experts from the U.S. and Mexico cooperated in drafting a *Bi-National Strategy* for reducing the demand for drugs in both countries, as well as performance measures of effectiveness for assessing the outcomes of the steps taken.

Development and Expansion of Prevention Alliances: Thirty-eight civic, service, fraternal, womens, and other organizations with national and international memberships representing more than 62 million volunteers have resolved to work together as part of the civic alliance

"Prevention Through Service". These organizations have pledged to volunteer one million hours to prevent drug abuse among youth. In Lima, Peru, for example, the Lions International has formed an alliance with the American Embassy, and the groups are working together to expand prevention efforts in Peru. The prevention alliance continues to conduct outreach to other international and national organizations to ensure that all youth have the opportunity to grow up drug free.

International Cooperation on Drug Abuse Research and Analysis: In collaboration with other nations, ONDCP is exploring how data sets gathered by various countries on drug abuse can be used in assessing the effectiveness of regional demand reduction efforts. It will also be used to analyze regional drug abuse and trafficking trends, implications for future research, and the development and implementation of effective prevention efforts. Research and surveillance of drug abuse on an international basis will be enhanced through extensive networking with other countries in the hemisphere and beyond. An important component will be strengthening the research and surveillance capacity of participating countries and sharing the latest research findings on demand reduction. NIDA is working with countries in Central America and the Caribbean to collaborate on drug research.

Bibliography

1. *1997 Annual Report on Adult and Juvenile Arrestees,* National Institute of Justice, July 1998.

2. *1997 National Household Survey on Drug Abuse,* Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1997.

3. *An Analysis of Worker Drug Use and Workplace Policies and Programs,* Substance Abuse and Mental Health Services Administration, Rockville, Maryland, 1997.

4. *California Drug and Alcohol Treatment Assessment,* Department of Alcohol and Drug Programs, Sacramento, California, 1994.

5. *Drug Abuse Treatment Outcome Study*, National Institutes of Health, National Institute on Drug Abuse, 1997.

6. *Drug Courts: Overview of Growth, Characteristics, and Results,* Government Accounting Office, Report to the Committee on the Judiciary, U.S. Senate, and the Committee on the Judiciary, U.S. House of Representatives, July, 1997.

7. *Drug Use Forecasting: Annual Report on Adult and Juvenile Arrestees,* U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1996.

8. Galleried, Darrell, and Allen Beck, *Prison and Jail Inmates at Midyear 1997*, Bureau of Justice Statistics, Washington, D. C. 1998.

9. Johnson, Lloyd, et al, *National Survey Results on Drug Use from the Monitoring the Future Study, 1975-1997*, National Institute on Drug Abuse, Rockville, Maryland, 1998.

10. *National Drug Control Strategy,* Executive Office of the President, Office of National Drug Control Policy, 1998.

11. *National Drug Control Strategy: Budget Summary*, Executive Office of the President, Office of National Drug Control Policy, 1998.

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

13. *Performance Measures of Effectiveness,* Executive Office of the President, Office of National Drug Control Policy, 1998.

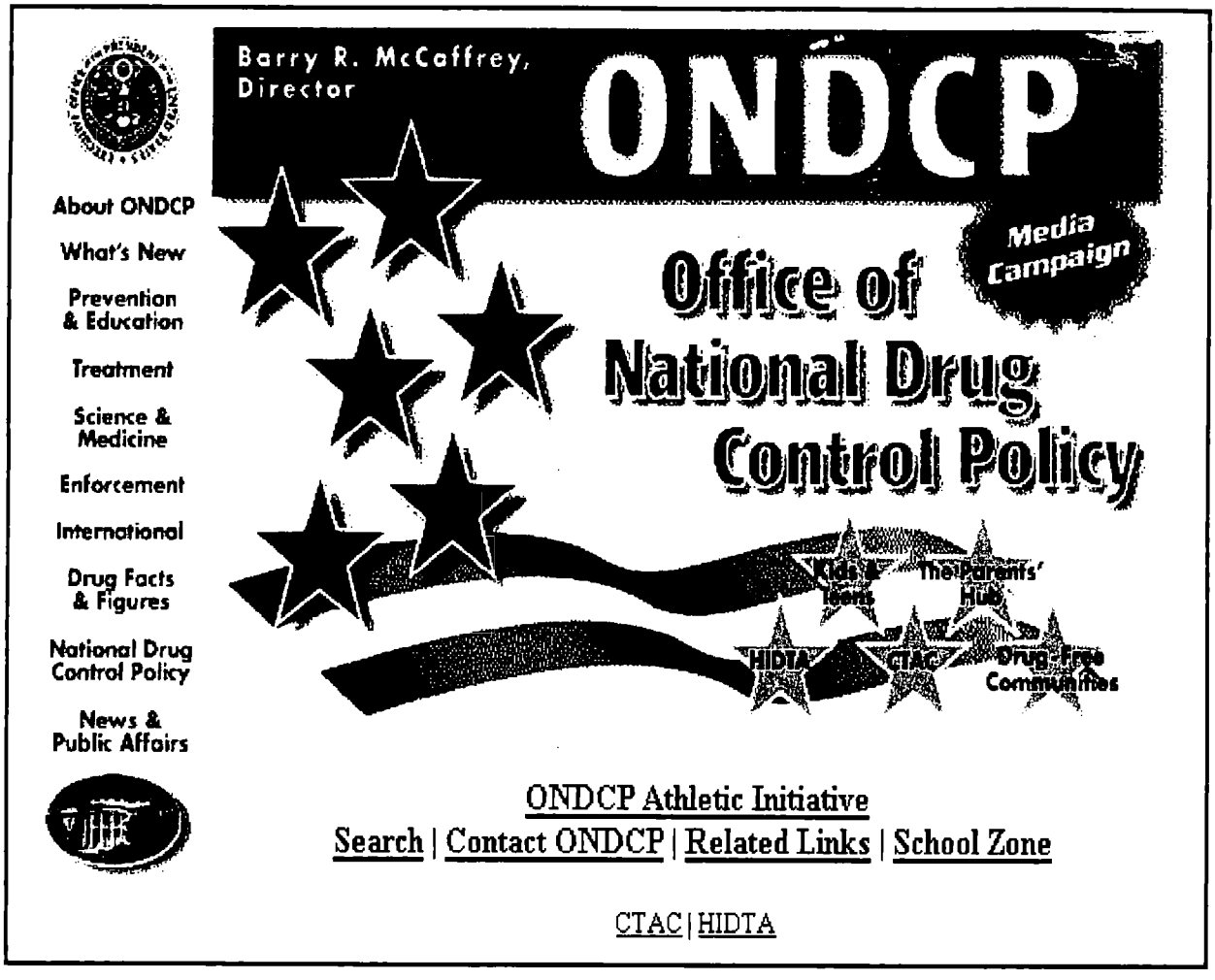
14. *Pulse Check: National Trends in Drug Abuse*, Executive Office of the President, Office of National Drug Control Policy, Summer, 1998.

15 *Services Research Outcomes Study*, U.S. Department of Health and Human Services, 1997.

16. *Uniform Crime Reports*, Federal Bureau of Investigation, U.S. Department of Justice, 1998.

17. *What America's Users Spend on Illicit Drugs: 1988-1995,* Executive Office of the President, Office of National Drug Control Policy, November 1997.

18. *Year-End Preliminary Estimates from the 1997 Drug Abuse Warning Network,* Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.



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

January 12, 1999

Dear Mr. Todd Summers:

Enclosed is an initial draft of the *1999 National Drug Control Strategy*. It has benefitted from the strength of your comments and insights. We ask that you provide comments to us on this draft as expeditiously as possible and no later than Tuesday, January 19th. Comments can be sent via fax (202-395-6641), phone (395-6710), or courier to Office of Strategic Planning, ONDCP, 8th Floor, 750 17th St., NW. Our intent is to submit a final draft for clearance through OMB on Monday, January 25th.

We ask your particular attention to:

- **Data presentation**. Please provide any updated information you may have on drug use, availability and consequences.

- **Discussion of initiatives**. Our intent is to reflect accurately the totality of the national anti-drug effort.

- **Consultation.** We are prepared to expand Chapter 6 to reflect your agency's activities and contacts in 1998. Please provide us input.

Goals and objectives will remain as they were agreed to by the interagency process. ONDCP's Office of Programs, Budget and Evaluation is developing the budget chapter (Chap. 5) of the *1999 Strategy*. The *Budget Summary and Performance Measures of Effectiveness System* volumes of the *Strategy* will also be released in February.

Thank you for your support.

Sincerely,

James R. McDonough
Director, Strategy

I: Drug-Control Strategy: An Overview

Introduction

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

Drug abuse afflicts considerable damage on our country. The pages that follow in this strategy detail the extent to which the nation suffers from drug abuse and what we plan to do about it. As the title of the strategy implies, drug abuse is a national problem that demands a national solution.

Illegal drug use and its consequences permeate every corner of our society. Drug abuse and the accompanying sickness afflict inner cities, affluent suburbs, and rural communities. It affects the rich and poor, educated and uneducated, professional and the blue collar workers. Seventy-three percent of drug users in America are employed. Addict populations include the aged and those -- were it not for their drug habit -- considered to be in the prime of their lives. Drug use is prevalent among the young (although not as widespread as many youth think). In recent years, we have seen the age for first use of drugs drop steadily. Innocent infants are suffering in great numbers from the chemical dependencies bequeathed them by mothers who are hooked on drugs. In short, there are no sanctuaries from the harm of illegal drug use.

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

When we relaxed our vigilance again, extensive drug abuse reappeared. New drugs came on the scene, often more powerful and more destructive than those that had come before. They brought with them subcultures that offered special appeal to different segments of society, too

often the young and impressionable. Once again drug abuse spread, and with it deleterious consequences. Three times in a century we have seen drug use rise and fall. Illegal drug use never disappeared entirely, although it is clear that we have and can bring the percentages of Americans who choose to use them go way down, approaching but not reaching zero.

Today, drug abuse in America is relatively low. With the concerted efforts outlined in this *Strategy*, we can lower the numbers further. Indeed, the will and commitment of the American people are such that we hope to see drug abuse cut in half, just as they are now half of the historical highs of the 1980s.

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

Drug abuse and its consequences can be reduced. The *National Drug Control Strategy* is a plan for bringing down drug abuse in our nation by 50 percent over the next several years.

An American View

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

The first duty of government is to provide security for citizens. The Constitution of the United States articulates the obligation of the federal government to uphold the public good, providing a bulwark against all threats, foreign and domestic. Drug abuse, and the illicit use of alcohol and tobacco by 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. Drug abuse diminishes the potential of citizens for growth and development. Not surprisingly, 56 percent of respondents to a survey conducted by the Harvard School of Public Health in 1997 identified drugs as the most serious problem facing children in the United States.[1]

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

A Comprehensive Long Term Plan

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

Mandate for a National Drug Control Strategy

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

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

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

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

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

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

- **The 1998 Act** in October 1998, Congress reauthorized the Office of National Drug Control Policy in the Omnibus Appropriations Act for Fiscal Year 1999. The Act specified ten major aspects in the reauthorization of importance to the implementation of the National Drug Control Strategy:

1) Development of a long-term national drug strategy.

2) Implementation of a robust performance measurement system.

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

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

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

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

7) Increased reporting to Congress on drug control activities.

8) Reorganization within ONDCP to provide more effective leadership of Federal anti-drug efforts.

9) Enhanced Foreign and Domestic Drug Intelligence Coordination.

10) Establishment of a Parents Advisory Council on Drug Abuse.

It was the sense of the Congress in this Act that substantial progress could be made toward specific reductions in relevant drug supply and demand data by the year 2003 as well as during the intervening years.* This Strategy sets in motion policies and programs designed to make progress toward these targets. Careful analysis of what is achievable by what time schedule is contained herein. As we succeed in reaching our targets, we will continue to achieve even further reductions insofar as resources allow.

*These exact targets are listed in the PME section of this *Strategy*.

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 breakthrough 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 governments and the private sector. They are discussed in detail in Chapter III.

Overview of the *1999 National Drug Control Strategy*

The Office of National Drug Control Policy Reauthorization Act of 1998 requires ONDCP to set forth a five-year plan for reducing drug abuse and its consequences in the United States. Specifically, ONDCP must submit to Congress by February 1, 1999 a comprehensive, research-based *National Drug Control Strategy* that includes measurable objectives and specific targets.

The *National Drug Control Strategy* takes a long-term, holistic view of the nation's drug problem. The *Strategy* maintains that no single solution can suffice to deal with the multifaceted challenge that several solutions must be applied simultaneously, and that focusing on outcomes– measured in declining drug use and a lessening of attendant social consequences – can achieve our goals.

The two major areas that the five goals of the *Strategy* are designed to limit are the demand for drugs and the supply of drugs. Both must be reduced if we are to be successful. It is only through a balanced array of demand reduction and supply reduction programs that we will be able to achieve our envisioned end state of a fifty percent reduction in drug use in America.

Based on empirical research and lessons learned from the history of drug abuse the *National Drug Control Strategy* argues that while both supply and reduction efforts must be advanced simultaneously, demand reduction is the priority. Drugs are supplied by traffickers only because a profit can be made; that profit stems from a craving for drugs. Consequently, demand fuels supply. In a perfect world, if we could bring demand to zero, the economic incentive to traffic drugs would evaporate and supply would disappear. This *Strategy* recognizes that in the real world there always will be some demand for illegal drugs. Therefore, demand reduction must be supported by supply reduction. Cheap and readily available drugs can undercut the effectiveness of otherwise successful demand reduction programs. Restricted availability and high prices help hold down the number of first-time users; prevent aggressive marketing of illegal drugs to the most at-risk population by criminal drug organizations; and reduce the human, social, and economic costs of drug abuse. The two approaches of demand and supply reduction must complement one another.

If demand reduction is the primary effort, prevention is the key. The *Strategy* focuses on our young, seeking to educate them about the dangers of drugs during their formative, vulnerable years. If we can bring the almost seventy million American children to adulthood free of substance abuse, the vast majority will avoid drug dependency for the rest of their lives. Accordingly, our primary goal is to educate and enable our youth to reject substance abuse.

In recent years, the rate of substance abuse by children has risen dramatically. This is, unfortunately, the opposite direction from the general trend of drug abuse in America, which is down significantly from where it was in the 1970s and 1980s. The problem is rooted in youth perceptions, which began in 1992 to reflect less concern for the risk of drug use and a belief that substance abuse was not all that harmful for them. Indeed, many young people believe that most of their peers are using tobacco, alcohol, and drugs, either singularly or in combination. This belief does not bear out in fact. Most youth, as the pages ahead will detail, do not use drugs. But it is true that there is a strong correlation between smoking, drinking, and taking drugs among youth. The more frequently each behavior is practiced, the more likely the others are to occur. The *National Drug Control Strategy* sets as its priority the prevention of our youth from using any of these substances.

Nevertheless, focusing on youth is not enough. We must also lower demand by decreasing the number of addicted individuals. We need to treat a large, mostly adult population of more than four million who constitute a major portion of domestic demand and that, without help, are doomed to lives of ill health, social degradation, and misery. In addition, since a parent's alcohol, and other drug abuse is a significant indicator of youth drug use, treatment for parents is key to preventing drug use among their children and to breaking the inter-generational cycle of addiction. Accordingly, the *Strategy* will focus on treating those in need through a variety of means that heighten the chances of successful recovery. Although this is a long and difficult process, we are convinced that treatment works. The *Strategy* will take advantage of all opportunities and incentives to encourage addicts to become drug-free – in the workplace, the criminal justice system, the community, on athletic fields, and among other appropriate groups. Indeed, there must be synergy among programs offered by both the nation's health care and criminal justice systems. Indeed, there must be a synergy among the anti-drug programs offered by the nation's health care, criminal justice, welfare, and job training systems.

Data indicate that a significant portion of the addicted enter into the criminal justice system each year. Indeed, the majority of the 1.8 million Americans behind bars on any given day last year were there for some relationship to substance abuse. The minority of these were incarcerated for violent crime or selling drugs. Most were either high on drugs when they committed a crime or were committing crimes to obtain the money for drugs. The population of non-violent, drug-related offenders will respond to a coerced abstinence system that offers treatment for substance abuse in lieu of incarceration. Experience shows that a rigorously applied system of treatment for those who face stark consequences -- such as immediate incarceration for violation of treatment protocols tend to abide by the rules and consequently have a high recovery rate. Over time, a standardized treatment system of coerced abstinence for those involved with the criminal justice system promises to decrease the overall addicted

population while reducing the number of Americans behind bars. However, the ultimate success of any of these programs will be measured by whether or not those with various combinations of substance-abuse problems, welfare dependency, and/or criminal backgrounds succeed in entering the workforce and becoming productive, self-sufficient, tax-paying members of society. Education and job-training programs must include supportive services which effectively treat addictions, when needed, and support recovery in training programs and in the workplace.

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

The *Strategy* also stresses the need to protect borders from drug incursion and to cut drug supply more effectively in domestic communities. We have developed initiatives to share information and intelligence, leverage technology, and coordinate efforts to arrest the flow of drugs.

Since the Southwest border is the major gateway for the entry of illegal drugs into the United States, the *Strategy* focuses on this area to synchronize technology, intelligence, and operations, and work cooperatively with Mexico to decrease drug trafficking. The *Strategy* anticipates that as we gain success at the U.S.–Mexican border, drug dealers will redouble their efforts elsewhere. Therefore we have allocated resources simultaneously to close other avenues into the United States: the Virgin Islands, Puerto Rico, maritime approaches to the United States, the Canadian border, and all our air and sea ports of entry.

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

The most efficient supply-reduction operations can be mounted at the source: the Andean Ridge for cocaine as well as some of the heroin supply; Mexico for a significant share of methamphetamine, heroin, and marijuana; and Southeast Asia and South Central Asia for much of the heroin. The *Strategy* describes a number of efforts to displace the growing and manufacturing of illegal drugs at the source. Where access to source regions is made difficult by

regional or political considerations, the *Strategy* supports international efforts to limit the supply of drugs exported.

Overall, the *National Drug Control Strategy* is based on the best available research and well-designed technological, informational, and intelligence systems. The *Strategy* is backed by a budget that reflects multiple proven approaches to the nation's drug problem. In that conditions are fluid, the *Strategy* will change as new drug trends develop. We will measure – target by target – how successful we are in achieving the goals and objectives. Constant reassessment will allow the *Strategy* to adapt continually in the face of new realities. The *Strategy* is informed by--and therefore seeks-- input and feedback from all governmental and non-governmental agencies, organizations, and individuals committed to the lessening of drug abuse.

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

Elements of the *1999 National Drug Control Strategy*

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

Outcome-oriented: To translate words into deeds, the *Strategy* must ensure accountability. *Performance Measures of Effectiveness: Implementation and Findings*[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. The 1999 *Strategy* continues to adhere to a principle that appeared originally ten years ago--that no single tactic -- pursued alone or to the detriment of other possible and valuable initiatives -- can work to contain or reduce drug use. We can expect no panacea, no "silver bullet," to solve the nation's drug-abuse problem. We will have to move forward simultaneously on several paths at once if we are to be successful.

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

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

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

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

Goals of the *1999 Strategy*:*

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

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

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

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

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

The five goals and thirty-five 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; international cooperation to confront drug cultivation, production, trafficking, and use; and research to provide a foundation based on science.

*The five goals and thirty-two objectives of the 1999 *National Drug Control Strategy* are displayed together at the centerfold on pages yy.

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

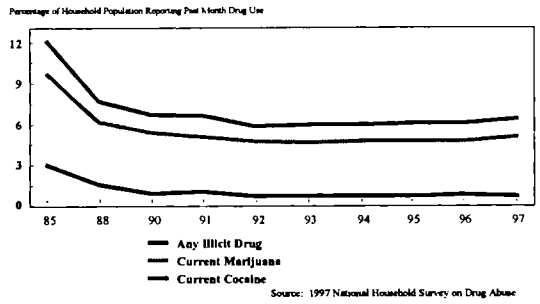
1. Harvard University/University of Maryland, *American Attitudes Toward Children's Health Care Issues* (Princeton, N.J.: Robert Wood Johnson Foundation, 1997).

2. Published simultaneously with this document and on the ONDCP Web site (*http://www.whitehousedrugpolicy.gov*).

Drug Use in America: A Declining but Serious Problem

TEXT

Since 1985, current drug use is down substantially

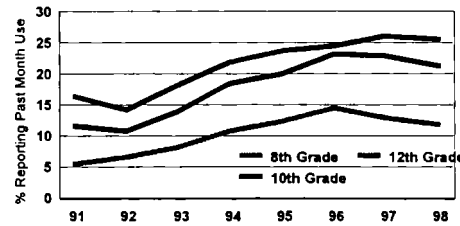


Source: 1997 National Household Survey on Drug Abuse

TEXT

Youth drug use has levelled off.

Past month use of any illicit drug.



Source: 1998 Monitoring the Future Study.

TEXT

TEXT

II: America's Drug Abuse Profile

DRUG ABUSE AMONG AMERICANS

Drug abuse is one of the most serious problems facing American society. Drugs and the devastation wrought by drugs plays a part in virtually every major social issue in America today, be it health care, crime, mental illness, the dissolution of families, child abuse, or the spread of disease. Overseas, drug traffickers ally with guerillas or corrupt government officials to subvert the rule of law and attempt to create narco-states. Drug abuse and the trade it establishes robs honest men and women around the world of good government, crime-free lives, adequate medical systems and the fullness of human potential.

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

The encouraging news is that, overall, drug abuse rates are about half of what they were in the late 1970s. Indeed, we appear to be moving towards a national rejection of drug abuse. In 1997 there were 13.9 million current users of any illicit drugs in the total household population, down from the peak year of 1979 when twenty five million (or 17.5 percent of the population) abused illegal drugs.[2]. The 13.9 number represents 6.4 percent of the total population and is statistically unchanged from 1996.[3*] Sixty percent of these users abused marijuana only.[4] But even with the dramatic drop in overall use, far too many Americans still use drugs. Thirty-five percent aged twelve and older have used an illegal drug in their lifetime. Of these, more than 90 percent used either marijuana or hashish and approximately 30 percent tried cocaine.[5]

Current rates of addiction are also very troubling. Today there are an estimated 4 million drug addicts in America: 3.6 million cocaine addicts (primarily crack cocaine) and 810,000 heroin addicts. Most of them started using marijuana in their youth and then moved on to heroin or cocaine. Addiction effects more than just the addict -- indeed the families, friends, and employers of drug addicts are depleted by the broken promises, deteriorating relationships, and lost productivity that abound in his wake. Approximately 45 percent of Americans report

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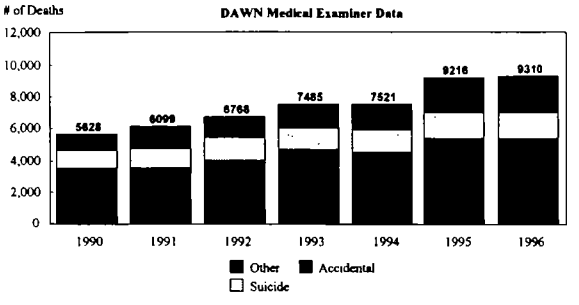
*A "current user" is an individual who consumed an illegal drug in the month prior to being interviewed.

knowing someone with a substance-abuse problem.[6] Even those Americans who do not come into contact with users of illicit drugs are not exempt from the burden of drug abuse. All of us pay the toll in the form of higher health-care costs, dangerous neighborhoods, and overcrowded criminal justice systems.

We All Pay the Price of Drug Abuse

TEXT

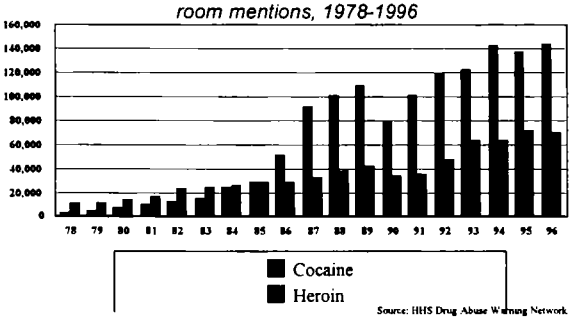
Drug-related deaths are rising



Source: HHS Drug Abuse Warning Network

The Health Impact of Drug Abuse

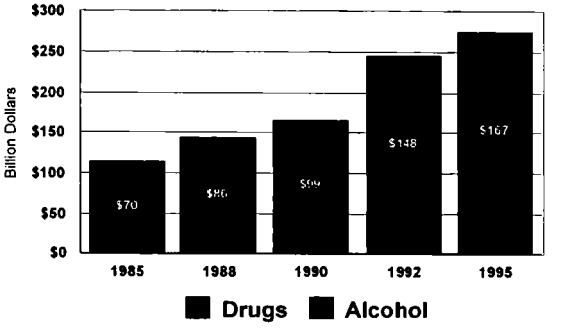
Cocaine and heroin hospital emergency room mentions, 1978-1996



Source: HHS Drug Abuse Warning Network

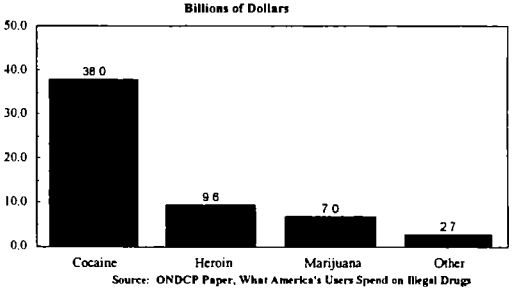
TEXT

The social costs of drug and alcohol abuse are increasing.



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

Americans spend $57 Billion on illegal drugs each year.



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

1998 National Drug Control Strategy

CONSEQUENCES OF ILLEGAL DRUGS

Illegal drugs -- such as heroin, marijuana, cocaine and methamphetamine -- inflict serious damage upon America and its citizens every year. Accidents, crime, domestic violence, illness, lost opportunity, and reduced productivity are the direct consequences of substance abuse. Drug and alcohol use by children often lead to other forms of unhealthy, unproductive behavior including delinquency and high risk sexual activity. Drug abuse and trafficking hurt families, businesses, and neighborhoods, impede education, and burden our criminal-justice, health, and social-service systems.

The costs we bear due to drug abuse are steep. Illegal drugs cost our society approximately 110 billion dollars each year.[7] Drug-related deaths have increased 60 percent since 1990, totaling more than 52,000.[8] We pay the cost of drug abuse in human lives either lost directly to overdose, or through drug abuse-related diseases such as tuberculosis, sexually transmitted diseases, hepatitis, and AIDS. We pay the cost in traffic accidents cause by intoxicated drivers, in street crime committed by addicts to support their addiction, and the resources expended to apprehend, sentence, treat, and incarcerate them.

Perhaps the most tragic cost of drug abuse is the lost human potential. Drug abuse is associated with a broad array of anti-social behavior. Children who begin to smoke marijuana at an early age are much more likely to not finish school and to engage in acts of theft, violence and vandalism than are children who do not smoke marijuana. Studies of adult users of cocaine and heroin have found that youth use of marijuana correlates strongly with later use of cocaine and heroin. Children aged 12-17 years old who use marijuana are 85 times more likely to use cocaine than children who have never used those substances.[9] But no study, statistic, or survey can accurately reflect the suffering and heartbreak that occurs when a father, mother, or child sinks into addiction.

What follows is an overview of America's drug abuse profile, including the most current data available.

Drug-related deaths, though declining, remain near historic highs. The National Center for Health Statistics reports 14,843 drug-induced deaths for 1996.**[10] The Substance Abuse and

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**The disparity between NCHS and DAWN estimates of deaths is due to different reporting requirements as well as the fact that the NCHS is a national estimate, while DAWN only deals with 41 cities.

Mental Health Service Administration (SAMHSA)'s Drug Abuse Warning Network (DAWN) Medical Examiner Report annually examines drug related deaths -- exclusive of deaths from AIDS, homicide and where the drug of abuse was unknown -- in 41 major metropolitan areas across the country. DAWN reports drug related deaths climbed throughout the 1990s, but appear to have leveled off at about 9,300 per year.[11] Drug deaths declined among those aged 18 to 34, but were offset by an increase among those aged 35 and older, particularly those aged 45 to 54. This trend may reflect the aging of the drug-abusing population in America, indicating that those who started drug abuse in the 1960s and 1970s are now succumbing to the cumulative health effects of years of abuse.

Drug-related medical emergencies remain near historic highs. SAMHSA's DAWN program reports drug-related hospital emergencies and provides a snapshot of the health consequences of America's drug problem.[12] DAWN indicates that drug-related emergency room episodes increased by seven percent between the first half of 1996 and the first half of 1997, from 214,600 to 269,000. The age groups driving this increase were those aged 18 to 25 (which saw an 11% increase) and aged 35 and over (which saw a 10% increase). The most frequently recorded reason for drug related emergency room visits in the first half of 1997 was overdose, which comprised 49% of all episodes. The most common motive for drug use was suicide attempt or gesture, which comprised 38 percent of all episodes, followed by drug dependence as a motive for drug use (33 percent), then recreational use as a motive (29 percent.[13]

Estimated emergency episodes for both cocaine and heroin in the first half of 1997 were at their highest levels since 1978. Cocaine-related cases remained about the same from the first half of 1996 to the first half of 1997 at about 80,000. Most distressingly, the largest percentage of increase in emergency room admissions during this period was among those aged 12 to 17 (76%). Even with this huge increase, a high percentage of cocaine episodes involved older Americans. In the second half of 1990, those aged 35 and older accounted for 3 in every 10 cocaine episodes. By the first half of 1997, this age group accounted for nearly half of all admissions, implying that the population of cocaine abusers is aging.[14] Heroin-related episodes showed a slight decline between the first half of 1996 (38,648) and the first half of 1997 (36,032), although this number is almost twice the amount in the last half of 1991. Methamphetamine-related emergency-room episodes in the first half of 1997 (8,398) were more than double that in the first half of 1996 (4,197), but still remained significantly below the peak levels in the last half of 1994 and the first half of 1995.[15] The increase in the first half of 1997 may reflect that methamphetamine, which was relatively scarce in the first half of 1996, is now more readily available. Indeed, geographic analysis of admissions to treatment for methamphetamine addiction shows a clear, tide-like spread of methamphetamine use from the west coast into the Midwest. Marijuana and hashish admissions continued to

climb upward, continuing a trend begun in the first half of 1992. The first half of 1997 saw 32,867 admissions for marijuana/hashish, an increase of almost 25 percent from the year before. This number is over four times the admissions from the second half of 1991.[16]

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." The National Institute on Drug Abuse (NIDA) has concluded that drug abuse is both a serious health and social issue since drug abuse is a major vector for the transmission of many serious infectious diseases -- particularly AIDS, hepatitis and tuberculosis -- and for the infliction of violence.[17] Finally, in an era in which health care costs are rising, drug abuse poses an intolerable burden on an already strained system. NIDA estimated that health care expenditures due to drug abuse cost America $9.9 billion in 1992.[18]

Homelessness. A strong correlation exists between drug abuse and homelessness. A San Francisco study found that from December 1997 to November 1998 drug abuse was the leading killer of the homeless. Of the estimated 4000 homeless, there were 157 deaths in a 12 month period. Sixty-two were attributed to drug overdose. Other causes of death, such as suicide and AIDS, may have had an origin, if not a proximate cause, in drug abuse as well.[19]

Cost of Drug Abuse to Workplace Productivity

According to the 1997 *NHSDA*, an estimated 6.7 million people (or 48 percent of current illegal drug users) were employed full-time. This represents 6.5 percent of the full-time labor force aged eighteen and older.[20] Another 1.6 million people (or 12 percent of current drug users) worked part-time.[21] In the same period, an estimated 13.8 percent of unemployed Americans were current drug users; thus, drug abuse is twice as prevalent among unemployed Americans than among those employed.[22] Sixty percent of Americans who use drugs on a monthly basis are employed.

Drug users are less dependable than other workers and decrease workplace productivity. They are more likely to have taken an unexcused absence in the past month; 12.1 percent did so compared to 6.1 percent of drug-free workers. Illegal drug users get fired more frequently (4.6 percent were terminated within the past year compared to 1.4 percent of non-users).

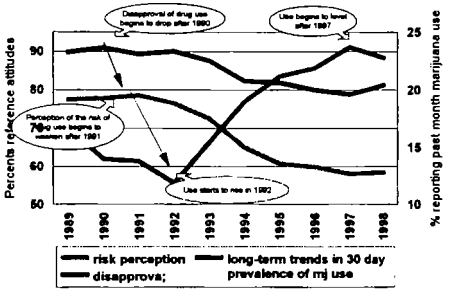
Drug users also switch jobs more frequently: 32.1 percent worked for three or more employers in the past year, compared to 17.9 percent of non-drug using workers. One quarter of drug users left a job voluntarily in the past year.[23] This high turnover increases training and

other productivity-related costs to American businesses. A 1998 National Institute on Drug Abuse (NIDA) study estimated that the cost to America in lost productivity due to drug abuse was $69.4 billion in 1992.[24]

Youth Drug Use: A Problem With Profound Implications

TEXT

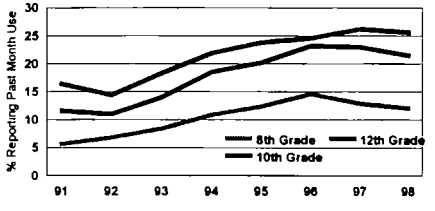
Youth attitudes determine youth marijuana use.
The case of 12th graders.



Source: 1998 Monitoring the Future Study.

Youth drug use has levelled off.

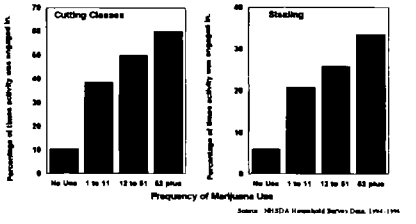
Past month use of any illicit drug.



Source: 1998 Monitoring the Future Study.

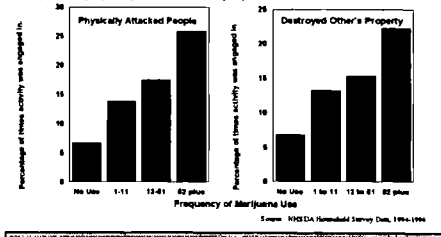
Delinquent Behavior is Clearly Linked to Marijuana Use

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



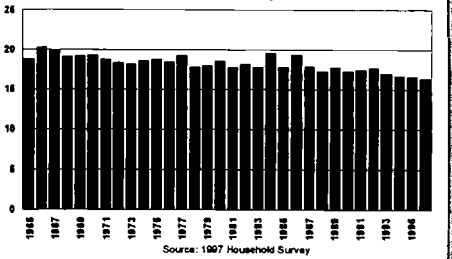
Aggressive anti-social behavior is clearly linked to marijuana use

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



Average age of first marijuana use is declining

Average age of first use of marijuana, 1965-96



Source: 1997 Household Survey

TEXT

TEXT

1998 National Drug Control Strategy

YOUTH DRUG USE: A PROBLEM WITH PROFOUND IMPLICATIONS

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

Drug abuse among youth rose dramatically from 1990 to 1996.

One of the most disturbing trends of the 1990's, reflected by the *University of Michigan's Monitoring the Future* (MTF) Study, was the increase in youth use of drugs. From 1991 to 1996, current illicit drug use among 8th graders more than doubled, from 6.7 percent to 14.6 percent. Current illicit drug use among 10th graders also doubled in the same period, from 11.6 percent to 23.2 percent. Current illicit drug use among 12th graders increased by more than 50 percent, from 16.4 percent to 26.2 percent. Presaging this increase in drug abuse was an erosion in youth disapproval of drug abuse and in the perceived risks of drug abuse by youth. The other main statistical indicator, the National Household Survey on Drug Abuse (NHSDA), has indicated that drug use among all those aged 12-17 has also doubled from the historic low year of 1992, when only 5.3 percent of those aged 12-17 were current drug users, to 11.4 percent in 1997. This level still remains below the 1979 rate of 14.2 percent. [25]

Youth marijuana use has been associated with a wide range of dangerous behavior. Nearly one million 16-18 year olds (11 percent of the total) reported driving in the past year at least once within two hours of using an illicit drug (most often marijuana).[26] A number of descriptive studies have demonstrated that people who use drugs are more likely to have mental disorders, physical health problems and family problems. In addition, a recent study showed that marijuana use by teenagers who have prior serious antisocial problems can quickly lead to dependence on the drug.[27]

Youth Drug Use is Linked to Anti-Social Behavior and Crime.

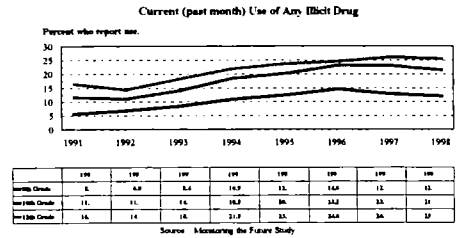
The correlation between youth use of marijuana and anti-social behavior was dramatically demonstrated by a NHSDA analysis. For youths aged 12 to 17, those who smoked marijuana within the past year were more than twice as likely to cut class, steal, attack people and destroy property than were those who did not smoke marijuana. The more frequently a youth smoked marijuana, the more likely he or she was to engage in these types of antisocial behavior.[28] An analysis of Maryland juvenile detainees found that forty percent were in need of substance abuse

treatment. Of this forty percent, 91 percent needed treatment for marijuana dependence.[29]

1998's Monitoring the Future: A Change for the Better

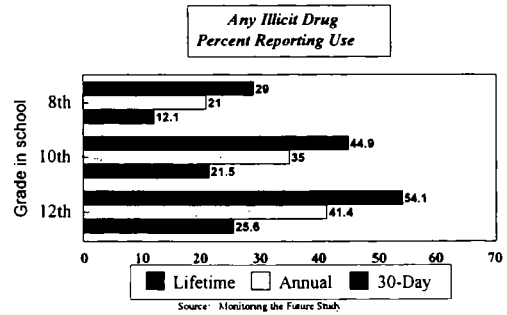
TEXT

The downward trend in youth drug abuse continued in 1998, though not enough to counter previous increases.



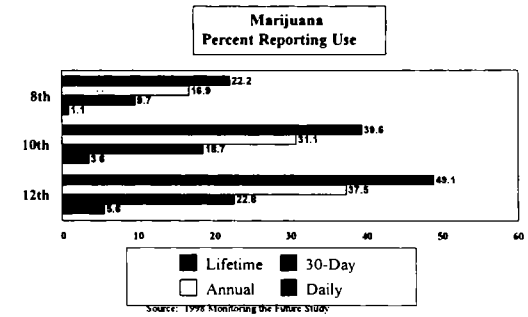
Source: Monitoring the Future Study

Drug use among children, although down, remains unacceptably high.



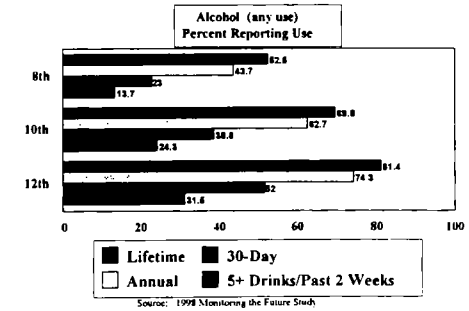
Source: Monitoring the Future Study

Almost 1 in 4 are 12th graders are current marijuana users; 1 in 20 use marijuana every day.



Source: 1998 Monitoring the Future Study

By 12th grade, more than three-fourths of students have used alcohol in their lifetime; 52 percent are current drinkers and 31.5 percent binge drinkers.



Source: 1998 Monitoring the Future Study

TEXT

1998 National Drug Control Strategy

1998's *MONITORING THE FUTURE STUDY:* A CHANGE FOR THE BETTER

Starting in 1997, the MTF study reported a leveling off of youth drug use. In 1998, this survey noted that overall youth drug rates remained flat and, in fact, began to decline in some areas. For the first time in six years, the use of marijuana and other illegal drugs did not increase among eighth graders. 1998 also saw a decrease in use of marijuana and any illicit drug among 10th graders, and stable use among 12th graders.[30] Furthermore, attitudes regarding drugs, which are key predictors of use, began to reverse in 1997 after several years of erosion. This disapproval by youths of drugs is likely to increase as social disapproval of drug abuse takes root. The rising drug use trends observed by MTF in the 1990s appears to have ended..

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

Among the specific findings of the **1998 Monitoring the Future Study are the following:**

- **1998 is the second straight year without significant increases in past month or past year use of any illicit drug.**
- **Marijuana use was significantly lower among 10th graders.**
- **All other drug use either remained statistically unchanged or decreased significantly,** except for increases in barbiturate and tranquilizer use among 12th graders and crack use among 8th graders.
- **The softening trend in youth attitudes about drug use also appears to be ending,** except for LSD. There were **significant increases in perception of harmfulness of marijuana use among 8th graders.**
- This is the second year that shows no major increases in drug use, and some specific segments have indications of improvement, not only in drug use behavior, but in attitudes as well. Data for 10th graders are particularly encouraging.

Based on the last two years of MTF results, **we could be at the threshold of a turnaround in the youth drug situation.** These data predate the implementation of the National Youth

Anti-Drug Media Campaign. With the added impact of that effort reinforcing positive trends in youth attitudes and behaviors, improvements should be enhanced.

Alcohol and Tobacco. The mandate of the Office of National Drug Control Policy extends to alcohol and tobacco use by underage youth.As with illicit drugs, youth use of alcohol and tobacco tends to presage adult addiction to these and stronger substances with all the subsequent crime and health care implications.

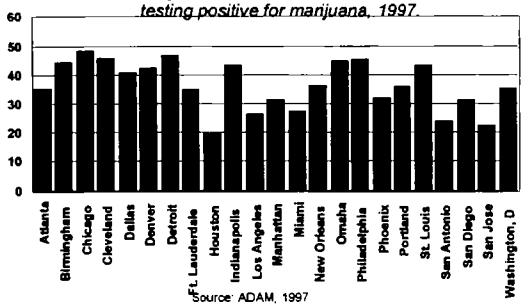
Tax increases in recent years on the price of alcohol have been effective at reducing adolescent consumption of alcohol. A study that appeared in a recent issue of the *Journal of Health Economics* finds that increases in alcohol prices, such as the beer tax, actually decrease the amount of marijuana consumed by adolescents, not increase it as was once thought. When it comes to adolescents, marijuana and alcohol are actually economic complements, not substitutes.[31] Parents who take comfort in thinking, "At least my child is only drinking alcohol and not using pot," as if one activity supplants the another, are finding false comfort. The only valid message we should be sending our children is that both alcohol and marijuana have their individual dangers.

Drugs and Crime: An Undeniable Nexus, A Heavy Price

TEXT

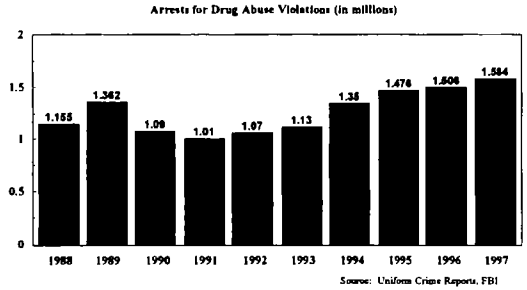
Marijuana use correllates with violent crime

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



Source: ADAM, 1997

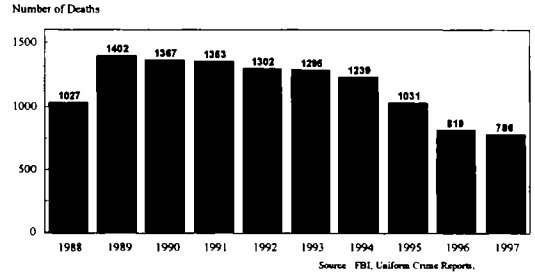
Drug Related Arrests are Rising



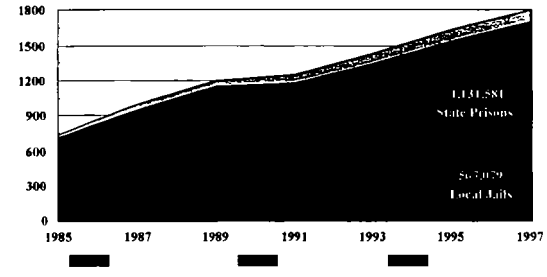
Source: Uniform Crime Reports, FBI

Drug related murders continue to decline.

Murders related to narcotic drug laws.



Source: FBI, Uniform Crime Reports.



TEXT

1998 National Drug Control Strategy

DRUGS AND CRIME: AN UNDENIABLE NEXUS, A HEAVY PRICE

While crime in general continues to decline, 1,583,600 Americans were arrested for drug-law violations in 1997, an all-time high.[32] Many crimes (e.g., assault, prostitution, and robbery) are committed under the influence of drugs or may be motivated by a need to obtain money for drugs. Drug trafficking and violence go hand in hand. Confrontation and interpersonal disputes fueled by substance abuse contribute to violence, as do drug markets in areas where legal and social controls against violence tend to be ineffective. The continued decline in drug related murders is testament to the effectiveness of law enforcement measures directed against drug violence at the federal, state, and local levels.

Arrestees frequently test positive for recent drug use. The National Institute of Justice's Arrestee and Drug Abuse Monitoring (ADAM) drug-testing program found that more than 60 percent of adult male arrestees tested positive for drugs in nineteen out of twenty-three cities in 1997.[33] In Manhattan, 81 percent of males arrested for assault tested positive for illicit drugs.[34] In recent years, cocaine abuse has been largely a problem among older arrestees. Whereas in the 1980s as much as 80 percent of male arrestees in large cities tested positive for cocaine use, now approximately 5 percent of youthful arrestees (age 15-20) test positive in cities such as Detroit and Washington DC.[35] This would suggest that the population of addicts is aging and illustrates the persistent nature of addiction. The surge in cocaine use in the 1980s continues to have effects on crime a decade later.

Heroin use is also found primarily among older arrestees, although in some cities such as Philadelphia, New Orleans and St. Louis, there is an increase in youth use. The long-term nature of heroin addiction makes any youth increase a matter of concern. An annual increase in youth use presages a cohort of chronic addiction for many years to come.[36]

For young adult males, the median rate of marijuana prevalence exceeded 64 percent in all cities in 1996, but then declined in 15 cities in 1997.[37] Marijuana use among arrestees is still concentrated disproportionately among youthful arrestees, however.[38]

Methamphetamine use, after declining among arrestees in 1996, rebounded in 1997 in the West and Southwest. Scant evidence exists, however, that methamphetamine use is reaching the East or Southeast in appreciable numbers. The fluctuations in use and the regional concentration suggests that methamphetamine is more sensitive than are other illicit drugs to law enforcement activity.[39]

Drug offenders crowd the nation's prisons and jails. According to Bureau of Justice

Statistics, in June 1997 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 every 117 male U.S. Americans was incarcerated in a state or federal prison at year end 1997, (this number excludes those incarcerated in local jails).[40] More Americans were behind bars than on active duty in the armed forces. The number of sentenced prisoners rose by 5.2 % in 1997. The number of female inmates serving time in state prisons for drug offences doubled between 1990 and 1996, while the number of male inmates in state prisons rose 55 percent during the same period.[41] Sixty percent of the inmates in the Federal system in 1996 were sentenced for drug offences, up from 53 percent in 1990.[42] Federal courts sentenced 18,813 people were sentenced in Federal court for drug violations in 1997; just under half of these cases involved cocaine.[43]

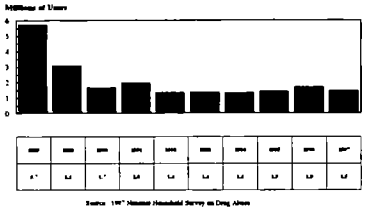
This high rate of incarceration is spread disproportionately among different ethnic groups in American society. In 1996, the rate of incarceration among black males was 3,098 per 100,000, compared to 1,278 for Hispanic males and 370 for white males.[44] A March 1997 study by the Bureau of Justice Statistics found that African-American men were nearly twice as likely to be incarcerated in their lifetime (28.5 percent) as Hispanic men (16.0 percent) and six times more likely than white men (4.4 percent).[45]

Costs for incarceration have risen. In 1993, state correction expenses exceeded $19 billion.[46] Some states now spend more on prisons than on education: for example, in New York State, funding for state and city universities has fallen since 1988 by $615 million, to $1.48 billion, while funding for the Department of Correctional Services has risen by $761 million to $1.76 billion. Across the nation, states spent 30 percent more on prison budgets and 18 percent less on higher education in 1995 than they did in 1987.[47]

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 survey of state child welfare agencies by the *National Committee to Prevent Child Abuse* found substance abuse to be one of the top two problems present in families reported for child abuse in 88 percent of respondent states.[48] In addition, women who abuse alcohol and other drugs are more likely to become victims of domestic violence than those who do not abuse substances. Research on the link between parental substance abuse and child maltreatment suggests that chemical dependence is present in at least one half of the families involved in the child welfare system.[49]

Cocaine Abuse: We Are Still Paying the Bill for the 1980s

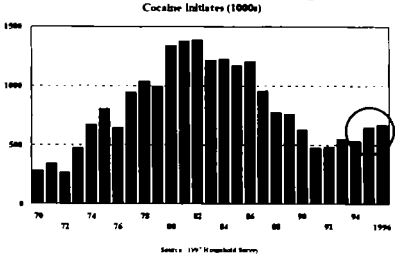
Current use of cocaine is down significantly.



TEXT

TEXT

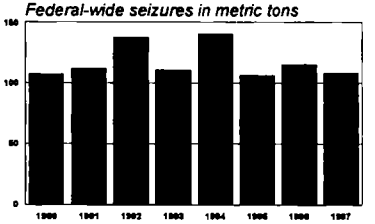
Cocaine Initiation Rates are a fraction of the 1970s rate, but are rising.



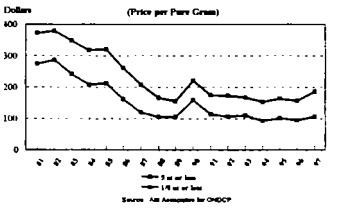
TEXT

Cocaine seizures remain constant.

Federal-wide seizures in metric tons



Cocaine prices began to climb in 1997 after years of decline or stability



TEXT

1998 National Drug Control Strategy

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

Cocaine, which devastated America's inner cities in the 1980s, is not as prominent today as a drug of choice except among those addicted to it. Casual use of cocaine is just a fraction of what it was in the 1980s. Studies such as ADAM and ONDCP's *Pulse Check* indicate that the population of cocaine abusers is aging. Given the overall decrease in cocaine abuse, the increase in emergency room admissions for cocaine abuse indicates that the cohort of cocaine abusers is suffering health damage which becomes more manifest after years of abuse. Put simply, we are paying accelerated health care costs now for the increase in cocaine and crack use in the 1980s.

Overall usage: In 1997, an estimated 1.5 million Americans were current cocaine users. This figure represents 0.7 percent of the household population aged twelve and over, a slight decline from 1996 and a substantial decline from the 1985 figure of 5.7 million, when it was (3 percent of the population. The current-use rate, however, has not changed significantly in the last seven years.[50] The number of first-time users in 1996 (675,000) was significantly lower than the years between 1977 and 1987 when more than one million Americans tried cocaine each year.[51] Estimates of the number of chronic cocaine users vary, but 3.6 million is a widely accepted figure within the research community.[52]

Use among youth: Cocaine use is not prevalent among young people. The 1998 *MTF* survey found that the proportion of students reporting use of powder cocaine in the past year to be 3.1 percent, 4.7 percent, and 5.7 percent in grades eight, ten, and twelve, respectively. This rate represents no statistically significant change from 1997. While year-to-year changes in use of cocaine have been slight and non-significant, the trend since 1993 has been steadily increasing and significant. The overall youth use rates are low, but are still a cause for concern. Young people are experimenting with cocaine, underscoring the need for effective prevention. This requirement is substantiated by the *NHSDA*'s finding of a steady decline in the mean age of first use from 22.6 years in 1990 to 18.7 years in 1996 -- the lowest since 1969.[53] Crack cocaine use, according to *MTF*, leveled-off in the eighth, tenth, and twelfth grades during the first half of the 1990s, reinforcing the aging of the crack using population.

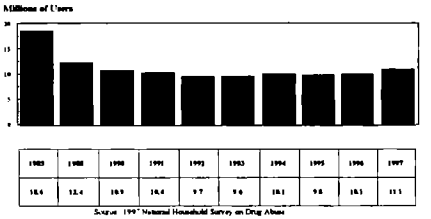
Availability: The August 1998 Semiannual Interagency Assessment of Cocaine Movement estimated that 151 metric tons of cocaine arrived in the U.S. in the first six months of 1998.[54] Powder cocaine retailed at approximately 130 dollars per gram in 1997, the first year average price increased since 1990.[55] Wholesale quantities (kilograms) are generally 80 to 100 percent pure. Average purity declined below 70 in 1997 for the first time since 1989. Retail purity levels vary widely according to local supply and demand. In the first six months of 1998, seizures of cocaine outside and at the borders of the U.S. totaled 81 metric tons, out of a total production of

232 metric tons.[56] An ONDCP internal analysis based on source and seizure data puts the total amount of cocaine available in the United States at 289 metric tons, the lowest amount in the 1980s and far below the peak of 451 metric tons in 1995.[57] Cocaine was readily available in all major metropolitan areas. Prices were generally the same at the kilogram level in 1997. Purity declined at the kilogram level, from 82 percent pure in 1996 to 80 percent in 1997, and at the ounce level, from 67 percent to 64 percent. Purity increased at the gram level from 61 percent in 1996 to 64 percent in 1997.[58]

Marijuana Abuse: The Most Commonly Abused Illicit Drug

TEXT

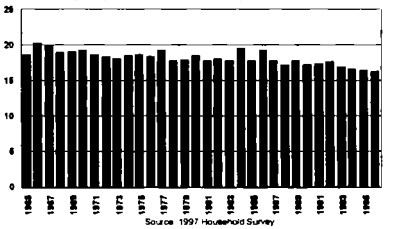
Current use of marijuana is down significantly



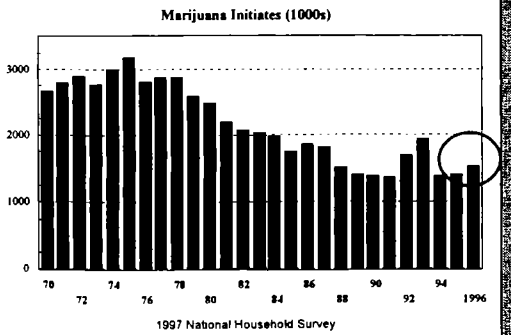
TEXT

Average age of first marijuana use is declining

Average age of first use of marijuana, 1965-96

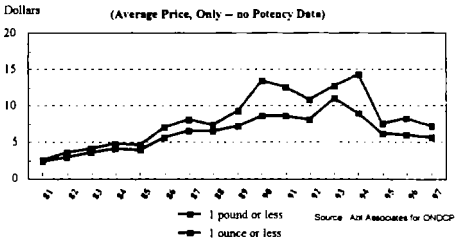


Marijuana Initiation Rates are less than half that of the 1970s, but are rising.



TEXT

Marijuana average price is down from the peak high price of the early 1990s.



TEXT

1998 National Drug Control Strategy

MARIJUANA: THE MOST COMMONLY ABUSED ILLICIT DRUG

Overall usage: The 1997 *NHSDA* estimated that 5.1 percent (11.1 million) of the population aged twelve and older were current marijuana or hashish users, an increase of 0.4 percent from 1996.[59] Marijuana is the most prevalent illegal drug in the United States; approximately four out of five (80 percent) current illegal drug users used marijuana or hashish in 1997.[60] The number of initiates in 1997 increased by over 100,000 to 2.5 million, continuing a trend begun in 1991. Disturbingly, 1996's mean age of initiation was the lowest recorded at 16.4 years old.[61]

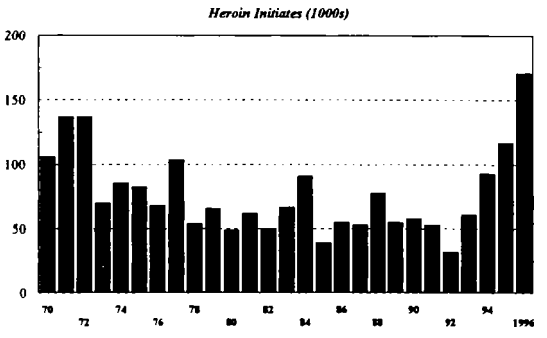
Use among youth: The 1998 *MTF* shows that marijuana continues to be the illegal drug most frequently used by young people. Among high school seniors, 49.1 percent reported using marijuana at least once in their lives, a decrease of half a point from 1997. By comparison, the figure was 44.9 percent for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

Availability: No precise system is available to estimate the amount of marijuana cultivated in the United States. Anecdotal evidence exists to suggest that recent so-called "medical marijuana" initiatives have encouraged the growing of marijuana in some states. One possible measure of the scale of marijuana availability is in the amount seized, which has risen constantly. The drop in marijuana prices, coming after a sharp drop two years ago, would also suggest that availability increased in 1997. In addition to marijuana grown in the United States and marijuana smuggled in from Mexico, Canada is emerging as a marijuana source nation. Press accounts from the Pacific Northwest, in particular, point to a new pattern in the trafficking of marijuana grown indoors in Canada and then sold in the United States as far south as California. This marijuana is so psychoactively powerful that it is bartered by criminal gangs for cocaine on a pound-for-pound basis.[62] During the late 1970s and early 1980s, the THC content of commercial-grade marijuana averaged below 2 percent and marijuana sold for prices ranging from $350 to $600 a pound. In 1997, the sale price typically did not fall below $1,300 per pound, and the average THC content was 4.95 percent.[63]

Heroin Abuse: A Resurgent Menace

TEXT

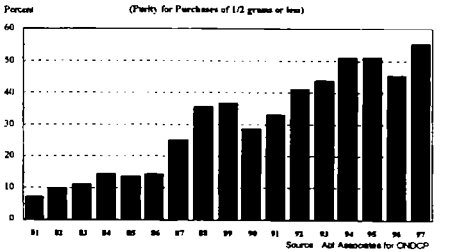
The number of heroin initiates is increasing



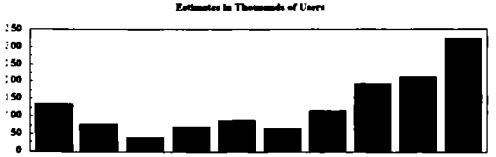
Source: Household Survey

TEXT

Heroin purity has increased dramatically.



Current heroin use, though still low, has increased significantly.

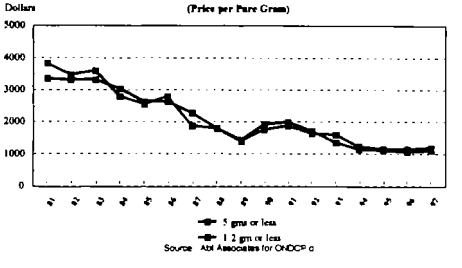


1988	1988	1990	1991	1992	1993	1994	1995	1996	1997
137	79	41	71	93	68	117	196	216	325

Source: 1997 National Household Survey on Drug Abuse

TEXT

Heroin prices have stabilized after years of decline.



TEXT

1998 National Drug Control Strategy

HEROIN ABUSE: A RESURGENT MENACE

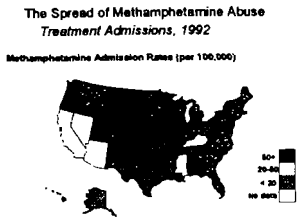
Overall usage: In the United States, approximately 320,000 occasional users and 810,000 chronic users consume heroin.[64] Injection remains the most efficient means of administration, particularly for low-purity heroin. However, the increasing availability of high-purity heroin has made snorting and smoking more common modes of ingestion, thereby lowering inhibitions to use. The advent of high-purity heroin has profoundly altered the nature of heroin addiction. With high purity heroin, a user can snort or smoke heroin and thus become addicted without ever injecting. Injection had, in the past, served as a major barrier to casual heroin use. It is now possible for a user to become addicted without using a needle. However, public awareness of the threat of heroin seems to have had some effect: the percentage of lifetime heroin users who smoked heroin declined by about 40 percent and the percentage of those who snorted declined by about 50 percent from 1996 to 1997.[65] This trend, while positive, must be viewed in light of past increases in lifetime smoking and snorting heroin, which increased from 55 percent in 1994 to 82 percent in 1996.[66]

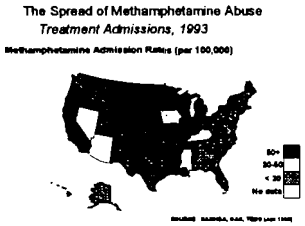
Use among youth: While relatively low, rates of heroin use among teenagers rose significantly in eighth, tenth, and twelfth grades during the 1990s. The ability to snort or smoke heroin, instead of injecting it, undoubtedly played a major role in increasing use of this drug. The 1998 *MTF* found no change between 1997 and 1998 in tenth grades, but concluded that use in eighth and twelfth grade has leveled-off and may have declined. Youth attitudes towards heroin remained statistically constant, with the highest perceived risk among tenth graders. The 1997 *NHSDA* found that the mean age of initiation declined from 27.3 years in 1988 to 18.1 in 1996, the lowest since 1972.[67] It appears, sadly, as though America's youth have yet to understand fully the danger and the devastation caused by heroin and heroin abuse. ONDCP ethnographic sources noted a disturbing increase in teenage heroin use in San Francisco, Newark, Miami and Atlanta, with users starting in some cities at the age of 13 and becoming chronic users by the time they are 15 to 17 years old.[68]

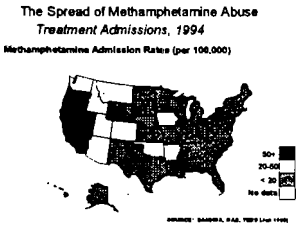
Availability: Information about the price and purity of heroin is imprecise. In 1997, the average retail price for a pure gram of heroin was approximately $1,375; the wholesale cost was$ 450 dollars. These prices were significantly lower than in 1981 when the retail price of a gram was estimated to be $3,000 and the wholesale price $1,700.[69] Ethnographers suggest that heroin is increasingly available in many cities; for example, ONDCP's Summer 1998 *Pulse Check* found that heroin use rose in some cities (San Francisco, Newark, Atlanta and Baltimore), remained stable at high levels in others (Bridgeport and Chicago) and stabilized in a few other cities (San Diego and Seattle). No city saw a decline.[70] South American heroin has become common in the Northeast, leading to speculation that cocaine trafficking and distribution organizations may be

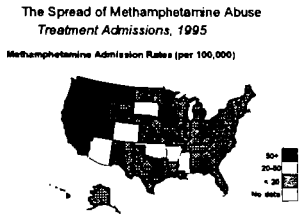
"double breasting" (i.e., using existing cocaine distribution and sales networks to sell heroin). Analysis of price, seizure and other data indicated that there are two distinct heroin markets in the United States, demarcated along the Mississippi River. In the east, high purity white powdered heroin from South America was predominantly available. In the west, lower purity Mexican "black tar" and brown heroin was the predominant form available.[71]

Methamphetamine: A dangerous drug, a rising threat.







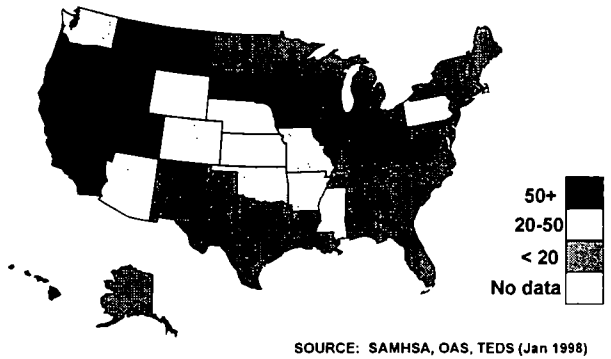


TEXT

The Spread of Methamphetamine Abuse

Treatment Admissions, 1996

Methamphetamine Admission Rates (per 100,000)



SOURCE: SAMHSA, OAS, TEDS (Jan 1998)

TEXT

1998 National Drug Control Strategy

METHAMPHETAMINE: A DANGEROUS DRUG, A RISING THREAT

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

The effects of methamphetamine on humans is profound. There is no accepted treatment regimen for methamphetamine addiction. The high from methamphetamine can last for hours, instead of minutes as with crack cocaine. The methamphetamine user often stays awake for days. As the high begins to wear off, the methamphetamine user enters a stage called "tweaking," in which he or she is prone to violence, delusions and paranoia. Many methamphetamine users try to alleviate the effect of methamphetamine withdrawal by using other drugs, such as cocaine or heroin. Methamphetamine is snorted, smoked or injected.

Overall usage: The 1997 NHSDA estimated that 5.3 million Americans (2.5 percent of the population) have tried methamphetamine in their lifetime, up significantly from the 1994 estimate of 1.8 million. The ADAM system (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. Methamphetamine use, according to ADAM, increased substantially in 1997, negating the progress achieved in 1996. In San Diego, roughly 40 percent of both male and female arrestees tested positive for methamphetamine.[72]

Use among youth: The 1998 *MTF* asked twelfth graders about the use of only crystal methamphetamine --known as "ice"-- which is smoked or burned in rock form. The survey found that lifetime ice use -- which had leveled-off at 4.4 percent in 1997 after a four year rise -- rose in 1998 to 5.7 percent.

Availability: Methamphetamine is by far the most prevalent synthetic controlled substance clandestinely manufactured in the United States. Mexican cartels have seized control of the market in the Southwestern United States from the biker gangs who used to control the methamphetamine trade. The Midwest has also seen an increase in methamphetamine production, trafficking and consequences. The drug is not commonly used in the East and Southeast, though an analysis of methamphetamine treatment admissions suggests that the use of

the drug is spreading eastward, as do increased seizures. The number of methamphetamine laboratory seizures reported to the DEA in 1997 increased dramatically, to 1,431 from 879 in 1996. This reflects the widespread proliferation in the manufacture, trafficking and use of the drug across the West, Midwest and portions of the South.[73]

Other Substances

Overall usage: The 1997 *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 1997.[74] The number of hallucinogen first-time users dropped from 1.2 million in 1995 to 1.1 million in 1996: unfortunately the mean age of initiation also dropped from the previous all-time low of 17.3 years to 17.2 years.[75] Current-use rates for psychotherapeutics dropped from 1.4 percent in 1996 to 1.2 percent in 1997.[76] In absolute numbers, 2.6 million Americans abused psychotherapeutics in 1997, less than half the number in 1985.[77]

Use among youth: The 1998 *MTF* reported that current inhalant use and current LSD use declined among eighth graders from 5.6 percent in 1997 to 4.8 percent in 1998 for inhalants and from 1.5 percent to 1.1 percent for LSD. Ethnographers continue to report "cafeteria use"*** of hallucinogenic or sedative drugs like ketamine, LSD, MDMA, and GHB throughout the country, often times tied into "rave culture."

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

Endnotes

1. Center for Substance Abuse Research, University of Maryland at College Park, "Drug Abuse Tops the List of American's Concerns for Children," CESAR Fax, Vol. 7, No. 11 (March 16, 1998).

2. ibid, 64.

3.Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Preliminary Results from the 1997 National Household Survey on Drug Abuse*, (Rockville, Md.: U.S. Department of Health and Human Services, 1998).

4. ibid, 9.

5. *1997 National Household Survey*, 87.

6.The Gallup Organization, *Consult with America: A Look at How Americans View the Country's Drug Problem, Summary Report* (Rockville, Md.: The Gallup Organization, 1996).

7. *Substance Abuse: The Nation's Number One Health Problem. Key Indicators for Policy* (Princeton, N.J.: Robert Wood Johnson Foundation, 1993).

8. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Drug Abuse Warning Network Annual Medical Examiner Data 1996* (Rockville, Md.: U.S. Department of Health and Human Services, 1998), 61.

9. Jeffrey Merrill, Kimberley Fox, Susan Lewis and Gerald Pulver, *Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use* (New York: Center on Addiction and Substance Abuse at Columbia University, 1994), iii.

10. Norman R. Deck, Unpublished ONDCP memo dtd 11 January 1999.

11. Office of Applied Studies, *Drug Abuse Warning Network Annual Medical Examiner Data 1996*, 58.

12. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Year-End Preliminary Estimates from the 1996 Drug Abuse Warning Network (DAWN)* (Rockville, Md.:U.S. Department of Health and Human Services, 1997), 20. Many health-

related complications of drug abuse do not immediately manifest themselves, and DAWN data are thus considered to be trailing indicators of the consequences of drug abuse. These preliminary results may be subject to upward revision.

13.. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Mid-Year 1997 Preliminary Emergency Department Data from the Drug Abuse Warning Network (DAWN)* (Rockville, Md.:U.S. Department of Health and Human Services, 1998), 5.

14. ibid, 6.

15. ibid, 57.

16. ibid, 55.

17. Leshner, Op cit, p. 3.

18. ibid, 4-2.

19. "Homeless Deaths Are Rising in San Francisco," *The New York Times*, 21 December 1998, A16.

20. Substance Abuse and Mental Health Services Administration, *Preliminary Results from the 1997 National Household Survey on Drug Abuse,* (Rockville, Md.:U.S. Department of Health and Human Services, 1998), 15.

21. ibid.

22. ibid.

23. Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *An Analysis of Worker Drug Use and Workplace Policies and Programs*, Analytic Series: A-2 (Rockville, Md.: U.S. Department of Health and Human Services, July 1997), 9.

24. National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, *The Economic Costs of Alcohol and Drug Abuse in the United States 1992*, (Rockville, Md.: U.S. Department of Health and Human Services, September 1998), 5-1.

25. *1997 National Household Survey*, 1.

26. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Driving After Drug or Alcohol Use: Findings from the 1996 National Household Survey on Drug Abuse*, Analytic Series A-8 (Rockville, Md.: U.S. Department of Health and Human Services, December 1998), 51.

27. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Analyses of Substance Abuse and Treatment Need Issues*, Analytic Series A-7 (Rockville, Md.: U.S. Department of Health and Human Services, 1998) 90.

28. ibid.

29. Center for Substance Abuse Research, University of Maryland at College Park, "Forty Percent of Juvenile Detainees in Maryland Need Treatment--Primarily for Marijuana Abuse/Dependence" CESAR Fax, Vol. 7, No. 42 (October 19, 1998).

30. ibid.

31. Rosalie Liccardo Pacula, "Does increasing the beer tax reduce marijuana consumption?" *Journal of Health Economics*, Vol. 17 (1998) 557-585.

32. Federal Bureau of Investigation, *Uniform Crime Reports 1997,* (Washington, D.C.: U.S. Department of Justice, November 1998), 222.

33. National Institute of Justice, *ADAM: 1997 Annual Report on Adult and Juvenile Arrestees*, (Washington, D.C.: U.S. Department of Justice, July 1998).

34. ibid., 37.

35. ibid., 1.

36. ibid., 2

37. ibid., 10.

38. ibid, 2.

39. ibid, 3.

40. Darrell Gilliard and Allen Beck, *Prisoners in 1997* (Washington, D.C.: Bureau of Justice Statistics, 1998), 1.

41. ibid, 11.

42. ibid, 12.

43. United States Sentencing Commission, *1997 Sourcebook of Federal Sentencing Statistics* (Washington, D.C.: U.S. Sentencing Commission, 1998), 68.

44. Darrell Gilliard and Allen Beck, *Prisoners in 1997*, op cit.

45. Bureau of Justice Statistics, *Lifetime Likelihood of Going to State or Federal Prison* (Washington, D.C: U.S. Department of Justice, 1997)

46.Kathleen Maguire and Ann L. Pastore, eds., *Sourcebook of Criminal Justice Statistics 1996*, 12.

47. Liz Leyden, "Study Contrasts N.Y. Prison, Education Priorities" *The Washington Post,* December 1, 1998, p. A07.

48. Ching-Tung Wang and Deborah Daro, *Current Trends in Child Abuse Reporting and Fatalities: the Results of the 1997 Annual Fifty State Survey* (Chicago, National Committee to Prevent Child Abuse, 1998), 2. *See also* National Committee To Prevent Child Abuse, *The Relationship between Parental Alcohol or Other Drug Problems and Child Maltreatment* (http://www.childabuse.org/fs14.html), January 24, 1998.

49. M.M. Dore, J.M. Doris and P. Wright, "Identifying Substance Abuse in Maltreating Families: A Child Welfare Challenge," *Child Abuse and Neglect*, Vol. 19, No. 5 (1995), 531-543.

50. *1997 National Household Survey*, 67.

51. ibid, 104.

52. Office of National Drug Control Policy, *What America's Users Spend*, 8.

53. *1997 National Household Survey*, 104.

54. Office of National Drug Control Policy, *Semiannual Interagency Assessment of Cocaine Movement* (Washington, D.C.: Office of National Drug Control Policy, August 1998).

55. Abt Associates, "Prices of Illicit Drugs: 1981–1997," unpublished memorandum prepared for the Office of National Drug Control Policy, 1997, 1.

56. Office of National Drug Control Policy, *Semiannual Interagency Assessment*

57. Dr. Michael Cala, unpublished memorandum, Office of National Drug Control Policy, Washington: D.C., January 1998.

58. National Narcotics Intelligence Users Committee (NNIC), *The NNIC Report 1997: The Supply of Illegal Drugs to the United States* (Washington, DC: U.S. Drug Enforcement Administration, November 1998) 1.

59. *1997 National Household Survey*, 16.

60. ibid.

61. ibid., 103.

62. David Crary, "Hottest New Import from Canada: Pot," *The (Tacoma) News Tribune*, April 18, 1998, A1.

63. *The NNIC Report 1997*, 73.

64. Office of National Drug Control Policy, *What America's Users Spend*, 8.

65. *1997 National Household Survey*, 102.

66. Substance Abuse and Mental Health Services Administration, *Preliminary Results*, 17.

67. *1997 National Household Survey*, 107.

68. Office of National Drug Control Policy, *Pulse Check: National Trends in Drug Abuse, Summer 1998* (Washington, D.C.: Office of National Drug Control Policy, 1998), 3.

69. Abt Associates, "Prices of Illicit Drugs," 13.

70. Office of National Drug Control Policy, *Pulse Check,* 3.

71. *The NNIC Report 1997*, 39.

72. *ADAM 1997*, 54.

73. *The NNIC Report 1997*, 63.

74. *1997 National Household Survey,* 19.

75. *1997 National Household Survey,* 106.

76. *1997 National Household Survey,* 68.

77. *1997 National Household Survey,* 66.

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

I. INTRODUCTION

This chapter explains the logic behind the **goals** that orient the national effort to reduce drug abuse and its consequences in the United States over the next five years. These five goals are succinct statements of the strategic aims of our national drug control policy: to prevent drug abuse (goal 1); to reduce the social harms associated with drug abuse (goals 2 and 3); to stop illegal drugs from entering the United States (goal 4); and to diminish illegal drug production (goal 5). Together, these goals define the end states of the *National Drug Control Strategy*. The five goals are comprehensive in that they cover the three broad aspects that drug control must address: demand reduction, supply reduction, and adverse consequences of drug abuse and trafficking. These goals are national in that they state what we must collectively achieve; they are not markers for a federal effort. The goals are research-based and quantifiable. We will measure progress toward their attainment using existing surveys such as the *National Household Survey on Drug Abuse, Monitoring the Future*, the *Arrestee Drug Abuse Monitoring* program, the *Drug Abuse Warning Network*, the *Federal-Wide Drug Seizure System*, and the *International Narcotics Control Strategy Report*.[1] Finally, the five goals are long-range because there is no short-term solution to this complex problem.

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

This chapter introduces **targets** that will be used to measure progress toward the desired strategic end state of reducing illegal drug use and availability by 50 percent. The Office of National Drug Control Policy -- in broad consultation with the Congress, national drug control program agencies, state and local officials, and private citizens and organizations with experience in demand and supply reduction -- has developed a performance-measurement system that links outcomes, programs, and resources.[2] The nucleus of the system consists of twelve targets that define results to be achieved by the *Strategy*'s five goals. Eighty-seven supporting performance measures also delineate mid- and long-term targets for the *Strategy*'s thirty-one objectives.

II. GOALS, OBJECTIVES, AND TARGETS

A. Goals and Objectives

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

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

The *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, productive 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 sports organizations 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.

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

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

Rationale: Values, attitudes, and behavior are forged by families and communities. Alcohol, tobacco, and drug-prevention for 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 illegal drugs, including alcohol and tobacco use by youth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug-related crime can be reduced through community-oriented policing and other law-enforcement tactics, which have been demonstrated by police departments in New York and other cities where crime rates are plunging. Cooperation among federal, state, and local law-enforcement agencies also makes a difference. So, too, do operations targeting gangs, trafficking

organizations, and violent drug dealers. Equitable enforcement of fair laws is critical. We are a nation wedded to the prospect of equal justice for all. Punishment must be perceived as commensurate with the offense. Finally, the criminal justice system must do more than punish. It should use its coercive powers to break the cycle of drugs and crime. Treatment must be made available to the chemically dependent in our nation's prisons.

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

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

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

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

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

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

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

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

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

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

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

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self-destructive and criminal behavior. Treatment can help them end dependence on addictive drugs. Such programs, moreover, 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. On the way to that goal, reducing drug use, improving the addict's ability to function, and minimizing medical consequences are useful interim outcomes. Treatment options include therapeutic communities, behavioral treatment, 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 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.[3] The same survey also revealed that long-term residential treatment achieved similar successes.

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.[4] NTIES' principal conclusions are that:[5]

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

- All types of programs can be effective. Methadone programs, outpatient treatment, and both short and long-term residential programs reduced drug use among participants.

- Criminal activity declines after treatment. Approximately half (48.2 percent) of the NTIES respondents were arrested in the year before treatment, but only 17.2 percent were arrested in

the year after treatment. Similar decreases were observed among respondents who claimed their primary income source were illegal activities.

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

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

For prevention and treatment to be effective, we must address the unique needs of different populations. As a result of managed care and changes in the welfare and health-care delivery system, needed services may be less available to vulnerable populations, including pregnant and parenting women; racial and ethnic minorities such as African-Americans, Native Americans, Hispanics, and Asian/Pacific Islanders; the children of substance-abusing parents; the disabled; youth living in poverty; and people with co-occurring mental disorders. Recent studies indicate that over 40 percent of persons with addictive problems also have co-occurring mental disorders. Our overall challenge is to help chronic drug users overcome dependency so that they can lead healthy and productive lives and the social consequences of illegal drug abuse are lessened.

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 adult drug users are employed. Workplace policies like drug testing and Employee Assistance Programs that include prevention, intervention, and referral to treatment can reduce drug use.

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

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

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

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

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

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

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

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

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

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

Each year, more than sixty-eight million passengers arrive in the United States aboard 830,000 commercial and private aircraft. Another eight million individuals arrive by sea, and a staggering 365 million cross our land borders driving approximately 115 million vehicles.

Ten million trucks and cargo containers and ninety thousand merchant and passenger ships also enter the United States annually, carrying some four hundred million metric tons of cargo. Amid this voluminous trade, drug traffickers seek to hide approximately three-hundred metric tons of cocaine, thirteen metric tons of heroin, vast quantities of marijuana, and smaller amounts of other illegal substances.

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

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

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

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

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

Rationale: Mexico -- both a transit zone for cocaine and heroin and a source country for heroin, methamphetamine, and marijuana -- is key to reducing the flow of illegal drugs into the United States. Also important in this regard are 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.

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

The United States continues to focus international drug-control efforts on drug-source countries. International drug-trafficking organizations and their production and trafficking infrastructures are most concentrated, detectable, and vulnerable to effective law-enforcement action in source countries. The coca and opium poppy growing areas are easily detectable and relatively fixed. The cultivation of coca and opium poppy and production of cocaine and heroin is labor intensive and can be easily disrupted. The international drug control strategy seeks to bolster source country resources, capabilities, and political will to reduce cultivation, attack production, and disrupt and dismantle trafficking organizations, including their command and control structure and financial underpinnings.

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

Rationale: Eliminating the cultivation of illicit coca and opium is the best approach to combating cocaine and heroin availability in the 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 and forfeiting their ill-gotten wealth, we can make them more vulnerable

to law enforcement and deny them experienced leadership, political power, and economies of scale that have enabled them to be so successful in the past.

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

Rationale: The United States must continue assisting major drug-producing and transit countries that demonstrate the political will to attack illegal drug production and trafficking. We should reinforce institutional capabilities to reduce drug-crop cultivation, drug production, 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 both developed and developing countries. The United States must continue providing leadership and assistance to strengthen the international anti-drug consensus. It is in America's interest to encourage all nations to join together against the threat of illegal drugs. The United States must also support multilateral drug control by maintaining full compliance with the 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 and forfeiture of associated assets.

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

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

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

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

B. Targets

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

- Reduction of unlawful drug use to 3 percent or less of the U.S. population by December 31, 2003 (as measured in terms of overall illicit drug use during the past thirty days by the National Household Survey) and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003 respectively.

- Reduction of unlawful adolescent drug use (as measured in terms of illicit drug use during the past thirty days by the Monitoring the Future survey of the University of Michigan or the National PRIDE survey conducted by the National Parents' Resource Institute for Drug Education) to 3 percent or less of the U.S. adolescent population by December 31, 2003 and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003 respectively.

- Reduction of cocaine, heroin, marijuana, and methamphetamine availability in the United States by 80 percent by December 31, 2003.

- Reduction of the nationwide average street purity levels for cocaine, heroin, marijuana, and methamphetamine (as estimated by the interagency drug-flow assessment led by ONDCP, the Drug Enforcement Administration, and other national drug- control program agencies) by 60 percent by December 31, 2003, and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003 respectively.

- Reduction of drug-related crime in the United States by 50 percent by December 31, 2003 and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003, respectively, including:

    - Reduction of state and federal unlawful drug trafficking and distribution.

    - Reduction of state and federal crimes committed by persons under the influence of unlawful drugs.

    - Reduction of state and federal crimes committed for the purpose of obtaining unlawful drugs or obtaining property that is intended to be used for the purchase of unlawful drugs.

- Reduction of drug-related emergency room incidents in the United States (as measured by the Drug Abuse Warning Network), including incidents involving gunshot wounds and automobile accidents in which illicit drugs are identified in the bloodstream of the victim, by 50 percent by December 31, 2003.

It is the sense of the Congress that these targets are important to the reduction of overall drug use in the United States, and that the *National Drug Control Strategy* should seek to achieve them. The extensive national consultation process that produced this *1999 National Drug Control Strategy* also yielded the conclusion that the specific targets outlined in the Office of National Drug Control Policy Reauthorization Act of 1998 cannot be achieved by December 31, 2003 but may be achieved by the end of 2007. Accordingly, this *Strategy* responds to Congressional guidance by listing ninety-four specific, quantifiable, and measurable targets for 2002 and 2007. Collectively, they will orient a national effort that can reduce illegal drug use and availability by 50 percent over the next eight years and the consequences of drug abuse by at least 25 percent. The twelve core targets follow.

Demand Reduction

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

2. **Reduce the prevalence of illicit drug and alcohol use among youth 20 percent by 2002 and 40 percent by 2007. Reduce the prevalence of tobacco consumption among youth 25 percent by 2002 and 55 percent by 2007** (compared to the base year -- 1996). In 1996, the prevalence of drug use in the twelve to seventeen-year-old population was 9 percent. The 40 percent reduction from the 1996 prevalence rate will produce a 5.4 percent rate in 2007. Achieving these critical targets will allow the nation's sixty-eight million young to fulfill their potential as healthy, productive members of society.

3. **Increase the average age of first-time drug use by twelve months by 2002 and thirty-six months by 2007** (compared to the base year -- 1996). In 1996, the mean age for first-time use of marijuana 16.4 years.[6] Research establishes that individuals who do not use alcohol, tobacco products, or psychoactive substances during adolescence have a greatly reduced likelihood of ever developing substance-abuse problems. Delaying the initial use of illicit substances and illegal drugs by thirty-six months will reduce substantially the number of individuals who have lasting substance-abuse or chemical-dependency problems.

4. **Reduce the prevalence of drug use in the workplace by 25 percent by 2002 and 50 percent by 2007** (compared to the base year -- 1996). Approximately 74 percent of adult drug users are employed. Consequently, workplace-based drug prevention and education programs can contribute to a reduction in the number of drug users and improve the health, safety, and productivity of the American workforce. In 1996, there were approximately 6.1 million employed drug users. Attainment of this target will reduce that number by three million.

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

The principal instruments that will be used to track progress for these demand-reduction impact targets are the Department of Health and Human Services' (HHS') *National Household Survey on Drug Abuse* and the federally-funded University of Michigan *Monitoring the Future* study. The interagency Data, Evaluation, and Interagency Coordination Subcommittee is examining ways to correct the tendency of existing surveys to undercount chronic drug users.

Supply Reduction

6. **Reduce the domestic availability of illegal drugs by 25 percent by 2002 and 50 percent by 2007** (compared to the base year -- 1996). In 1996, an estimated *xix* metric tons (MTs) of cocaine, *y.* MTs of heroin, *z* MTs of methamphetamine, and *ww* MTs of marijuana were available for consumption in the United States. Variations in wholesale/retail prices and purities of drugs are indirect and often inaccurate estimates of availability as a result of their dependence on both supply and demand. Reduced supply, for example, would result in higher prices and lower purity levels were demand to remain constant. Conversely reduced demand and constant supply would result in lower prices and higher purity levels.

7. **Reduce the rate of shipment of illegal drugs from source countries by 15 percent by 2002 and 30 percent by 2007** (compared to the base year -- 1996). In 1996, an estimated *xix* metric tons (M.S.) of cocaine and *y.* Metric tons. of heroin were available for export from cocaine and heroin-producing countries.

8. **Reduce the rate at which illegal drugs enter the United States by 10 percent by 2002 and 20 percent by 2007** (compared to the base year -- 1996). ONDCP is leading an interagency effort to develop an official estimate of drug flow through the transit and arrival zones.

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

Consequences

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

12. **Reduce the health and social costs associated with drug trafficking and use by 15 percent by 2002 and 30 percent by 2007** (compared to the base year -- 1996). Drug abusers engage in high-risk behavior making them and their associates susceptible to a range of diseases, like tuberculosis, HIV and hepatitis. Drug use contributes to birth defects and infant mortality, facilitates the spread of infectious diseases, undermines workplace safety, and leads to premature death. According to the Centers for Disease Control and Prevention, 1,919 cases of TB that were reported in 1996 were related to drug use (11.5 percent of all cases).

III. MONITORING THE *STRATEGY'S* EFFECTIVENESS

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

The PME system identifies ninety-four performance targets, of which twelve (outlined in the preceding section) indicate the impact of national drug-control activities on the *Strategy's* five overarching goals. The other eighty-two measure progress toward the *Strategy*'s thirty-two supporting objectives. These targets represent desired end-states for the years 2002 and 2007. They are "stretch targets" in that they require progress above that attained in previous years.

This assessment is in keeping with recommendations from the National Academy of Public Administration, the General Accounting Office, and other organizations advocating good government practices. The overall performance system is described in detail in a companion volume to this *Strategy -- Performance Measures of Effectiveness: Implementation and Findings.*

Progress toward each goal and objective will be gauged using existing research and new surveys. *Monitoring the Future* and the *National Household Survey on Drug Abuse,* for example, both estimate risk perception, rates of current use, age of initiation, and life-time use for alcohol, tobacco, and most illegal drugs. The *Arrestee Drug Abuse Monitoring* system and *Drug Abuse Warning Network* indirectly measure the consequences of drug abuse. The State Department's annual *International Narcotics Control Strategy Report* provides country-by-country assessments of initiatives and accomplishments. It reviews statistics on drug cultivation, eradication, production, trafficking patterns, and seizure along with law-enforcement efforts including arrests and the destruction of drug laboratories. The 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 data shortfalls related to drug policy. The Department of Agriculture, for example, is designing a first-ever domestic cannabis cultivation survey. It will produce annual by-state estimates of areas under cultivation and potential yields.

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

This PME system complies with Congressional guidance that the *National Drug Control Strategy* contain measurable objectives and specific targets to accomplish long-term quantifiable goals. Indeed, the Office of National Drug Control Policy Reauthorization Act of 1998 strongly endorses this performance measurement system. In accordance with the Act, this system establishes clear outcomes for reducing drug use nationwide during the next five years and is linked to all agency drug-control programs and budgets receiving funds scored as drug-control agency funding. These targets and the accompanying performance measurement system will allow Congressional appropriations and authorizing committees to restructure appropriations in support of the *National Drug Control Strategy.*

Implementation of the PME system has begun within the federal government. Federal drug-control program agencies have formed five steering groups and twenty-one working groups. The former consist of higher-level agency representatives and provide guidance for the PME development and implementation processes. The latter are assessing the adequacy of data

sources to support the PME system. To date, the working groups have identified adequate databases for twenty-seven of the ninety-four performance targets in the PME system. They also have determined that the twenty-eight performance targets that are milestones do not require databases. Finally, they have determined that thirty-nine milestones are not adequately addressed by existing databases and have recommended new survey instruments to the interagency Data, Evaluation, and Interagency Coordination Subcommittee.

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

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

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

Endnotes

1. Brief descriptions of the major data sources used to estimate illegal drug availability, prevalence, and the criminal, health, and social consequences of their use is contained in the data appendix of this *Strategy*.

2. *Performance Measures of Effectiveness: Implementation and Findings* is a companion volume to this document.

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

4. Substance Abuse and Mental Health Services Administration, *Services Research Outcomes Study (SROS)* (Bethesda, Md.: U.S. Department of Health and Human Services, 1997); National Institute on Drug Abuse, *Drug Abuse Treatment Outcome Study (DATOS)* (Bethesda, Md.: U.S. Department of Health and Human Services, 1997), and D. R. Gerstein et al., *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA)* (Sacramento, Calif.: California Department of Alcohol and Drug Programs, 1994).

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

6. Estimates of age of first-time use are made by comparing data from the last two surveys. Thus, a 1998 survey which collects data in 1997 will compare figures to 1996 data to yield a 1996 figure for first-time use. *NOTE - this needs to be explained clearly by our data experts.*

IV: A Comprehensive Approach

In the preceding chapter, we detailed the goals and objectives that comprise the *Strategy*. This chapter provides the action plan that enables the accomplishment of the defined goals and objectives.

Governments set policy. But policy can only be implemented with specific, resourced programs. The pages that follow identify specific components of the national drug problem, outline how challenges will be met and opportunities seized in each of these areas, and describe what programs will be used to effect progress in reducing drug abuse and its consequences. As such, this chapter presents the operational core of the *Strategy*.

1. A National Strategy

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

The United States is not an island disconnected from the rest of the world. Although we grow or manufacture many of the illegal drugs we consume (such as marijuana and methamphetamine), the international drug trade is driven in large part by our citizens' demand for drugs and their willingness to pay for them. Moreover, we understand that not only do our cravings and money fuel the drug trade, but that as we bring our consumption patterns down, drug traffickers will search for markets elsewhere creating problems for other nations. Therefore, though national in focus, the *Strategy* includes bilateral, multilateral, and international initiatives designed not only to lessen our own drug problems, but to help all countries address the illegal drug threat to their own well being, as well.

It is clear, however, that domestically the job of reducing drugs in America cannot be done without coordination across government lines at the federal, state, and local level nor without close cooperation between the public and private sector. Such joint effort is motivated by the strong concern Americans have for their children in light of the drug threat. In a 1997 poll, for example, when asked to mention the top problems facing children, responders mentioned drugs at more than twice the rate of the second most mentioned problem (crime) and almost four times the rate for such basic issues as a good education. [1] This concern for children and the nation at large has resulted in a significant commitment from the federal government whose aggregate counterdrug budget has grown from $13.5 billion in fiscal year 1996 to $17.8 billion in 1999. Over fifty federal agencies work together under the guidance of this *Strategy* to reduce the scope of the national drug problem.

State and Local Government

But the federal government cannot accomplish the objectives laid out in this *Strategy* without the support of the fifty states and four territories of the United States, and the thousands of city, county, and local governments confronted by the dangers of illegal drugs. State governments, for example, have enormous potential for solving the problem. They administer the school systems, exercise far-reaching jurisdictional power, channel money and resources to specific needs, and educate citizens about the dangers of illegal drugs so that collective action is possible. States funds account for perhaps two-thirds of spending on drug prevention and treatment and provide funds to more than seven thousand community-based treatment programs, and a similarly large number of prevention providers. State government can and should play an important role in integrating federal funding and coordinating statewide responses to the drug threat. Each of the states must join as partners with the federal government to counter its drug challenges. Focus on the specifics of regional and local drug problems by state governments in consideration with the federal government promises to maximize return on efforts and resources invested.

While each state and municipality has its own drug challenge, every level of government can organize for effective counter-drug measures. As the *Strategy* points out, any counter-drug approach should offer several distinct solutions to a multifaceted problem. Prevention, law enforcement, correctional system initiatives, education, treatment, and community-based efforts can focus on different aspects of the issue while integrating approaches to produce a total greater than the sum of its parts. Organization is the key for it allows information to be shared, actions to be coordinated, and accountability to the public maintained.

Coalitions and Civic Organizations

Government response, however, is only a small part of what must be a truly national effort to counter illegal drugs. More than four thousand community-based organizations are coordinating local responses to the illegal drug problem. The Community Anti-Drug Coalitions of America (CADCA) supports these coalitions through technical assistance, leadership development, and information dissemination. The Corporation for National Service is supporting coalitions through initiatives like Learn and Serve, Americorps, and SeniorCorps programs. The National Guard also supports communities by providing administrative and logistical support to coalitions, education, and support for prevention programs like Adopt-a-School. Civic and service alliances likewise offer a great deal of support to the national counter-drug effort. Almost fifty national and international civic and service organizations have been involved in prevention and education activities that have helped to mobilize their aggregate fifty-five million volunteers. A significant majority of these organizations have agreed to integrate their activities through a core alliance ["Prevention Through Service"], pledging over a million volunteer hours to prevent the use of illegal drugs.

Drug-Free Workplace Programs

According to the *1997 National Household Survey on Drug Abuse*, 6.7 million current illegal drug users were employed full time. This number represents 6.5 percent of full-time employees aged 18 and older. Early identification of impaired employees combined with the provision of appropriate treatment services reduces employers' costs associated with employee recruitment, selection, training, and retention and improves productivity. Early intervention for working drug abusers is also an effective prevention strategy, since one of the best ways to prevent substance abuse by adolescents is to motivate their parents to reject illegal drugs and substance abuse. Prevention in the workplace will also reduce the number of initiates since many people begin to use illegal drugs after entering the workplace. Fully one-third of all current adult marijuana users began using drugs after completing the twelfth grade.

Private businesses, too, have and must continue to join in the nationwide resistance to drug abuse. Indeed, both public and private work places have organized to keep their environments drug-free. The *Strategy* encourages public and private-sector employers to include the millions of small businesses to initiate comprehensive drug-free workplace programs. Effective procedures could include written anti-drug policies, education, employee-assistance opportunities featuring problem identification, referral, treatment 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 for help. Workplace anti-drug policies can help prevent drug abuse among millions of young people who have part-time jobs. As the nation'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, Office of Personnel Management and Department of Justice. These agencies represent about 1.8 million employees--the vast majority of the federal civilian workforce.

The U.S. military is a prime example of how institutional values and leadership can create a drug-free environment. A generation ago, the uniformed ranks were notoriously drug laden. Today, a minuscule proportion (in the neighborhood of one per cent) of defense personnel, uniformed and civilian, use drugs. That turn-around was achieved by prevention and education combined with strong first-line supervisory leadership that made it clear that illegal drug use was unacceptable behavior.

The Omnibus Transportation Employees Testing Act of 1991 requires drug testing of approximately eight million safety-sensitive employees in the United States who work in regulated business in the aviation, motor, carrier, rail, transit, pipeline, and maritime industries. Consequently, the Department of Transportation (DOT) oversees the nation's largest workplace drug-testing program. DOT requires workers in safety-sensitive positions who test positive for drugs to be referred to substance-abuse professionals before returning to work. If substance abuse is diagnosed, the employee must receive treatment before resuming duties. This program--which also requires drug testing for operators of commercial motor vehicles from Canada and Mexico--has become a model for non-regulated employers throughout the United States and in other countries around the world. 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 Information Database.

Athletic Initiative

Organized athletics also offer opportunities to reach young people across America and engage them in drug free activities. Each year approximately 2.5 million young people play high and junior high football and basketball alone. Millions of other children are involved in other sports, such as youth soccer leagues. Studies show that a young person involved in sports is roughly 40 percent less likely to get involved with drugs than an uninvolved peer. At the same time, however, scores of children look up to professional and other elite athletes; often, the messages being sent to young people by these athletes about drugs are mixed, if not pro-drug use. In 1998, ONDCP began an Athletic Initiative designed to both eliminate drug use within sports, and to encourage the athletic world to speak out against drug use and encourage youth to get involved with sports not drugs. ONDCP's National Coachathon Against Drugs involved professional and amateur sports leagues. One hundred thousand copies of a *Coaches Playbook Against Drugs* were distributed. Eighteen Major League Baseball clubs and several National Football League teams now show anti-drug messages in their stadiums. In 1999, ONDCP will conduct a national summit to address the full range of sports-related drug issues.

Faith Initiative

The faith community plays a vital role in building societal values, informing the actions of individuals and inculcating young people life skills, all of which are critical to the fight against drugs. The clergy--rabbis, priests, clerics, ministers and others--are civic leaders. Many also run programs that provide much needed counseling and drug treatment support to members of their communities. For these reasons, the Office of National Drug Control Policy is expanding our outreach to the faith community. In 1999, we will expand efforts to encourage the religious community of this nation to speak out with one voice against drugs and to further develop faith-based initiatives to treat and prevent drug use.

Countering Attempts to Legalize Drugs:

Given the negative impact of drugs on American society, it is not surprising that the overwhelming majority of Americans reject illegal drug use. Indeed, millions of Americans who once used drugs have since turned their backs on such self-destructive behavior. But if most Americans remain steadfast in their condemnation of drugs, small elements at either end of the political spectrum argue that it is not drugs, only their prohibition, that create problems. They offer their solution in various guises, but at the center of all of these positions is the point that "harm reduction" of drug use can be achieved by legalizing some (indeed, some argue all) drugs.

The so-called harm-reduction approach to drugs uses misleading terminology. All drug policies claim to reduce harm. No reasonable person advocates a position consciously designed to be harmful. The real question is: which policies actually decrease harm and increase good?

The approach advocated by people who say they favor "harm reduction" would, in fact, harm Americans.

The theory behind what they call harm reduction is that illegal drugs cannot be controlled by law enforcement, education, and other methods: therefore, proponents say, harm should be reduced by decriminalization of drugs, heroin maintenance, and other measures. But the real intent of many harm reduction advocates is the legalization of drugs, which would be a mistake.

Some of these advocates argue that they are not calling for the legalization of drugs, or if they are, only for "soft" drugs. The latter is a meaningless categorization since many people enter treatment every year for help to recover from chronic compulsive use of marijuana and other so-called "soft" drugs. Others would argue they are calling merely for the decriminalization of drugs, a view that while drug use remains outside the law, penalties should be so minor as to not demand any serious punishment of those who would use them anyway, thereby making illegal drug use analogous to minor social indiscretions like jay-walking. Yet, others would argue the anecdotal therapeutic value of specific drugs or the economic viability of a drug-related product. By making drug use more acceptable and less constrained, these people argue, society would thereby reduce the harm associated with drug use.

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

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

Countering Attempts to Legalize Marijuana

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

In response to anecdotal claims about marijuana's medical effectiveness, NIDA has sponsored conferences, involving leading researchers and is supporting peer-reviewed research on the drug's effects on the immune system. ONDCP is also supporting a major study of existing research on marijuana's potential benefits and harms. This eighteen-month study, conducted by the National Academy of Science's Institute of Medicine, is considering scientific evidence on several topics related to the use of marijuana, including: marijuana's pharmacological effects; the state of current scientific knowledge; the drug's psychological 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 may offer potential therapeutic benefits. However, both law and common sense dictate that the process for establishing substances as medicine be thorough and science-based. By law, laboratory and clinical data are submitted to medical experts in the Department of Health and Human Services including the Federal Drug Administration for evaluation of their safety and efficacy. If the scientific evidence is sufficient to demonstrate that the benefits 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 de facto legalization of marijuana cultivation because both hemp and marijuana come from the same plant--cannabis sativa, which contains THC, the active ingredient in marijuana. Chemical analysis is the only way to differentiate between *Cannabis* variants intended for hemp production and hybrids grown for their psychoactive properties.[2] Current law declares that THC is a Schedule I controlled substance; the amount of THC in the plant is not defined in the law, thereby rendering any amount of THC as a Schedule I controlled substance. Furthermore, in June 1998, a New Hampshire magistrate determined that the Controlled Substances Act clearly and unambiguously prohibits the cultivation of hemp. The magistrate found that hemp (plant) is marijuana under the statute's definition.

Nor, according to a Department of Agriculture review of university studies, is hemp likely to be a sustainable, economically viable alternative crop given the uncertainty about demand and expected market prices. The current U.S. market for hemp products is small and the potential seems to be high to reach a situation of oversupply quickly in this niche market. For every proposed use of industrial hemp, there already exists competing raw materials and proven manufacturing practices. The ready availability of other lower-cost raw materials is a major reason for a 50 percent drop in worldwide hemp production since the early 1980s.

Given the concerns about encraching efforts to justify the legalization of harmful psychoactive drugs, the *1999 Strategy* outlines specific steps to counter the potential harm such activities pose. These steps are elaborated throughout this document and include:

(1) Presenting the facts ands information that establish the harm caused by substance abuse.

(2) Educating our youth that substance abuse is antithetical to their health and well being.

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

(4) Working with state and local governments to as well as community coalitions and civic associations to educate them on the techniques and risks associated with the legalization movement.

(5) Ensuring the rule of law.

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

2. Preventing Drug Abuse

Preventing or delaying use of psychoactive drugs among adolescents is a critical national public health goal. The simplest and most cost-effective way to lower the human and societal costs of drug abuse is to prevent it in the first place – as the saying goes, an ounce of prevention is worth a pound of cure. More than 255 million Americans do not use illegal drugs. Some sixty-one million Americans who once used illegal drugs have now rejected them. Those former drug users, their families, their communities, and their fellow students and employees would all have been far better off if they had not used illegal drugs in the first place. Many of those drug users suffered as a result of their drug abuse. Accidents, addiction, criminal involvement, damaged relationships, impaired judgement, and lost educational and employment opportunities were their common experiences. Of the fourteen million Americans who currently use illegal drugs, some four million are addicted. Clearly, preventing America's sixty-eight million children from turning to drugs will safeguard our society. It is one of the best investments we can make in our country's future and preferable to having to deal with the consequences of drug abuse through enforcement or treatment.

If there is one single age group where prevention holds the most promise, it is our impressionable young. People are most susceptible to the allure of illicit drugs during their adolescent years.[3] Delaying or preventing the onset of substance use (including illegal drugs, alcohol, and tobacco) during adolescence and young adulthood is essential. Not only does hazardous use during adolescence put young people at risk of experiencing negative short-term consequences of substance use, but the early onset of substance use is an independent risk factor for substance-related harm and adjustment problems in later life.[4] In other words, those who do not use illegal drugs, alcohol, or tobacco during adolescence will probably never develop a

chemical-dependency problem. This is also the group where prevention is demonstrably most effective.

In addition to completely deterring some initiations, prevention programs help to influence those that do use drugs to use lower amounts in less destructive ways. Drug prevention programs also generate diverse collateral benefits.[5] Successful substance abuse prevention also leads to reductions in traffic fatalities, violence, unwanted pregnancy, child abuse, sexually transmitted diseases, HIV/AIDS, injuries, cancer, heart disease and lost productivity. Preventing an initiation into drug use is cost effective. Historically, the average career of cocaine use has involved consumption of 300-400 grams of cocaine. In 1992, twenty-three billion dollars in social costs were associated with the 291 metric tons of cocaine consumed in the US, or about $80 per gram.[6] That suggests that preventing an average cocaine initiation averts on the order of $24,000 - $32,000 in social costs.

Prevention Works

Evidence from controlled studies, national cross-site evaluations, and Center for Substance Abuse Prevention (CSAP) grantee evaluations demonstrates that prevention programs work.[7] School-based prevention programs have delayed or negated the onset of substance use. Interventions involving as few as ten to thirty contact hours can affect not only attitudes and knowledge about drugs, but also use of cigarettes and marijuana.[8] The positive effects of good junior high school interventions persist at least into the 12th grade.[9] Examples of CSAP prevention successes include a Cornell University study of six thousand students in New York state that found that the odds of drinking, smoking, and using marijuana were 40 percent lower among students who participated in a school-based substance abuse program in grades 7-9 than among their counterparts who did not, and an assessment of Project Star that found that forty-two participating schools in Kansas City, Missouri reported less student use of alcohol, tobacco, and marijuana than control sites.[10]

The Central Role of Parents

Parents remain the greatest influencers of children. More than 80 per cent of all youth don't use drugs. When asked the main reason for their abstinence, the overwhelming answer is that their parents told them not to. Conversely, when children that use drugs are asked if their parents told them not to, the majority replied in the negative. Parents of children ages 8 to 12 are especially important in affecting youth behavior. Children in this age group normally have negative attitudes toward the use of drugs. Such attitudes and their attendant behavior are readily reinforced by involved parents. Parents who defer guiding their children away from drugs until after they reach the age when they are more easily influenced by peers or after they have started using alcohol, tobacco, or other drugs decrease their ability to influence their children's attitudes and behavior.

Parental example is also a key determinant of adolescent drug use. Parents, who are children's first heroes, model the use of substances from a tender age and as part of the daily fabric of life. Research has consistently demonstrated that children who have alcohol or other drug-addicted parents are at the highest risk for developing problems with drugs and alcohol, and a host of other related problems. There are an estimated eleven million such children under age 18 in the United States. These children receive many conflicted and confusing messages about substance use and abuse in their homes every day. Specially crafted education and prevention messages can break through the levels of denial inherent in these family messages.

Teachers, coaches, youth workers in all areas of life from faith communities to scouts, and extended family members also provide important protection for youth and support of parental prevention messages by modeling, teaching, and reinforcing life skills. These "occasional preventionists"are especially vital to touching the lives of children living in chemically dependent families. They must understand the nature of adult addiction and its devastating impact on children and that, with small steps, they can make a permanent difference in the trajectory of an affected child's life.

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Limitations of Prevention

Prevention programs must not be seen as vaccinations that inoculate against substance abuse. Sadly, significant numbers of youth that receive best practice programs will go on to use drugs. Prevention program effectiveness is difficult to measure given the significant time lag between attitudinal shifts and actual drug use. *Monitoring the Future* (MTF) historical data, for example, demonstrates that youth marijuana use tends to change inversely proportional to the percentage of youths who disapprove of occasional marijuana use or perceive such use as being risky. According to MTF data, usage rates change two years after attitudes do. Prevention affects the number of initiates and light users much more than it does the number or consumption patterns of heavy users. Finally, since rates of drug use over time display an epidemic character, with phases of incubation, expansion, plateau, and decline,[11] prevention will be more effective early in this cycle when use spreads like a contagion with existing users introducing others to the drug. At that time, convincing one person to abstain can preempt a cascade of initiations as others follow suit. It will be less effective in the later stages of the epidemic. This suggests that prevention programs must continuously reach each rising cohort and not be reactive.

National Youth Anti-Drug Media Campaign

The goal of the National Youth Anti-Drug Media Campaign is to educate and enable America's youth to reject illegal drugs. This goal includes preventing drug use and encouraging occasional users to discontinue use. The campaign focuses on primary prevention of drug abuse, which means preventing drug abuse *before* it starts, for three reasons. First, primary prevention targets the underlying causes of drug use, and, therefore, has the greatest potential to reduce the scope of the problem over the long term. Second, over time a primary prevention

campaign will lessen the need for drug treatment services, which are in short supply. And third, a media campaign has greater potential to affirm and reinforce the anti-drug attitudes of youth who are not involved in drug use than to persuade experienced drug users to change their behavior.

Media have come to play an increasingly important role in public health campaigns due to their wide reach and ability to influence behavior in a variety of ways. There is convincing evidence that carefully planned mass media campaigns can reduce substance abuse by countering false perceptions that drug use is normative and by influencing personal beliefs that motivate drug use. Media campaigns have been used to prevent or reduce consumption of illegal drugs and smoking and risky behaviors such as driving under the influence of alcohol or without seat belts. For all their power to inform and persuade, the media alone are not likely to bring about large, sustained changes in drug use behavior. This campaign will be truly successful only if media efforts can be coordinated with and reinforce other initiatives in homes, schools, and communities.

The campaign began in January 1998 in twelve test sites and was expanded to the entire country in August. It is harnessing a diverse media mix including television, video, radio, print, and Internet and other forms of new media to deliver anti-drug messages. The campaign's communication objectives are "universal" in that they are intended for virtually all adolescents and their parents or other primary care givers. The specific messages developed to realize those objectives, and the channels through which these messages are delivered are tailored to respond to regional, ethnic, and cultural, gender, and age differences among members of the target audiences. Within the media mix, messages are being delivered through the full range of media content including paid and public service advertising, news, public affairs programming, and entertainment programming. The campaign has further extended its reach and opportunity to tailor messages by developing partnerships with a broad range of community and civic groups, professional associations, government agencies, and corporations. In its first year, the campaign has exceeded the goal of reaching 90 percent of the target audience with four messages a week. Presently, 95 percent of the target audience receives seven anti-drug messages a week.

Drug Prevention Coordinators in Schools

This federal program will support the hiring of drug prevention coordinators in middle schools across the country to help improve the quality and effectiveness of drug prevention programs. School coordinators will analyze their schools' drug problems, identify appropriate research-based prevention programs to address those problems; assist teachers, coaches, counselors and faculty adopt and implement those programs, and integrate school-based prevention programs to their communities. This program will also require coordinators to provide feedback on program effectiveness to state educational agencies. The Department of Education's Safe and Drug Free Schools program will fund this program.

Drug-Free Schools State Supplement

The Safe and Drug-Free School and Communities Program (SDFSC) is the only federal drug prevention program intended to reach all school-age children. Under current law, states receiving Safe and Drug-Free Communities funding are given wide latitude in the use of federal funds. Many states make grant awards for anti-violence programs with little, or no, drug prevention nexus. In addition, many schools that use SDFSC funds for prevention activities do not use the funds for research-based prevention programs. The Drug-Free Schools State Supplement (DFS3) is a new program that will provide increased funding for research-based drug prevention programs in schools and leverage additional funds for research-based drug prevention activities from the SDFSC state grant program. The DFS3 program is a voluntary, competitive grant program making supplemental funding available to state agencies that provide funding for research-based drug prevention activities. States interested in participating in DFS3 will be required to identify matching funding within funds provided to the state as part of the SDFSC program that support research-based prevention activities. The matching requirement will be 1:1 for first year participation in this program. For each year thereafter, the matching requirement will increase by 0.5, up to a maximum matching requirement of 4:1.

Mentoring Initiative

This initiative will implement a national mentoring program which focuses on reducing some of the problem areas with which youth struggle, especially alcohol and drug use. This will be accomplished by recruiting and training adult mentors to reach at-risk youth in at least four states through demonstration programs, and, if evaluations of the program are positive, will be expanded to more states by FY 2004. This initiative will be administered by the Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration (SAMHSA). The National Family Strengthening Initiative will help communities to adopt science-based effective family strengthening, tutoring and mentoring programs, which both enhance youth resiliency and reduce family psychosocial risk factors.

Research-Based Prevention Programs in Schools

The Department of Education will establish research-based drug prevention programs in five-hundred additional school districts by FY 2004. This program will include demonstrations to test, evaluate, and promote effective drug prevention programs. The dissemination as well as translation and application of new prevention knowledge is also accomplished through applied activities such as the SAMHSA Knowledge Development and Application program.

Youth Drug Prevention Research

NIDA will conduct research on use by adolescents of legal drugs as well as illegal drugs. This basic research on drug abuse and addiction among children and adolescents, plus the increased dissemination of research project findings, will strengthen prevention program activities. To accomplish this, NIDA will conduct a program of basic, clinical and epidemiological research designed to improve the understanding of drug abuse and addiction

among children and adolescents. These findings will be shared with outside groups to assist in the development of effective prevention programs.

Youth Substance Abuse Prevention

This initiative will use findings from successful programs to develop new state incentive grant drug prevention programs in early childhood as well as among adolescents. CSAP will administer this State Incentive Grant (SIG) program. These competitive grants will foster the implementation of science-based and effective prevention services by requiring each state to direct 85 percent of awards to support community-based substance abuse prevention services. The SIG program serves as an incentive for governors to leverage prevention funding streams and develop and implement comprehensive plans for a more strategic allocation of prevention funds. This SIG program is a key activity within CSAP's Knowledge, Development and Application program.

Youth Tobacco

The Youth Tobacco Initiative is a multifaceted approach to reducing youth tobacco use. The campaign includes regulatory and legislative aspects as well as programmatic funding for the Department of Health and Human Services for an array of activities spanning prevention research to regulatory enforcement. This initiative combines the efforts of the National Institute on Drug Abuse (NIDA) with the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC). NIDA's efforts for this initiative are focused on developing research on science-based drug abuse prevention programs, which can be effective in reducing the risk of adolescent drug use.

The Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) within HHS are the lead agencies for developing legislative, regulatory and programmatic issues relating to youth tobacco prevention. The CDC supports the Youth Tobacco Initiative through funding it provides to state health departments and national organizations to conduct tobacco use prevention and reduction programs. State tobacco control programs assist and support local communities to undertake tobacco control activities, conduct media and educational campaigns, support training on tobacco topics, and monitor changes in tobacco use behaviors. The CDC effort includes funding for a nationwide paid counter-advertising campaign to deglamorize tobacco use. Resources will also allow for enhancement of national surveillance systems to monitor state-specific tobacco use.

The FDA efforts are focused on three areas: Compliance Outreach, Enforcement and Evaluation, and Product Regulation. Compliance Outreach will increase the outreach efforts to increase the knowledge of retailers and enlist their support in enforcing FDA rules and regulations on the advertising and sale of tobacco products to youth. The requested FY 2000 level will allow outreach to 2 to 3 markets in all 50 states. Enforcement and Evaluation funding will be used to commission state and local officials to conduct unannounced purchase attempts using young people under the age of 18. Enforcement goals include having all retail establishments compliance checked at least once per year. Finally, Product Regulation funding

will implement the final rule on cigarette classification and provide necessary funding for inspections of tobacco companies to review and analyze ingredients, constituents, and additives and to assist with compliance.

Youth Alcohol

Alcohol is by far the drug of choice of American youth. Data from the National Longitudinal Alcohol Epidemiologic Survey sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides convincing evidence that the younger an individual is when he or she begins drinking, the greater the chances of developing a clinically diagnosable alcohol use disorder in the future. The relative risk for many alcohol-related illnesses rises along with the quantity and frequency of alcohol consumption. Other consequences include motor vehicle crashes, injuries, high-risk activities, unprotected sex, violence, crime, and costs to society for police, courts, and jails. NIAAA is sponsoring research that addresses the problems of adolescent and childhood drinking, especially the effects of individual biology, childhood home and school environments, and employment and social policies on pre-adult drinking. NIAAA is funding alcohol prevention research, especially on college campuses.

Drug-Free Communities

The community-based anti-drug movement in this country is strong, with more than 4,300 existing coalitions already organized. These coalitions are significant partners for local, state and federal agencies working to reduce drug use, especially among young people. Coalitions typically include schools, businesses, law enforcement agencies, social service organizations, faith communities, medical groups, local and county government and youth groups. Coalitions develop plans and programs to coordinate anti-drug efforts for the benefit of communities. In many locations, integrating efforts have created comprehensive prevention infrastructures that have reduced drug use and its consequences. These community-based responses to the drug problem deserve continued support. The Drug-Free Communities Act of 1997 is currently the only federal program that explicitly funds anti-drug coalitions. The program's genesis and growth has been fueled by an unprecedented level of bipartisan support. To date, ninety-three communities have received federal grants under this program and a presidentially appointed Advisory Commission has been established. CSAP-funded Centers for the Advancement of Prevention Technology are providing communities with effective coalition training and related materials.

3. Reducing the Addicted Population

Despite our best efforts, some people will invariably use drugs. A proportion of them will become addicted. Since they constitute a group that causes untold damage to themselves, their families, and to their communities, the addicted population is a group which, though difficult to keep from abusing drugs, must be targeted as a vital part of the *Strategy*. Indeed, addicts will consume most of the heroin and cocaine in the America in any given year. Over 60 percent of them will be involved with the criminal justice system in that same time frame. By reducing the number of addicts, we can greatly decrease the negative social and human consequences of drug abuse. Drugs have well-known and severe negative consequences for abusers' health, both mental and physical. Drug abuse and addiction also have tremendous implications for the health of the public, since drug use, directly or indirectly, is now a major vector for the transmission of many serious infectious diseases, particularly HIV/AIDS, hepatitis, and tuberculosis -- and for the infliction of violence as well. Because addiction is such a complex and pervasive health issue, overall strategies must encompass a committed public health approach, including extensive education and prevention efforts, treatment, and research.

Scientific research and clinical experience have yielded a greater understanding of the essence of addiction, manifested by compulsive drug seeking and use, even in the face of negative health and social consequences.[12] Virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain, the mesolimbic reward system. Activation of this system appears to be a common element in what keeps drug users taking drugs. This is not unique to any one drug; all addictive substances affect this circuit.[13] Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional.[14]

The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting brain changes are idiosyncratic to specific drugs, whereas others are common to many different drugs.[15] We can actually see these changes through use of recently developed technologies, such as positron emission tomography. The effects that addicting substances have in common suggest that a common brain mechanism underlies all addictions.[16] Understanding that addiction is, at its core, a consequence of fundamental changes in brain function means that a major goal of treatment must be either to reverse or to compensate for those brain changes through either medications or behavioral treatments.

But addiction is not just a brain disease. The social contexts in which the disease both develops and is expressed are critically important. The case of the many thousands of returning Vietnam veterans who were addicted to heroin illustrates this point clearly. In contrast to addicts on the streets of America, treating the returning veterans' addictions was relatively easy. This was possible because the American soldier in Vietnam became addicted in an almost totally different setting from the one to which he returned. At home in the United States, he was

exposed to very few of the conditioned environmental cues that had initially been associated with drug use in Vietnam. Exposure to those conditioned cues can be a major factor in causing persistent or recurrent drug cravings and drug use relapses even after successful treatment.[17]

Addiction is rarely an acute illness. For most people, it is a chronic, relapsing disorder with a significant volitional dimension. Total abstinence for the rest of one's life is a relatively rare outcome from a single treatment episode. Relapses are more the norm. Thus, addiction must be approached more like other chronic illnesses -- diabetes, chronic hypertension -- than like an acute illness, such as a bacterial infection or a broken bone.[18] This has tremendous implications for how we evaluate treatment effectiveness and treatment outcomes. Viewing addiction as a chronic, relapsing disorder means that a good treatment outcome -- and the most reasonable expectation -- is a significant decrease in drug use and long periods of abstinence, with only occasional relapses. Thus, a reasonable standard for treatment success is not curing the illness but managing it, as is the case for other chronic illnesses.[19]

Close the Public System Treatment Gap

The number of individuals requiring treatment for illegal drug dependency is in the range of 3.7 to 4.3 million.[20] Slightly less than two million persons currently receive drug treatment services. The treatment gap is particularly wide for community-based treatment that meets the needs of severely drug-troubled teens. Moreover, there is an even more dramatic shortage of treatment in the juvenile correctional system. Adolescents with alcohol and drug problems are not adequately served in most existing drug treatment programs because these are designed for adults and not tailored to meet the specific needs of adolescents. The Institute of Medicine's 1990 report, *Treating Drug Problems*, estimated that about four hundred thousand people under 18 were annually in need of treatment. Clearly, there is a substantial gap between the number of persons in need of and the number receiving treatment services. This initiative will reduce this gap through additional federal support of treatment services. The major component of this initiative is expansion of SAMHSA's Substance Abuse Block Grant. These grants are awarded to states based on a formula that includes funding for a number of purposes including drug and alcohol services for prevention as well as treatment. SAMHSA estimates that each federal dollar spent on treatment through this grant program generates $1.50 in state and local spending on treatment. The second component is expansion of the Targeted Capacity Expansion program. This program makes awards directly to states, localities and service providers based on demonstrated need.

Parity for Substance Abuse Treatment

Presently, most employer-provided insurance policies require greater patient burdens in terms of cost sharing, co-payment, and deductibles, while offering less coverage for number of visits or days of coverage and annual/lifetime dollar expenditure limits for treatment. Many health insurance companies also impose lower lifetime limits on amounts that can be expended for drug and alcohol treatment than for treatment of other illnesses. Under parity, substance abuse treatment would be subject to the same benefit levels and limitations as other chronic relapsing disorders.

Parity is affordable. According to the study *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, the average premium increase due to full parity would be just 0.2 percent -- just one dollar per month for most families.[21] Another study found that full parity for alcohol and drug treatment would increase composite per capita health insurance premiums by only 0.5 percent, merely pennies per day per person covered.[22] Moreover, other medical expenses incurred by treated patients are less than for untreated clients. A five-year follow-up study of clients receiving publicly funded substance abuse treatment in Washington State found that treated clients incurred lower medical expenses than did those who did not receive treatment ($4,500 per year compared to $9,000 per year).

Ending this disparity through legislation will reduce the treatment gap by making treatment more affordable. It will be particularly helpful for adolescents who are covered by parents' insurance plans and policies. Parity legislation will lessen demands on publicly funded treatment programs by those with private insurance. In 1993, for example, 20 percent of public treatment funds were spent on people with private health insurance. Parity and the ensuing privatization of treatment will also encourage more effective interventions. Indeed, the lack of private insurance for substance abuse treatment discourages the development of new therapies.[23] Legislation supporting parity will move drug treatment further into the mainstream of health care and reduce the stigma associated with addiction.

Medications for Drug Dependence

Pharmacotherapies are essential to reducing the number of addicted. Methadone therapy, for example, is one of the longest-established, most thoroughly evaluated forms of drug treatment. The scientific findings are overwhelmingly in favor of methadone treatment. The National Institute on Drug Abuse's Drug Abuse Treatment Outcome Study found that methadone treatment reduced participants' heroin use by 70% and criminal activity by 57% while increasing full-time employment by 24%. A 1998 review by the General Accounting Office put it this way: "Research provides strong evidence to support methadone maintenance as the most effective treatment for heroin addiction." Methadone therapy helps keep more than 100,000 addicts off heroin, off welfare, and on the tax rolls as law-abiding, productive citizens. Research can result in similarly effective medications.

NIDA will continue to fund a high-priority program for discovering new medications to treat drug abuse. These research projects may result in the development of new pharmacotherapies. Specific projects include development of medications to treat cocaine addiction, development of a controlled-release dosage form of oral methadone, development of medications to treat withdrawal symptoms in babies born to opiate-dependent mothers, and development of a naturally occurring substance that may be deficient in certain individuals with opiate addiction problems.

National Drug Treatment Clinical Trials Network

Over the past decade, NIDA-supported scientists have developed and improved pharmacological and behavioral treatments for drug addiction. However, most of these newer treatments are not widely used in practice, in large part because they have been studied only in relatively short-term and small-scale studies conducted in academic settings on stringently selected patient populations. To reverse this trend and to improve treatment nationally, NIDA is establishing a National Drug Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, controlled multi-site Stage III and Stage IV treatment studies in community settings using broadly diverse patient populations. CTN will enable rapid, concurrent testing of a wide range of promising science-based behavioral therapies, medications, and their combined use, across a range of patient populations, treatment settings, and community environments nationwide. Science-based behavioral therapies that are in queue for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and new, manualized approaches to individual and group drug counseling. Medications to be studied include naltrexone, LAAM, buprenorphine for heroin addiction, and those currently being developed by NIDA for cocaine.

Treatment Research and Evaluation.

NIDA conducts 80 percent of the world's research on drugs of abuse. Recent research in the area of pharmacotherapies and behavioral therapies for the treatment of the dependence on and abuse of cocaine/crack, marijuana, opiates and stimulants, including methamphetamine, has shown great promise. Advances in these therapies will improve the likelihood of successfully treating substance abuse for users/abusers. Further research is needed to improve existing therapies and to explore promising new therapies. In addition, a comprehensive epidemiological measurement system needs to be developed to measure the success of these new therapies. NIDA will expand research on and demonstrations for new pharmacotherapies and behavioral therapies. SAMHSA will support effectiveness studies of pharmacotherapies and behavioral therapies and establish epidemiological measurement systems.

Federal Drug-Related Data Systems

This initiative will ensure the development of a comprehensive data system that adequately informs drug policy makers. It will specifically support the ninety-four targets that constitute the *Strategy's* performance measurement of effectiveness system. The ONDCP coordinated Drug Control Research, Data, and Evaluation Committee is reviewing existing data systems to identify "data gaps" and determine what additions or modifications can be made to enhance performance measurement efforts. SAMHSA, for example, is increasing the sample size of the National Household Survey on Drug Abuse and expanding its scope. More frequent estimates of the social costs of drug abuse will also be made. The U.S. Interdiction coordinator will also complete the "cocaine flows" estimate model.

Behavioral Treatment Initiative

Behavioral therapies remain the only available effective treatment approaches to many drug problems, including cocaine addiction, where viable medications do not yet exist. Behavioral interventions are needed, even when pharmacological treatments are being used. An explosion of knowledge in the basic behavioral science field is ready to be translated into new behavioral therapies. NIDA is encouraging research to develop and establish the efficacy of promising behavioral therapies, to determine how and why a particular behavioral intervention is effective; to develop and test behavioral interventions to reduce AIDS risk behaviors, and to disseminate efficacious behavioral interventions to practitioners in the field. More specifically, NIDA's behavioral research initiative will focus on therapies for adolescent drug use, addressing drug addiction treatment as HIV risk reduction, and determining the transportability of behavioral therapies to the community.

Reducing Infectious Disease Among Injecting Drug Users

The Centers for Disease Control and Prevention (CDC) estimates that 650,000 to 900,000 Americans are now living with HIV and at least 40,000 new infections occur each year. Although AIDS case rates have dramatically declined during the past two years because of the introduction of new combination therapies, HIV infection rates have remained relatively constant. Many of the new infections are occurring among African Americans and women. Studies of HIV prevalence among patients in drug treatment centers and among childbearing women demonstrate that the heterosexual spread of HIV in women closely parallels the spread of HIV among injection drug users (IDUs). The highest prevalence rate in both groups have been observed along the East coast and in the South. All of the prevalence studies in high-risk populations find the rates of HIV among African American and Hispanic populations to be dramatically higher than those among whites. This indicates that the disproportionate toll of this epidemic among minorities continues.

NIDA research has determined specific factors that should be present in intervention programs aimed at reducing the spread of HIV, especially among youth. NIDA will continue research on the enhancement and further development of behavioral therapies focusing on AIDS risk reduction. This research will identify the most effective types of interventions appropriate for different groups and communities, as well as the effect of abused drugs on the progression of AIDS. Further research will identify appropriate interventions for different groups and communities as well as the effect of abused drugs on the progression of AIDS. SAMHSA will continue its support of early intervention services for HIV through the Substance Abuse Prevention and Treatment (SAPT) Block Grant. SAMHSA will also fund a National Minority AIDS Council. IDUs represent a major challenge. This population is difficult to reach. Addicted IDUs frequently have multiple health, mental health, and complex social issues that must be overcome in order to successfully address their addiction, criminal recidivism, and disease transmission problems.

Training for Substance Abuse Professionals

Many health care professionals lack the education and training to identify substance abuse symptoms. Most medical students, for example, 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. An associated problem is that many competent community-based treatment personnel lack professional certification. SAMHSA/CSAT will develop a flexible credentialing system that respects the experience of treatment providers while they earn professional credentials would address this problem. Their publication -- *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice* – outlines criteria with which to certify practitioners.

4. Breaking the Cycle of Drugs and Crime

Drug-dependent individuals are responsible for a disproportionately large percentage of our nation's violent and income-generating crimes like robbery, burglary, or theft. According to the Arrestee Drug Abuse Monitoring (ADAM) program, between one half and three quarters of all arrestees tested in thirty-five cities around the country had drugs in their system at the time of arrest. About half of those charged with violent or income-generating crimes test positive for more than one drug. According to the Justice Department's Bureau of Justice Statistics, in 1997 more than 570,000 of the nation's prisoners (51 percent) reported using alcohol or other drugs when committing the offenses that led to their incarceration.[24] Nineteen percent of the state inmates and 16 percent of the federal inmates reported that they committed the offenses to obtain money for drugs (up from 17 percent and 10 percent respectively in 1991).

Most of the highest volume drug buyers, whose purchases fund the drug-trafficking industry that devastates neighborhoods and absorbs police time and prison space, are also frequent arrestees. Chronic drug users consume perhaps two-thirds of the cocaine, heroin, and methamphetamine in the United States. Reducing the number of drug-dependent criminals is a sure way to decrease the amount of drugs consumed, the size of illegal drug markets, the number of dealers, and drug-related crime and violence.

Drug-law offenders are filling our prisons at great expense. The nation's incarcerated population is now more than 1.8 million. By 2002, this figure could reach 2.1 million. According to the Department of Justice, drug offenders make up almost 60 percent of the federal prison population and account for 72 percent of the increase between 1990 and 1996. In 1997, 23 percent of inmates were incarcerated for drug-law violations, up from 9 percent in 1985.[25] The number of drug-law violators in state correctional facilities increased by 511 percent between 1985 and 1996, rising from 38,900 to 237,600.

Unfortunately, the criminal justice system has been slow to address substance-abuse problems among both adult and juvenile offenders. In 1997, just 12.4 percent of federal inmates with drug histories and 11.5 percent of drug-abusing state inmates had undergone treatment.[26] The number of arrestees who require drug treatment may exceed two million a year, including many chronic users of cocaine, heroin, and methamphetamine. When not incarcerated, many in this

hard-core group remain under the jurisdiction of the criminal justice system through probation or parole. Chronic drug users spend up to 25 percent of their drug-consuming and criminal careers under the jurisdiction of the criminal justice system. Just a small fraction of non-violent drug offenders and individuals on probation or parole are involved in diversionary programs. Drug courts reach only 1 or 2 percent of non-violent drug-law offenders.

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

Incarcerating offenders without treating their underlying substance-abuse problems simply defers the time when they are released back into our communities to start harming themselves and the larger society. Between 60 and 75 percent of untreated parolees with histories of cocaine and/or heroin use reportedly return to those drugs within three months of release. As a crime-control measure alone, drug treatment for criminally active addicts is strikingly cost-effective. It offers the potential of reducing crime by about two-thirds at a fraction of the cost for a prison cell.[27] Imprisoning an addict costs more than twenty-five thousand dollars a year. Outpatient treatment costs less than five thousand dollars a year, and residential treatment ranges between five and fifteen thousand dollars annually. A variety of programs based in the criminal justice system -- including the juvenile justice system -- are demonstrating their effectiveness across the nation.

Treatment Alternatives to Street Crime (TASC)

Created in the early 1970s, TASC has demonstrated that the coercive power of the criminal justice system can be used to get individuals into treatment and manage their behavior without undue risk to communities. Through TASC, some drug offenders are diverted out of the criminal justice system into community-based supervision. Others receive treatment as a part of probation, and still others are placed into transitional services as they leave an institutional program. TASC monitors client progress and compliance -- including expectations for abstinence, employment, and improved personal and social functioning -- and reports results to the referring criminal justice agency.[28]

Drug Courts

Drug courts have been a real step forward in producing an effective way to divert those with health problems into treatment and other community resources, leaving the criminal justice system to deal with those who had committed violent and criminal acts. Title V of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322) authorizes the Attorney

General to make grants to state and local governments to establish drug courts. As of October 1, 1998 323 drug courts were operating nationwide, and over two hundred were in the planning stages, up from a dozen in 1994. Drug courts seek to reduce drug use and associated criminal behavior by retaining drug-involved offenders in treatment. Defendants who complete the drug court program either have their charges dismissed (in a diversion or pre-sentence model) or probation sentences reduced (in a post-sentence model). More than 100,000 persons have entered drug courts, 70 percent of whom have graduated or remain as active participants. A review of thirty evaluations involving twenty-four drug courts found that these facilities retain felony offenders in treatment or other structured services at roughly double the retention rate of other community programs. Drug courts provide closer supervision than other community programs and substantially reduce drug use and criminal behavior among participants.[29]

The Federal Bureau of Prisons' Drug Treatment Program

The Federal Bureau of Prisons (BOP) provides drug treatment to inmates prior to release. The number of institutions offering residential treatment has grown from thirty-two to forty-two since FY 1994. In FY 1997 nearly 31,000 inmates participated in BOP treatment programs. A joint BOP/NIDA study examined the effects of treatment during the first six months after release from Bureau custody. This period is significant because recidivism is generally highest within the first year following release. The study found that the treatment population was 73 percent less likely to be re-arrested and 44 percent less likely to use drugs than a comparison group that received no treatment.[30]

Delaware's In-prison Programs

The Delaware Corrections Department, which has provided institutional and transitional drug treatment since the late 1980s, serves as an example of what could be effective in other areas of the country. Individuals who participated in both institutional and transitional treatment programs were 57 percent less likely to be re-arrested on charges involving drugs and 37 percent less likely to use drugs within eighteen months of release from custody compared to the non-treatment group.[31]

Breaking the Cycle (BTC)

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

The Drug-Free Prison Zone Demonstration Project

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

The corrections and treatment professions must join in common purpose to break the tragic cycle of drugs and crime by reducing drug consumption and recidivism among individuals in the criminal justice system. We should accelerate the development and expansion of programs that offer alternatives to imprisonment for non-violent drug law offenders. We must expand treatment availability both for drug-dependent inmates and those on probation or parole. Finally, we should ensure adequate transitional support programs following detention. By doing so, we can slow and eventually reverse the trend that will otherwise produce hundreds of thousands of additional Americans behind bars. The end result will be fewer addicts and drug users, less demand for drugs, less drug trafficking, less drug-related crime and violence, safer communities, and fewer people locked up. To that end, over the next five fiscal years (FY2000 – FY 2004) the federal government will expand the Arrestee Drug Abuse Monitoring (ADAM) system to seventy-five sites, increase BOP's treatment capacity by ten thousand spaces, assist states in expanding correctional treatment capacity to seventy thousand, and double the number of drug courts. Finally, in 1999 the federal government will convene a national summit on substance abuse and criminal justice policy to encourage the expansion by state and local jurisdictions of alternatives to incarceration for non-violent offenders and treatment for drug-dependent offenders in all phases of the criminal justice system.

5. Enforcing the Nation's Laws

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

Police forces continue to be the front-line defense against criminals. Men and women in uniform show supreme dedication and face risks on a daily basis in defense of citizens against criminal activity. Since 1988, nearly 700 law enforcement officers throughout the country have been killed in the line-of-duty and over 600,000 officers have been assaulted. We owe a debt of gratitude to those who put their lives on the line in defense of our safety.

Our nation is based on the rule of law that ensures the safety and security of all people. Reducing drugs and crime are among the nation's most pressing social problems. Trafficking and use of illicit drugs are inextricably linked to crime and places a tremendous burden on the economic and social conditions of our communities. Drugs divert precious resources that support the quality of life that all Americans strive to achieve. They create widespread problems that corrode communities with fear, violence and corruption, leaving residents afraid to leave their homes, legitimate businesses to flee, and quality of life to suffer. The data displayed in Chapter 2 of this *Strategy* give clear indication of the nexus between drugs and crime. Strong law enforcement policies contribute a great deal to reducing drug abuse and its consequences.

Coordination Among Law Enforcement Agencies

Continued involvement by citizens within the community enhanced by community policing, innovative approaches to reducing crime, and assertive law enforcement continue to reinforce efforts to reduce drug-related crime in America. We must organize our law enforcement efforts for success as we continue to improve the coordination and synchronization of our precious law enforcement resources. The sharing of extensive research and technology eliminates duplication of efforts, and allows the flexibility needed to more effectively uphold the law.

Intelligence/Information Sharing

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

Technology

Technology can play a dramatic role in combating drug-related crime. Law enforcement agencies are able to increase their effectiveness by integrating technology and coordinating their operations. ONDCP's Counterdrug Technology Assessment Center (CTAC) was established by the Counter-Narcotics Technology Act of 1990 (P.L. 101-510) as 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. CTAC's *Ten Year Counterdrug Technology Plan and Development Roadmap* provides a framework for law-enforcement exploitation of technological advances. [32]

Organized Crime Drug Enforcement Task Forces (OCDETF)

These integrated task forces draw on the expertise of various members of federal, state, and local law enforcement and prosecutorial agencies to coordinate investigations and prosecutions of domestic and international drug trafficking organizations, money laundering operations, gangs, and public officials involved in drug trafficking enterprises. The collaboration between law enforcement and U.S. attorneys, the state and local levels of district attorneys and attorneys general play an integral part in the success of OCDETF in the fight against drug traffickers and dealers.

In 1998, a three-year OCDEFT operation in St. Louis culminated in the arrest and federal indictment of a drug-ring leader and thirty-two defendants. These individuals were responsible for trafficking more than 45 kilograms of "black tar" heroin across numerous state lines . Through cooperative efforts and an array of investigative techniques, the entire drug operation was wiped out.

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. Attorneys' 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.

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; there are currently twenty-one HIDTAs. 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 of local, state, and federal law-enforcement officials. HIDTAs strengthen America's drug control efforts by forging partnerships between local, state, and federal law enforcement agencies. HIDTAs facilitate cooperative investigations, intelligence sharing, and joint operations against trafficking organizations. The Department of Defense provides priority support to HIDTAs in the form of National Guard assistance, assignment of intelligence analysts, and technical training. In 1998, HIDTAs were designated in central Florida (including Orlando and Tampa), the Milwaukee metropolitan area, and the marijuana-growing regions of Kentucky, Tennessee, and West Virginia.

Community Policing

Community policing is a policing philosophy that promotes and supports organizational strategies to address the causes and reduce the fear of crime and social disorder through problem-solving tactics and community-police partnerships. Cooperation and integration of civilians and police forces working together within communities across the country have successfully decreased drug-related crime. Resources provided by DOJ's Community Oriented Policing Services (COPS) program have been successful in bringing up to a hundred thousand additional police officers to our streets. The strength of the COPS program is its emphasis on long-term innovative approaches to community-based problems. COPS reinforces efforts that are already reducing the incidence of drug-related crime in America.

Targeting Gangs and Violence

Initiatives targeting gangs and violent crime have reduced drug trafficking. Gangs are involved in national distribution of drugs and frequently use highly lethal automatic weapons. Thirty years ago, just twenty cities reported gang activity. Today, more than seven-hundred do. The DEA and FBI lead federal efforts to break up trafficking organizations. The FBI has established 166 Safe Street task forces to address violent crime, most of which is drug-related. The Department of Justice is using the National Gang Tracking Network, a comprehensive computer database that keeps tabs on gangs and gang members that operate across state lines. The Bureau of Alcohol, Tobacco, and Firearms (ATF) targets armed drug traffickers through the Achilles Program which oversees task forces in jurisdictions where drug-related violence is severe. The ATF also conducts Gang Resistance Education and Training (G.R.E.A.T.) in schools. Since 1992, more than two million children have received G.R.E.A.T. instruction. HIDTAs and OCDETFs also coordinate multi-agency attacks on criminal drug organizations.

The Edward Byrne Memorial State and Local Law Enforcement Assistance Program (Byrne Program).

The Bureau of Justice Assistance (BJA) provides criminal justice support through the Byrne Program, which is designed as a working partnership among Federal, state, and local governments to provide safer communities and a high quality of justice. BJA awards formula grants to states and territories and discretionary grants to public and private agencies and non-profit organizations for activities that are directly related to drug-related crime and violence prevention and control. Byrne Program funds are granted following approval of a required state strategic plan encompassing the use of all criminal justice resources. For FY99, $__ million was appropriated for the Grant Program. (Per Jon Rice, OJP is supposed to release some numbers on 11 Jan)

Equitable Sentencing Policies

Community support is critical to the success of law enforcement. Sentencing structures that appear unfair undermine law enforcement. Consequently, the Administration supports revision of the cocaine penalty structure so that federal law enforcement will have additional incentive to target major distributors of crack and powder cocaine.

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.

6. Shielding U.S. Borders from the Drug Threat

Borders delineate the sovereign territories of nation-states. Land borders, coastlines, and air, land, and seaports of entry are the entry and exit points for all conveyances, goods, and persons entering or departing a country. It is, consequently, vital to control borders and ports of entry in order to ensure the rule of law and prevent the flow of contraband -- including illegal drugs. All our borders, seaports, and airports are vulnerable to the drug threat. Puerto Rico, the U.S. Virgin Islands, South Florida, the Southwest border, gateway airports in Chicago, Honolulu, Miami, New York, and Seattle, seaports along the Atlantic Seaboard, in the Gulf of Mexico, and on our Pacific coast, the Great Lakes region, and the land border with Canada have all experienced problems with drug trafficking. The ultimate destination of imported illegal drugs is our cities, suburbs, and rural communities where drugs are retailed in local markets. By curtailing their flow across our borders, we reduce drug availability throughout the United States and greatly reduce the consequences of drug abuse and trafficking in our communities. Drug smuggling is an intolerable affront to the nation's well-being. Countering it is a function that must be performed by federal, state, and local law-enforcement agencies.

Organizing Against the Drug Threat

The U.S. Customs Service has primary responsibility for ensuring that all movements -- both cargo and passenger -- through ports of entry comply with federal laws. Customs is the lead agency for preventing drug trafficking through airports, seaports, and land ports of entry. Customs is also responsible for stemming the flow of illegal drugs into the United States through the air. It accomplishes this task by detecting and apprehending drug smuggling aircraft entering the country. Customs' Aviation Interdiction program conducts 24-hour surveillance along the entire southern tier of the United States, and Puerto Rico and the Caribbean utilizing a wide variety of civilian and military ground-based radars, tethered aerostat radars, airborne reconnaissance aircraft and other sensors. The U.S. Border Patrol is the primary federal drug interdiction agency along our land borders with Canada and Mexico. The Border Patrol specifically focuses on drug smuggling between land ports of entry. The Coast Guard is the lead federal agency for maritime drug interdiction and shares lead responsibility for air interdiction with the U.S. Customs Service. Our Armed Forces provide invaluable support to federal, state, and local law enforcement agencies, involved in drug-control operations, particularly in the Southwest Border region.

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

Trafficking across the Southwest Border

More than half of the cocaine on our streets and large quantities of heroin, marijuana, and methamphetamine enter the United States across the Southwest border. Illegal drugs enter by all modes of conveyance. They come through ports of entry by car, truck, train, and pedestrian border-crossers. They come across the open desert in armed pack trains as well as on the backs of human "mules." They are tossed over border fences from urban locale to urban locale, then sped away surreptitiously by foot and vehicle. Planes and boats find gaps in U.S./Mexican coverage and position drugs close to the border for eventual transfer to the United States. Small boats in the Gulf of Mexico and the eastern Pacific seek to outflank our interdiction efforts and deliver drugs directly to the United States. Whenever possible, traffickers seek to exploit incidences of corruption in U.S. local, state and federal border agencies to facilitate drug smuggling. It is a tribute to the vast majority of U.S. federal, state, and local officials dedicated to the anti-drug effort that dedication, integrity, courage and respect for human rights overwhelmingly characterize their service. Rapidly growing commerce between the United States and Mexico will present greater challenges to our efforts to keep drugs out of cross-border traffic. Since the Southwest border is presently the most porous part of the nation's borders, it is there that we must mount an immediate, determined, and coordinated effort to stop the flow of drugs. At the same time, we cannot concentrate resources along the Southwest

border at the expense of other vulnerable border regions, for traffickers follow the path of least resistance and will funnel the destructive flow of drugs to undefended or under-resourced areas.

All Borders

We must stop drugs everywhere they threaten to enter the United States, be it in the Gulf Coast, Puerto Rico and the U.S. Virgin Islands, Florida, Northeastern and Northwestern United States, or the Great Lakes region. For example, Florida's location, geography, and dynamic growth will make the state particularly vulnerable to traffickers for the foreseeable future. Its six hundred miles of coastline made it a major target for over-the-shore and air-drop deliveries in the 1980s. The state is astride Caribbean and Gulf of Mexico trafficking routes. The busy Miami and Orlando airports and its seaports -- gateways to drug-source countries in South America -- are used as distribution hubs by international trafficking organizations. To varying degrees, Florida's predicament is shared by other border areas and entry points. At the same time that we focus efforts on specific parts of our borders, we must anticipate the effects elsewhere. In the end, we need to shield the entire border from the destructive flow of illegal drugs into the United States.

Organizing for Success

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

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

Port & Border Security Initiative.

This initiative seeks to reduce drug availability by preventing their entry into the United States. The Port and Border Security initiative covers all U.S. ports-of-entry and borders but focuses on the Southwest border. Over the next five years, this initiative will result in more Immigration and naturalization Service (INS) inspectors and border patrol agents, substantial increases in Customs' agents, analytic, and inspection staff, improved communication and coordination between Customs and INS, employment of advanced technologies and information management systems and greater U.S. - Mexico cooperation.

Working with the Private Sector to Keep Drugs Out of America.

Agreements with the private sector can deter drug smuggling via legitimate commercial shipments and conveyances. As the primary drug-interdiction agency 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.

Harnessing Technology.

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

Review of Counterdrug Intelligence Architecture.

Drug intelligence and information collection, analysis, and dissemination are essential for effective drug control. An extensive, comprehensive interagency review of counterdrug intelligence missions, activities, functions, and coordination was conducted during 1998 under the auspices of the secretaries of Defense, State, Transportation, and Treasury, the Attorney General, the Director of Central Intelligence, and the Director of National Drug Control Policy.

The review suggested how federal, state, and local drug control efforts could be better supported by drug intelligence and law enforcement information. An interagency plan is being drafted that will clarify missions, define lanes of authority, and establish an interagency problem-solving structure that will better enable federal, state, and local law enforcement and military professionals to protect our communities and safeguard our borders from the drug threat.

7. Reducing the Supply of Illegal Drugs

Supply reduction is an essential component of a well-balanced strategic approach to drug control. Demand reduction cannot be successfully undertaken without simultaneously limiting drug availability. When illegal drugs are readily available, the likelihood increases that they will be abused. Heroin is a case in point. Increasing heroin purity in recent years has resulted in greater numbers of initiates because injection is no longer a prerequisite for use. Undeterred by the abhorrence of needle injection, would-be heroin users are more inclined to partake. Indeed, heroin has become more available, in part, because criminal Colombian drug organizations made a strategic decision earlier this decade to cultivate opium poppy, produce heroin, and sell it in the United States. According to DEA seizure data, Colombian heroin, which accounts for less than 5 percent of the global production potential, has captured 70 percent of the heroin market in the eastern United States. Cocaine traffickers have responded to a decline in demand for powder and crack cocaine by also selling heroin -- a technique known as "double breasting."

Supply reduction has both domestic and international attributes. Within the United States, supply reduction includes regulation (e.g. The Controlled Substances Act), enforcement of anti-drug laws, eradication of marijuana cultivation, control of precursor chemicals, Customs' inspections of commerce and persons entering the country, screening for drugs in prisons, and the creation of drug-free school zones. Internationally, supply reduction efforts include building consensus, bilateral, regional, and global accords, coordinated investigations, interdiction, control of precursors, anti-money-laundering initiatives, drug-crop substitution and eradication, alternative development, strengthening of public institutions, and foreign assistance. Supply reduction has resulted in the seizure of about one third of a ll the cocaine trafficked each year.

Coordinated Interdiction Operations

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

Drug traffickers are adaptable, reacting to interdiction successes by shifting routes and changing modes of transportation. Large international criminal organizations have nearly unlimited access to sophisticated technology and resources to support their illegal operations. The United States must equal and surpass traffickers' flexibility, quickly deploying resources to changing high-threat areas. Consequently, the U.S. government designs coordinated interdiction operations that anticipate shifting trafficking patterns. The building blocks for integrated operations are professional, committed organizational structures that know their business and demonstrate the will and leadership to get the mission done. We have this in Joint Inter-Agency Task Forces (East - based in Key West, West - based in Alameda, CA, and South – based in Panama) which coordinate transit zone activities; Customs' Domestic Air Interdiction Coordination Center (Riverside, CA) which monitors air approaches to the United States; and the El Paso, Texas-based Joint Task Force Six and Operation Alliance which coordinate activities along the Southwest Border.

Interdiction resources and capabilities will increase significantly in 1999 as the result of Congressional appropriation of 942 million dollars for international drug control and interdiction spending in the conference report on H.R. 4328, the Omnibus Consolidated and Emergency Supplemental. The Congress agreed within the same legislation to authorize the expenditure of 2.34 billion dollars during fiscal years 1999, 2000, and 2001 to support drug interdiction and anti-drug activities in the source and transit zones. In 1999, the merger of Joint Inter-Agency Task Forces East and South will provide an opportunity to optimize the regional interagency architecture for the interdiction of drugs as they are moved from South America, through the Caribbean, Central America, and Mexico, and to the United States.

Transit Zone Operations

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 U.S. An estimated 32 percent of this amount was seized; 84 metric tons in the transit zone and 54 metric tons in the arrival zone. ***We need to add in comparative 1998 data.*** Smuggling using "Go-Fast" boats is an emerging threat in the Caribbean. These high-speed boats can leave Colombia after dark and deliver drugs to other vessels off the shore of Haiti before dawn. They are difficult to detect and to intercept.

The Coast Guard is the lead federal agency for maritime interdiction and co-lead with U.S. Customs for air interdiction. The interagency mission is to reduce the supply of drugs from the source by denying smugglers the use of air and maritime routes in the transit zone. In meeting the challenge of patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations cooperating within the transit and source zones. Coast Guard operations account for a quarter of U.S. cocaine and marijuana seizures. In fiscal year 1998, total seizures involving Coast Guard assets included thirty-eight

metric tons of cocaine, fourteen metric tons of marijuana products, and 3.4 pounds of heroin. The Coast Guard does not estimate the volume of drugs destroyed at sea due to jettisons or scuttling in which contraband is not recovered. The retail value of the drugs seized by the Coast Guard was three billion dollars.

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It also involves denying traffickers safe havens in countries within the transit zone and preventing their ability to corrupt institutions or to use financial systems to launder profits. International cooperation and assistance, consequently, is an essential aspect of successful interdiction. Accordingly, the United States is assisting Caribbean and Central American nations implementing 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.

Breaking Cocaine Sources of Supply

Coca, the raw material for cocaine, is grown in the South American countries of Bolivia, Colombia, and Peru. Regional efforts have attained significant successes in the past three years. Coca cultivation in Peru has plummeted by 56 percent from 115,300 hectares in 1995 to 51,000 hectares in 1998. Potential cocaine production declined from 460 metric tons to 240 metric tons over the same period in Peru, while in Bolivia potential production declined from 255 metric tons in 1994 to 150 metric tons in 1998. The combined drop in potential production of 325 metric tons exceeds the estimated U.S. annual demand for cocaine. These successes can be attributed to many factors, including: political will in both countries to confront the illegal drug trade; the regional air interdiction campaign that targeted drug-laden aircraft flying between coca-growing regions of Peru and processing laboratories in Colombia; control of precursor chemicals; diminished strength of insurgent forces in Peru; and effective alternate development programs. The fact that coca leaf prices have dropped by more than 50 percent in Peru over the past three years suggests that this progress can be sustained.

This progress in Bolivia and Peru, however, has been offset by a *xx* percent expansion in coca cultivation in Colombia in that same period. Virtually all of the coca-growing regions there are under guerrilla or paramilitary group control, making eradication and interdiction operations difficult and dangerous, and alternative development projects unfeasible. Without greater security in the countryside, the government cannot deliver programs targeted at providing licit income alternatives to the coca labor force. This continued growth in Colombian illicit drug cultivation has added substantially to the war chests of the guerrilla and paramilitary groups, which protect and/or control various aspects of the drug industry. The net result has been problematic for the Colombian Government's ability to bring illegal drug operations under control.

Nevertheless, the Colombian National Police (CNP) sprayed more than 60,000 hectares of illicit crops in 1998. In the zones where aerial eradication has been possible, coca cultivation has declined by more than XX%. The Colombian government formed a joint task force with elements from all the military services and the CNP to mount counterdrug operations in guerrilla-controlled territory. The CNP also instituted a general aviation aircraft control system, which resulted in the seizure of 54 trafficker aircraft in 1998.

The Government of Colombia is developing a national alternative development plan. The United States will provide fifteen million dollars over the next three years to support alternative development projects in areas under government control. The United States will continue to support eradication and alternative development in all three countries; suppress aerial, riverine, and maritime trafficking; strengthen the anti-drug capabilities of judicial systems, law-enforcement agencies, and security forces; and encourage greater regional cooperation. The objective is to reduce total South American coca cultivation by 20 percent over the next four years and 40 percent by 2007.

Breaking Heroin Sources of Supply

Efforts to reduce domestic heroin availability face significant challenges. The production of opium poppy has more than tripled since 1985. Worldwide illicit opium production was estimated at 3,352 metric tons in 1998, down 20 percent from 1997's figure. This decrease resulted from a widespread, severe drought, not governmental action. Approximately 92 percent is produced in Burma and Afghanistan, where the United States has limited access or influence. Moreover, the U.S. heroin market consumes perhaps only 3 percent of the world's production; indicating that every pound of heroin law enforcement takes off domestic markets is readily replaceable by international supply. The existence of widely dispersed growing areas, multiple trafficking organizations and diversified routes and concealment methods makes supply reduction difficult.

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

Still, progress is achievable if governments have access to or the ability to cordon off growing areas 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 Guatemala, Mexico, Pakistan, Thailand, and Turkey. Progress is, however,

unlikely in Afghanistan where the ruling Taliban does not appear committed to narcotics control. The United States will continue to support UN drug control programs in Burma and encourage other countries to press the Government of Burma to take effective anti-drug action. In Colombia, the United States will provide additional support to the CNP opium poppy eradication campaign. We will also help strengthen law-enforcement efforts in heroin source and transit countries by supporting training programs, information sharing, extradition of fugitives, and anti-money laundering measures. Finally, the United States will work through diplomatic and public channels to increase the level of international cooperation and support the ambitious UNDCP initiative to eradicate illicit opium poppy cultivation in ten years.

Domestic heroin demand-reduction programs are all the more essential due to the difficulties in attacking heroin sources of supply. They will, nevertheless, be supported by domestic and international heroin-control measures. U.S. law-enforcement agencies will use strategic information about domestic heroin distribution rings to break up international criminal organizations. 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 FBI, and DEA.

Countering the Spread of Methamphetamine

Since the mid-1980s, the world has faced a wave of synthetic stimulant abuse with approximately nine times the quantity seized in 1993 than in 1978, equivalent to an average annual increase of 16 percent.[33] The principal synthetic drugs manufactured clandestinely are the amphetamine-type stimulants. Domestic manufacture and importation of methamphetamine pose a continuing public-health threat. In the past, methamphetamine was largely produced and supplied by outlaw motorcycle gangs. More recently, however, organized crime polydrug trafficking groups operating from Mexico are dominating the wholesale trafficking in the United States. These large organized groups have developed large-scale laboratories--both in Mexico and the United States-- which are capable of producing large quantities of methamphetamine. The manufacturing process involves toxic and flammable chemicals. Abandoned labs require expensive, dangerous clean up. Between January 1, 1994 and September 30, 1998, the DEA was involved in the seizure of over 4,140 methamphetamine laboratories throughout the country, including 1,240 labs in the first nine months of 1998. State and local law-enforcement authorities, especially in California but increasingly in other states, were involved in thousands of additional clandestine lab seizures.

The 1996 National Methamphetamine Strategy (updated in May of 1997) remains the basis of the federal response to this problem. It was buttressed by the Comprehensive Methamphetamine Control Act of 1996, which increased penalties for production and trafficking while expanding control over precursor chemicals (like ephedrine, pseudoephedrine,

and phenylpropanolamine). Federal, state, and local investigators and prosecutors are 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. Cooperation with Mexico which houses powerful methamphetamine trafficking organizations is crucial. A bilateral chemical-control-working group oversees cooperative investigation of cases of interest to both countries and exchanges information on legal and regulatory matters. Mexico recently came into compliance with the 1988 U.N. Convention against Traffic in Narcotic Drugs and Psychotropic Substances.

Reducing Domestic Marijuana Cultivation

Marijuana is the most readily available illegal drug in the United States. While no comprehensive survey of domestic cannabis cultivation has been conducted, the DEA estimates that much of the marijuana consumed in the United States is grown domestically -- in commercial and private operations, both outdoors and indoors. To be successful, domestic cannabis crop reduction efforts must be supported by accurate information about drug crop locations and potential. The Department of Agriculture's Agricultural Research Service will make annual estimates of domestic marijuana cultivation by surveying marijuana-cultivation areas, estimating yields, and analyzing detection, eradication, and seizure data. These annual surveys will be used to assess progress in reducing cultivation and to orient anti-marijuana efforts.

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

8. International Drug Control Cooperation

Our efforts to reduce drug availability, drug abuse, and their consequences within the United States are supported by extensive international activities. Indeed, only the federal government as opposed to state governments can undertake international supply reduction. This specific and unique function is reflected in this *Strategy*, the accompanying *Classified Annex*, and the programs and budgets that implement it. International programs confront illegal drug cultivation, production, trafficking, abuse, the diversion of precursor chemicals, and the corrosive effects of the illegal drug trade, including corruption, violence, environmental degradation, weakening of anti-democratic forces, and economic distortion.

A broad series of unilateral, bilateral, multilateral, sub-regional, regional, and global accords create a strong backdrop for effective anti-drug measures. The myth that the United States is the engine that drives the international drug trade has been rejected as a result of the international community's mature understanding of the scope of the global problem. Indeed, the United States comprises just 2 percent of the world's consumers. Even with the relatively high prices Americans are willing to pay for illegal drugs, they still account for 10 to 15 percent of the more than four hundred billion dollars spent globally on drugs every year.[34]

An annual certification process is one of the key instruments made available by Congress to ensure drug policy is included on our international agenda and that other countries are making counter-drug efforts a serious part of their policies and actions. By law, the President is required to determine whether major narcotics- producing and transit countries (the "majors"list) 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. A presidential finding that a nation has failed to meet these standards results in foreign assistance sanctions and mandatory U.S. votes against multilateral development bank loans. This unilateral certification system is extremely contentious, particularly in countries that have not always been committed to effective counter-drug efforts. Nevertheless, the certification process has succeeded in giving greater international prominence to drug control.

The International Anti-Drug Consensus

The United States seeks to improve international cooperation to strengthen regional enforcement efforts and deny sanctuary to international criminal organizations. Because traffickers do not respect national borders, no country can be effective unilaterally with what is a global problem. Only multinational coordination and cooperation can deal with a problem this big and so widespread. In June 1998, a special session of the United Nations General Assembly underscored the need for international opposition to the illegal drug trade. As a result, the international community adopted the proposal made in the *1998 United States Drug Control*

Strategy for a ten-year conceptual framework to counter the drug problem and set five and ten-year target dates for reducing the supply and demand for illicit drugs.

The political declaration on global drug control adopted during the session represents a forceful, high-level commitment to addressing all elements of the drug problem at both the national and international level. It emphasizes the importance of pursuing a balanced approach calling for simultaneously targeting the objectives of reducing drug abuse, eliminating illicit supply, and countering drug trafficking. It also sets clear target dates for member states to take action required in specified areas. 2003 is the target date for national-level action for stemming the tide of illegal abuse and trafficking in amphetamine type stimulants; for national legislation on money laundering; for promotion of judicial cooperation; and for implementing new and enhanced demand reduction strategies. The year 2008 is the target date for achieving significant and measurable results in demand reduction; in eliminating or significantly reducing illicit drug cultivation; and in reducing the manufacture and trafficking of psychotropic substances, including synthetic designer drugs and the diversion of precursors.

The accompanying declaration on the Guiding Principles on Drug Demand Reduction makes clear that demand reduction is an indispensable pillar of the global response to the drug problem. The declaration is the closest the global community has come so far to an international treaty on demand reduction. The balanced approach being pursued by the United Nations International Drug Control Programme will contribute to the lessening of drug trafficking and abuse and their consequences in the United States.

Promoting International Demand Reduction

The problem of increasing drug abuse is one shared by many nations. In the United Kingdom, for example, 48 percent of 16-24 year olds questioned in 1996 had ever used illegal drugs and 18 percent were past-month users. The number of offenders dealt with under the Misuse of Drug Act of 1971 increased from 86,000 in 1994 to 95,000 in 1996. The number of drug misusers attending services was 24,879 in the six month period ending September 1996, 48 percent higher than the equivalent period three years earlier The number of deaths in the UK attributable to the misuse of drugs rose from 1,399 in 1993 to 1,805 in 1995.[35]

In Mexico, a 1997 report by the Ministry of Health indicates that cocaine use has quadrupled among Mexicans ages 12 to 19 in the past six years. In Mexico City, where the number of patients at government-run treatment has increased from 4,500 to 13,500 in the same period, marijuana is the drug of choice among adolescents, but cocaine, particularly crack, ranked second -- before cheaper choices like glue and paint thinner. The government is responding by increasing funding of treatment centers, conducting the "Live Without Drugs" public service campaign, and providing educational programs in schools and on the Internet.

In Brazil, cocaine abuse has become more prevalent. In the capital of Brasilia, 50 percent of drug abusers smoke cocaine in either crack or "merla" form. Nationally, injecting drug users most frequently abuse cocaine. Drug injection is associated with more than 50 percent of new HIV infections in major cities and with 21 percent of all cases in the country. In 1998, the federal government launched a five-point national drug-control strategy to reduce drug abuse, availability, and its consequences by 50 percent in the next ten years.[36]

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

Supporting Democracy and Human Rights

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

Drug Control in the Western Hemisphere

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

The institutions required for successful hemispheric cooperation are firmly established. Many of the requisite mechanisms and processes are also in place or under development. The

anti-drug action agenda signed during the 1994 Miami Summit of the Americas is being implemented. All members of the Organization of American States endorsed the 1995 Buenos Aires Communique on Money Laundering and the 1996 Hemispheric Anti-Drug Strategy. The hemisphere's thirty-four democratically elected heads of states agreed during the 1998 Summit of the Americas in Santiago, Chile to a Hemispheric Alliance Against Drugs. All nations agreed to broaden drug prevention efforts, cooperate in data collection and analysis, prosecutions and extradition, establish or strengthen anti-money laundering units; and prevent the illicit traffic and diversion of chemical precursors. The centerpiece of the agreement is a commitment to multilateral evaluation -- essentially a hemispheric system of performance measurement. Substantial progress was made by the Organization of American States' Inter-American Drug Abuse Control Commission this past year in developing this evaluation system. Specific performance indicators have been agreed on, including requirements for comprehensive national strategies; national laws to combat chemicals, money laundering and firearms; central coordination government bodies; development of drug-use prevalence surveys; and inventories of prevention and treatment programs.

Bilateral Cooperation with Mexico

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

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

Strong political will at the senior levels of the Government of Mexico confronts the serious national security threat posed by drug trafficking and drug-related corruption and violence. The capacity of the Government of Mexico to achieve concrete results in terms of disruption of major trafficking organizations and a decrease in the amount of drugs that enter the United States is limited. Mexico is challenged by corruption, under-funded, under-trained and under-equipped counter-drug institutions, and a legal system that provides advantages to well-funded drug traffickers that they would receive in the United States.

In the last three years Mexico has investigated and prosecuted high-ranking public officials for corruption. It has enacted anti-crime laws that strengthen law enforcement institutions and

provide the basis for more effective prosecution. We have improved cooperation noticeably in the past three years in information sharing, cooperative investigations, extraditions, and military counterdrug coordination. Major traffickers such as Juan Garcia Abrego, and, for now, the Amezcua brothers have been taken out of circulation.

The United States and Mexico last year developed a comprehensive US-Mexico Binational Drug Strategy. The strategy builds upon the Binational Drug Threat Assessment and the US-Mexico Alliance Against Drugs signed by Presidents Clinton and Zedillo in 1997. The agreement demonstrates our continued shared commitment to address drug challenges forthrightly while upholding the principles of sovereignty, mutual respect, territorial integrity, and nonintervention. An agreed set of measures of effectiveness for the Binational Drug Strategy will be completed in early 1999.

Long term, we need to preserve institutions of cooperation such as the HLCG and the Senior Law Enforcement Plenary, and help strengthen Mexican law enforcement institutions and anti-corruption efforts. With a healthy and cooperative binational relation ties we establish the conditions under which the Unite States and Mexico can work effectively through small, special counter-drug units that target trafficking organizations and are reasonable secure from corruption. The success of such specialized units and continued law enforcement institutional strengthening can increase Mexico's counter-drug capacity sufficiently to reduce the flow of drugs through that country and into the United States.

Mexican/Central American Initiative.

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

Caribbean Violent Crime and Regional Interdiction Initiative.

Drug smuggling in the Caribbean is increasing as traffickers respond to successful interdiction efforts along the Southwest border. To counter this increase, this initiative will expand counterdrug operations targeting drug trafficking-related criminal activities and violence in the Caribbean Region including South Florida, Puerto Rico, U.S. Virgin Islands, and the independent states and territories of the Eastern Caribbean. This initiative will: implement mutual cooperative security agreements between the United States and Caribbean nations and territories; implement commitments made by the President of the United States during the Caribbean Summit held in Barbados in May 1997; expand assistance to Caribbean nations participating in regional interdiction operations to support development of their maritime law enforcement capabilities; increase the capability of Caribbean nations to intercept, apprehend

and prosecute drug traffickers through modest expansion of training, equipment upgrades and maintenance support; institutionalize the Americas Counter Smuggling Initiative (ACSI) to provide at-risk commercial carriers, industry and government offices training to prevent goods and conveyances from being utilized to smuggle illegal drugs; and increase interdiction capabilities and support law enforcement activities in the Caribbean.

Targeting International Drug Trafficking Organizations

The malevolence and unbounded greed of the criminal organizations trafficking in drugs feel both the demand for and the supply of drugs and cannot be ignored or understated. Domestic trafficking organizations are often inextricably associated with foreign traffickers. To be successful in controlling the drug problem, we must remove both the criminal drug trafficking organizations as well as the drugs they sell.

Trafficking organizations are characterized by centralized control at senior levels and task compartmentalization and specialization at lower levels. International criminal organizations appear to have no problems recruiting couriers, enforcers, and farmers. U.S.-supported programs help disrupt and dismantle international drug organizations, attacking their leadership, trafficking, production, and distribution infrastructure, and their financial underpinnings. The objectives of these programs are to break the power of drug organizations, reduce the threat they pose to democratic institutions, and reinforce the political will of our allies to confront traffickers. Going after top-level leadership is the most effective way of breaking these organizations.

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

Following the Money

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

The Department of Treasury works extensively with U.S. banks, wire remitters, vendors of money orders and travelers' checks, and other money service businesses to 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 and DOJ's prosecution of such cases are examples of effective interagency counter-measures. 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 supports global efforts to disrupt the flow of illicit capital, track criminal sources of funds, forfeit ill-gained assets, and prosecute offenders. For example, with the assistance of Colombian law enforcement and private sector organizations, the United States has imposed economic sanctions pursuant to the International Economic Emergency Powers Act against more than four hundred businesses affiliated with Colombian criminal drug organizations. Elsewhere, U.S. experts have helped draft regulations to protect foreign financial sectors. Twenty-six nations are members of the Financial Action Task Force, 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. The Department of Justice consulted and assisted in the drafting of asset-forfeiture legislation in Bermuda, Bolivia, Brazil, Colombia, Mexico, South Africa, and Uruguay. The Department of Justice also coordinates international forfeiture cases in Austria, Britain, Luxembourg, Mexico, Switzerland, and other countries. The department's Criminal Division, for example, secured a commitment from the Swiss government to seize two hundred million dollars deposited in Swiss banks by a major cocaine trafficker.

Controlling Precursor Chemicals

The twenty-two chemicals used most commonly in the production of cocaine have extensive commercial and industrial applications as well. We can, however, disrupt illegal drug producers if essential chemicals are denied to them. The bulk of chemical substance seized globally are intended for the clandestine manufacture of cocaine. Between 1990 and 1994, around four billion 'potential dosage units' of precursors -- or the amount of precursors needed to produce as many doses -- were seized annually.[37] 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, for example, establishes the obligation of parties to the treaty to institute controls to prevent the diversion of chemicals from legitimate commerce to illicit drug manufacture.

The tracking of international shipment and the investigation of potentially illegal diversions are demanding tasks. Yet, major strides have been made in international efforts to prevent the illegal diversion of chemicals. In 1997, the United States and the European Union signed an agreement to enhance cooperation in chemical diversion control. In Brazil, the government regulates the sale of gasoline, which can be used as a precursor chemical and to fuel trafficker aircraft and boats in the Amazon Region. The United States continues to urge the adoption and enforcement of chemical-control regimes by governments that do not have them or fail to enforce them. The goal is to prevent diversion of chemicals without hindering legitimate commerce.

Reducing Corruption

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

Endnotes

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

2. E.P.M. de Mejier, H.J. vander Kamp, and F.A. Ewuwijk, "Characterization of Cannabis Accessions with Regard to Cannabinoid Content in Relation to Other Plant Characteristics," *Euphythica*, 62 (1992) 187-200.

3.Kandel, D.B. & Logan, J.A. (1984). Patterns of drug use from adolescence to young adulthood: 1. Periods of risk for initiation, continued use, and discontinuation. *American Journal of Public Health, 74,* 660-666.

[4] (Lynskey & Hall, In press; Yamaguchi & Kandel, 1984).

[5] Caulkins, Jonathan P., Nora Fitzgerald, Karyn Model and H. Lamar Willis [1994], "Youth Drug Prevention Through Community Outreach: The Military's Pilot Programs," MR-536-OSD, RAND, Santa Monica, CA.

[6] ***Rydell and Everingham (1994)***

[7] See, for example, *Preventing Drug Use Among Children and Adolescents a Research-Based Guide*, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication No. 97-4212, Printed March 1997, Reprinted November 1997. http://www.health.org/pubs/prev/PREVOPEN.html

[8] ***Botvin et al., 1995)***

[9] Botvin, Gilbert J., E. Baker, L. Dusenbury, E.M. Botvin, and T. Diaz [1995], "Long-Term Follow-Up Results of a Randomized Drug Abuse Prevention Trial in a White Middle-Class Population," Journal of the American Medical Association, Vol. 273, pp. 1106-1112.

[10] ***More information about prevention findings at Cornell University, Project Star and other CSAP grantee programs can be found at http://p2001.health.org/preview/ctssubj.htm***

[11] ***Golub, Andrew Lang and Bruce D. Johnson [1997], "Crack's Decline: Some Surprises Across U.S. Cities," National Institute of Justice Report NCJ 164262, Washington, DC. See also Musto David F. [1987], The American Disease: Origins of Narcotic Control. New York: Oxford University Press.***

[12] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Washington, DC: American Psychiatric Association Press, 1994; and Institute of Medicine, Pathways of Addiction, Washington, DC: National Academy Press, 1996.

[13] Koob, G.F., Trends Pharmacol. Sci. 13 (1992): 177; and Koob, G.F., et al., Semin. Neurosci 6 (1994): 221.

[14] Hyman, S.E., Neuron 16 (1996): 901; Nestler, E.J., Neuron 16 (1996): 897; Melega, W.P., et al., Behav. Brain Res. 84 (1997): 259; Ortiz, J., et al., Synapse 21 (1995): 289; Volkow, N.D., et al., Am. J. Psychiat. 147 (1990): 719; Nestler, E.J., et al., Mol. Psychiat. 1 (1996): 190; and Self, D.W., and E.J. Nestler, Annu. Rev. Neurosci. 18 (1995): 463.

[15] Nestler, E.J., J. Neurosci. 12 (1992): 2439; Robinson, T.E., and K.C. Berridge, Brain Res. Rev. 18 (1993): 247; Terwilliger, R.Z., et al., Brain Res. 548 (1991): 100; and Koob, G.F., Neuron 16 (1996): 893. See also notes 6 and 7.

[16] Leshner, A.I., Hospital Practice: a Special Report, Minneapolis: McGraw-Hill, 1997; Koob, Trends in Pharmacol. Sci.; Koob et al., Semin. Neurosci; Koob, Neuron; Nestler et al., Mol. Psychiat.; and Self and Nestler, Annu. Rev. Neurosci.

[17] Childress, A.R., et al., NIDA Res. Monographs 84 (1988): 25; Daley, D.C., and G.A. Marlatt, in Substance Abuse: a Comprehensive Textbook, 3rd ed., ed. J.H. Lowinson et al., Baltimore: Williams & Wilkins, 1997; O'Brien, C.P., Pharmacol. Rev. 27 (1975): 535; O'Brien, C.P., et al., Addictive Behav. 15 (1990): 355; and Grant, S., et al., Proc. Natl. Acad. Sci. U.S.A. 93 (1996): 12040.

[18] O'Brien and McLellan, *Lancet.*

[19] See notes 1 and 2.

[20] The lower estimate is based on a methodology developed by SAMHSA using data from the National Household Survey on Drug Abuse (NHSDA). The higher estimate is derived from data collected in the 1992 National Institute on Alcohol and Alcoholism's National Longitudinal Alcohol Epidemiology Survey (NLAES). While this 1992 study focused on alcohol, detailed questions were asked about other drugs, including marijuana and cocaine.

[21] Source: Linda Kaplan's (NAADAC) letter which cites the study that was apparently conducted by Mathematica Policy Research, Inc.

[22] Milliman & Robertson, Inc., "Premium Estimates for Substance Abuse Parity Provisions for Commercial Health Insurance products," September 1997, pp. 1-2.

[23] See for example *The Development of Medications for the Treatment of Opiate and Cocaine Addictions*, Institute of Medicine, 1995 and *Market Barriers to the Development of Pharmacotherapies for the Treatment of Cocaine Abuse and Addiction*, HHS, September 1997.

[24] Ross Deck has the study – data came from him.

[25] Ross Deck has the study – data came from him.

[26] Ross Deck has the study – data came from him.

[27] CALDATA study conducted by the California Department of Alcohol and Drug Programs and the National Opinion Research Center.

[28] "Drug Abuse Treatment in Criminal Justice Settings." Journal of Drug Issues Winter 1993, 23(1).

[29] Belenko S. 1998. "Research on Drug Courts: a Critical Review." In *National Drug Court Institute Review,* 1 (1).

[30] We need to cite the appropriate study.

[31] We need the correct citation for the study. Subsequent reports will cover 42 and 54 months after release.

32. We should provide the website location for this CTAC document.

33. *World Drug Report,* United Nations International Drug Control Programme, ISBN 0-19-929320-8, ISBN 0-19-829299-6 (Pbk.) 1998, p. 19.

[34] ***World Drug Report,*** p. 124. The report notes that "many estimates have been made of the total revenue accruing to the illicit drug industry - most range from US$300bn to US$500bn. However, a growing body of evidence suggests that the true figure lies somewhere around the US$400bn level. a US$400bn turnover would be equivalent to approximately 8 per cent of total international trade. In 1994 this figure would have been larger than the international trade in iron and steel and motor vehicles and about the same size as the total international trade in textiles."

35. *Tackling Drugs to Build a Better Britain.* The Government's Ten-Year Strategy for Tackling Drugs Misuse. Presented to Parliament by the President of the Council by Command of Her Majesty, April 1998. http://www.official-documents.co.uk/document/cm39/3945/3945.htm

36. The Brazilian National Drug Control Strategy can be viewed at http://www.planalto.gov.br/militar/senad.htm

37. *World Drug Report.* p. 29.

PREVENTION INSERT # 1

Ten Actions Families can take to Raise Drug-Free Kids

1. **Start:** It is never too early to prevent your children from trying drugs. Building protective factors, such as letting your child know you care, with even the youngest children, plays an important role in protecting them from drugs.

2. **Connect:** Take every opportunity to build lines of communication with your children. Do things as a family. Spend time together -- eat dinner, read together, play a game, attend services. Show that fun doesn't require drugs.

3. **Listen:** Take a more active interest in what is going on in your child's life. Listen to their cares and concerns. Know what they are up to -- what parties are they going to, with whom, what will be served/available.

4. **Educate:** Spend at least 30 minutes every month explaining in simple facts to your kids how drugs can hurt them and destroy their dreams.

5. **Care:** Spend at least a few minutes each day telling and showing your children that you care. Make sure they know you care that they are drug free. Explain to your child that you are always there for them -- no matter what happens. Make sure that they know to come to you first for help or information. The extended family plays a major role in influencing a child's life.

6. **Be Aware:** Look for the warning signs that your child may be developing a substance-abuse problem and get help before the problem occurs. Your pediatrician can help.

7. **Learn:** Children today are sophisticated. In order to educate your child about the danger of drugs, you need to educate yourself first. In many cases, you and your child can learn side by side. Sit down together and learn about the risks drugs pose.

8. **Set Limits:** By setting limits on what is acceptable behavior you show your children you care and help guide them to a safer, drug-free future. Declare limits -- this family doesn't do drugs, this family doesn't hang around people who do drugs. Enforce these limits -- if you say no drugs, or no drinking and driving it applies to parents. Be consistent.

9. **Get Involved:** Effective prevention extends beyond the home into the community. Get involved in your community. Ensure that your community's streets, playgrounds and schools are safe and drug free. Start or join a community watch group or community anti-drug coalition. Become active in the PTA. Get involved in your church, synagogue, or faith.

10. **Lead:** Young people are as aware of what you do, as much as what you say. Don't just say the right things, do the right things. Set a good example. If you, yourself, have a substance abuse problem get help.

PREVENTION INSERT # 2:

Some Research-Based Drug Abuse Prevention Programs

The following programs have been developed as part of a research protocol and tested in a family, school, or community setting over a reasonable period with positive results. These programs are categorized by a new series of definitions adopted in the prevention field, which describe the programs by the audience for which they are designed. Specifically, they are universal programs, selective programs, and indicated programs.

Universal programs reach the general population-such as all students in a school.

Selective programs target groups at risk or subsets of the general population-such as children of drug users or poor school achievers.

Indicated programs are designed for people who are already experimenting with drugs or who exhibit other risk-related behaviors.

Project STAR (Pentz et al. 1989; Pentz 1995). This is a universal drug abuse prevention program that reaches the entire community population with a comprehensive school program, mass media efforts, a parent program, community organization, and health policy change. Research results on this project have shown positive long-term effects: Students who began the program in junior high, and whose results were measured in their senior year of high school, showed significantly less use of marijuana (approximately 30 percent less), cigarettes (about 25 percent less), and alcohol (about 20 percent less) than children in schools that did not offer the program. The most important factor found to have affected drug use among the students was increased perceptions of their friends' intolerance of drug use.

Life Skills Training Program (Botvin et al. 1990, 1995a,b). This universal classroom program is designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. Results indicate that this prevention approach can produce 59- to 75-percent lower levels (relative to controls) of tobacco, alcohol, and marijuana use. Booster sessions can help maintain program effects. Long-term follow-up data from a randomized field trial involving nearly 6,000 students from 56 schools found significantly lower smoking, alcohol, and marijuana use 6 years after the initial baseline assessment. The prevalence of cigarette smoking, alcohol use, and marijuana use for the students who received the Life Skills Training program was 44 percent lower than for control students, and the regular (weekly) use of multiple drugs was 66 percent lower.

Seattle Social Development Project (Hawkins et al. 1992) A universal program, the Seattle project is a school-based intervention for grades one through six that seeks to reduce shared childhood risks for delinquency and drug abuse by enhancing protective factors. Long-term results indicate positive outcomes for students who participated in the program: reductions in antisocial behavior, improved academic skills, greater commitment to school, reduced levels of alienation and better bonding to pro-social others, less misbehavior in school, and fewer incidents of drug use in school.

Adolescents Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al. 1996a,b). ATLAS is a multi-component universal program for male high school athletes, designed to reduce risk factors for use of anabolic steroids and other drugs while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances. Student athletes receiving the ATLAS program report better understanding of the effects of anabolic steroids and other drugs, greater belief in personal vulnerability to the adverse effects of anabolic steroids, and more certainty that their parents and coaches are intolerant of drug use. Importantly, these high school athletes continued to resist the temptation to use anabolic steroids and maintained better nutrition and exercise behaviors one year after the intervention.

Strengthening Families Program (Kumpfer et al. 1996). Strengthening Families is a selective prevention program, a multi-component, family-focused program that provides prevention programming for 6- to 10-year-old children of substance abusers. The program began as an effort to help substance-abusing parents improve their parenting skills and reduce their children's risk factors. The program has been culturally modified and found effective (through independent evaluation) with African-American, Asian/Pacific Islander, and Hispanic families. This intervention approach has been evaluated in a variety of settings and with several racial and ethnic groups. The primary outcomes of the program include reductions in family conflict, improvement in family communication and organization, and reductions in youth conduct disorders, aggressiveness, and substance abuse.

Focus on Families (Catalano et al., in press). A selective program for parents receiving methadone treatment and for their children, Focus on Families has a primary goal to reduce parents' use of illegal drugs by teaching them skills for relapse prevention and coping. Parents are also taught how to manage their families better. Early results indicate that parents' drug use is dramatically lower and parenting skills significantly better than are seen in control groups; the program's effects on children have not yet been assessed, however.

Reconnecting Youth Program (Eggert et al. 1994, 1995). Reconnecting Youth is a school-based indicated prevention program that targets young people in grades 9 through 12 who show signs of poor school achievement and potential for dropping out of high school. Research shows that this program improves school performance; reduces drug involvement; decreases deviant peer bonding; increases self-esteem, personal control, school bonding, and social support; and decreases depression, anger and aggression, hopelessness, stress, and suicidal behaviors. Further analysis indicates that the support of Personal Growth Class teachers contributes to decreases in drug involvement and suicide risk behaviors.

Adolescent Transitions Program (ATP) (Dishion et al., in press). The ATP is a school-based program that focuses on parenting practices and integrates the universal, selective, and indicated approaches for middle and junior high school interventions within a comprehensive framework. The goal, through collaboration with the school staff, is to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance use.

V: The National Drug-Control Budget

This chapter is currently under development. Several National Drug Control Agencies received final figures for FY 2000 during the week of January 4. All agencies are now in the process of estimating drug control funding data for FY 1998 to FY 2000 for presentation in the *1999 National Drug Control Strategy* (NDCS) and the President's FY 2000 Budget. ONDCP continues to work closely with each agency and the Office of Management and Budget (OMB) as these data are developed. Agency budget offices will supply input for this chapter.

When complete, this chapter will include the following major elements:

Spending by Department

Proposed funding by department will be displayed in Table 1.

Table 1: Drug Spending by Department ($ Millions)

Department
Defense
Education
Justice
ONDCP
State
Transportation
Treasury
Veterans Affairs
All Other
Total

The following increases in drug-control funding are included in the President's FY 2000 budget:

- **Defense:** TBD

- **Education:** TBD
- **Health and Human Services**: TBD
- **Justice**: TBD
- **ONDCP:** TBD
- **State:** TBD
- **Transportation:** TBD
- **Treasury:** TBD

Spending by Strategy Goal

Funding by *Strategy* goal is summarized in Figure 2 and the accompanying table. 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). For FY 2000, funding for goal 1 will be xx billion, an increase of yy percent over FY 1999 and nearly zz billion for goal 3, an increase of ww percent. Further, multi-agency efforts, which target ports-of-entry and the southwest border, will expand funding for goal 4 to aa billion for FY 2000, an increase of bb percent. Funding for goal 2 will be cc billion in FY 2000. Resources devoted to goal 5 will reach dd billion in FY 2000, an increase of ee percent.

Figure 2: Drug Funding by Goal - FY 00

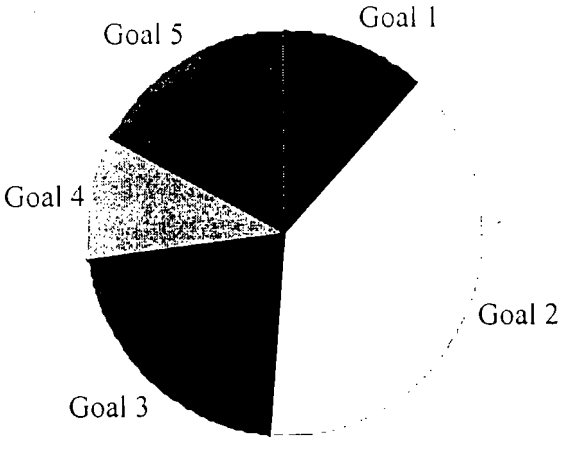

Figure 1

Table 2: Drug Funding by Goal ($ Millions)

Goal
1. Reduce youth drug use
2. Reduce drug-related crime
3. Reduce consequences
4. Shield air, land, and sea frontiers
5. Reduce sources of supply
Total

Federal Funding Priorities: FY 2000 - FY 2004

The *Strategy* is supported by a five-year budget from FY 2000 through FY 2004. The federal budget covers the following programs, which will remain priorities for funding over this planning period. Through at least FY 2004, 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

VI: Consultation

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

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

Consultation with Congress

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

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

- Reauthorization of ONDCP for five years which significantly altered ONDCP's authorities.
- Launching the National Youth Anti-Drug Media Campaign.

- Implementation of the Drug-Free Communities Act of 1997.
- Enhancement of the High Intensity Drug Traffic Areas program.
- Endorsement of the medico-scientific process for approving substances as medicine.
- Reducing the problem of drugs in prisons by including a provision in the Office of Justice Program's appropriation allowing up to 10 percent of funds going to states for prison construction to be used for drug testing and treatment.
- Development of a plan do more effectively gather and utilize counter drug intelligence.
- Passage of the Drug-Free Western Hemisphere Act..
- Passage the Drug-Free Workplace Act of 1998.

ONDCP was pleased to testify and brief the Congress on all aspects of drug control including prevention, treatment, drug legalization, interdiction, international drug control, bilateral cooperation with Mexico, the federal drug-control budget, and the *National Drug Control Strategy's* supporting Performance Measures of Evaluation system, drug abuse prevention and treatment, counterdrug cooperation in the Western Hemisphere, interdiction of illegal drugs, drug legalization, Southwest Border and Intelligence Architecture. ONDCP also welcomed and incorporated suggestions of senators, representatives, and supporting staff in the *1999 National Drug Control Strategy*

Consultation with National Drug-Control Program Agencies

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

Consultation with state and local officials

This *Strategy* incorporates the suggestions of governors from all states as well as American

Samoa, Puerto Rico, and the U.S. Virgin Islands. State drug-control agencies also provide input in the areas of prevention, treatment, and enforcement. ONDCP worked closely throughout the year with organizations such as the National Governor's Association, Council of State Governments, the U.S. Conference of Mayors, and the National Association of Counties to coordinate policies and programs. Perspectives were solicited from every mayor of a city with at least 100,000 people and from key county executives. Additionally, local prevention experts, treatment providers, and law-enforcement officials provided "street-level" views of the drug problem along with potential solutions.

Consultation with private citizens and organizations

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

Consultation with representatives of foreign governments and international organizations

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

Publications.

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

National Drug Control Strategy: Budget Summary. Contains detailed drug-control budget data by agency, function, and goal. This 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* and updated

this year, describes the performance measurement system that orients national drug-control program.

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

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

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

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

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

A Cognitive-Behavorial Approach: Treating Cocaine Addiction (1998). First in the "Therapy Manuals for Drug Addiction" series. Describes cognitive-behavorial coping skills treatment (CBT), which is a short-term, focused approach to helping cocaine-dependent individuals become abstinent from cocaine and other substances. Chapters include coping with craving, integrating CBT and medication, and shoring up motivation and commitment, and reducing HIV risk.

A Collection of NIDA Notes Articles on Drug Abuse Treatment (1998). Presents articles from 1995 to 1997 newsletters, including "Voucher System is Effective Tool in Treating Cocaine

Abuse"; "Rats Immunized Against Effects of Cocaine"; "Rate and Duration of Drug Activity Play Major Roles in Drug Abuse, Addiction, and Treatment."

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

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

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

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

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

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

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

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

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

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

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

(NOTE: Input needed from all sections to capture conference reports and ONDCP publications & White Papers)

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 ***yy*** people per month.

ONDCP also informs the public of drug-policy issues through an extensive media and outreach program. In 1998, more than ***xx*** television and radio interviews were conducted across the United States. Detailed briefings were provided to editorial boards of yy newspapers and magazines. Spanish-language materials were produced for domestic and Latin American organizations. Op-eds, journal articles, and published speeches were placed in major publications.

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

Conferences and meetings

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

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

U.S./Mexico High Level Contact Group (HLCG) on Drug Control: Created in March 1996, this group met April 6-7, 1998 in Mexico City and December 14-16, 1998, in Washington. On February 6, 1998, the HLCG released the U.S.-Mexico binational Drug control Strategy which outlined domestic and cooperative counterdrug goals and actions for the two countries. The HLCG continues to work on developing Performance Measures of Effectiveness (PMEs) for the binational strategy. The PMEs will be completed in early 1999.

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

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

ONDCP Caribbean Regional Drug Control Conference. ONDCP and the Department of State hosted this conference in Miami, October 14-16, 1998. The conference involved the participation of over 150 high-level attendees, including Caribbean Ministers from 15 island nations; representatives from British, French, and Dutch Caribbean territories; Puerto Rico and

U.S. Virgin Islands; the UK drug czar; drug-related officials from France, UK, the Netherlands, Spain, UNDCP, OAS/CICAD, Austria (as EU President), and the European Commission; academics; and, U.S. Government drug officials. As a follow-up to the Caribbean/US Summit, the conference focused on implementing the Barbados Plan of Action to strengthen nations' national drug control strategies, addressing both supply and demand reduction issues, and improve coordination of national and regional drug control programs.

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

Colombia Trip. The Deputy Director for Supply Reduction led an interagency counterdrug team to Colombia, October 4-7, 1998. The team included representatives from DoS INL, DoS ARA, DOD/DEP&S, DoJ, and USAID. This was the first official USG contact with the Government of Colombia on the whole range of drug policy issues. The team discussed narcotics certification criteria, Pastrana administration counterdrug plans, and upcoming operations and programs.

Europe Trip. The Director visited Stockholm, Vienna, Zurich, Amsterdam, and Lisbon July 11-18, 1998. During the trip, ONDCP representatives learned more about European drug control efforts (i.e., especially demand reduction programs for prevention and treatment); reviewed UNDCP initiatives with Executive Director Pino Arlacchi; followed up on UNGASS issues; and, expanded US-EU dialogue and cooperation on drug issues. Events culminated with a multilateral US-EU drug forum with senior-level drug policy officials.

Second Summit of the Americas (SOA). Director McCaffrey traveled to South America April 15-22, 1998 to participate in Summit of the Americas events with the President and to visit Brazil, Bolivia, and Peru. While at the summit in Santiago, Chile, Director McCaffrey met with the Chilean Drug Policy Council and other hemispheric drug policy officials. In Brazil, Director McCaffrey met key Brazilian government drug policy officials and arranged a working lunch with Congressional and private Brazilian citizens to discuss drug issues. In Bolivia, Director McCaffrey discussed drug control issues with Vice President Jorge Quiroga. Finally, in Peru, the Director met with President Alberto Fujimori, the Health Minister and Contradrogas President Costa Bauer and the Contradrogas Executive Board.

UN General Assembly Special Session (UNGASS) on Drugs. UNGASS marked the 10th anniversary of the adoption of the 1988 UN Drug Convention and the opportunity to further

adopt concrete actions to implement the Convention. Representatives from 150 countries, including President Clinton and 31 other Heads of State and Heads of Government, attended the three-day session, 8-10 June 1998. The formal business of the Session involved adopting five Action Plans (on Precursor Chemicals, Amphetamine-Type Stimulants (ATS), Judicial Cooperation, Money Laundering, and Eradication of Illicit Drug Crops and Alternative Development) and two Declarations (Guiding Principles of Drug Demand Reduction and a strong Political Declaration). Director McCaffrey participated in UNGASS events, consulted with senior UNDCP officials, and conducted 18 bilateral meetings with senior drug control officials from Mexico, Europe, Asia, and Pacific rim nations. Representatives from NSC, State, HHS, DOJ, Treasury, DEA, USIA, and NIDA also attended UNGASS events.

Southern Frontiers Law Enforcement Issues Meeting. ONDCP participated in the Southern Frontiers Law Enforcement Issues meeting chaired by Attorney General Janet Reno, November 16, 1998 in Washington, DC. Attendees included deputy-level officials from FBI, DEA, DOJ, Customs, and Border Patrol, as well as other representatives from the interagency. Discussions were held on several topics, including anti-narcotics enforcement on the Southwest Border, development of "Performance Measures of Effectiveness" for the US/Mexican Drug Strategy, US/Mexican law enforcement cooperation, and implementation of the interagency plan for Central America.

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

Quarterly Meetings of the Counter-Narcotics Interagency Working Group (CN-IWG) ONDCP hosts these interagency meetings in Washington, DC to address key issues affecting international counternarcotics policy. The membership includes high-level representatives from the relevant U.S. Government agencies and organizations. The CN-IWG reports results of its policy deliberations to the National Security Council structure.

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.

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

100 Black Men of America, Inc.
Academy of TV, Arts and Sciences
Addiction Research and Treatment Corporation
Ad Council
Adjutant General Association of the United States
Advertising Council
AFL-CIO
African American Parents for Drug Prevention
Alcohol and Drug Problems Association of North America
Alcohol Policy Coalition
Alcohol Policy Foundation
Alcoholics Anonymous World Services
Alianza para un Puerto Rico sin Drogas
America's Promise
American Academy of Addiction Psychiatry
American Academy of Family Physicians
American Academy of Healthcare Providers in the Addictive Disorders
American Academy of Nurse Practitioners
American Academy of Pediatrics
American Academy of Physician Assistants
American Association of Halfway House Alcoholism Programs
American Association of Health Plans
American Association of Pastoral Counselors
American Association of Preferred Provider Organizations
American Association of School Administrators
American Association of University Women
American Bar Association
American College of Emergency Physicians
American College of 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
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
ASPIRA
Association for Hospital Medical Education
Association for Medical Education and Research in Substance Abuse (AMERSA)
Association for Worksite Health Promotion
Association of Academic Health Centers
Association of Caribbean Commissioners of Police
Association of Jesuits Colleges and Universities
Association of Junior Leagues
Association of State Correctional Administrators
Association of Southeast Asian Nations
BACCHUS and GAMMA Peer Education
Baltimore Council of Foreign Affairs
Benevolent and Protective Order of Elks
Bensinger DuPont & Associates
Big Brothers Big Sisters of America
Bodega de la Familia (New York City)
Boy Scouts of America
Boys and Girls Clubs of America
Brookings Institute
Business Roundtable
B'nai B'rith International
B'nai B'rith Youth
California Border Alliance Group
California Narcotics Officers Association
California School Board Association
Camp Fire Boys and Girls
Caribbean Common Market and Community
Caribbean Customs Law Enforcement Council
Carter Center
Catholic Charities U.S.A.
Center for Alcohol and Drug Research Education
Center for Health Promotion
Center for Media Education, Inc.
Center for Media Literacy
Center for Medical Fellowships in Alcoholism and Drug Abuse
Center for Science in the Public Interest
Center on Addiction and Substance Abuse of Columbia University (CASA)
Chicago Project for Violence Prevention
Child Welfare League of America, Inc.
Children's Defense Fund
Christian Life Commission
Church of Jesus Christ and Latter Day Saints
Church Women United
Cities in Schools
Civitan International
Cobb County Chamber of Commerce
College on Problems of Drug Dependence

Commission on Narcotic Drugs of the United Nations Economic and Social Council
Communitarian Network
Community Anti-Drug Coalitions of America
Community Crusade Against Drugs
Congress of National Black Churches
Corporate Alliance for Drug Education (CADE)
Corporations Against Drug Abuse
Council of State Governments
Council on Foreign Relations
D.A.R.E. America
Delancey Street Foundation
Drug Strategies
Drug Watch International
Drugs Don't Work
Educational Video Center
Emergency Nurses Association
Employee Assistance Professionals Association
Employee Assistance Society of North America
Employee Health Programs
Empower America
Entertainment Industries Council, Inc.
European Commission
Families and Schools Together (FAST)
Families U.S.A. Foundation
Family Research Council
Federal Law Enforcement Officers Association
Florida Alcohol and Drug Abuse Association, Inc.
Florida Chamber of Commerce
Foster Grandparents Program
Fox Children's Network
Fox News Channel
Fraternal Order of Eagles
Fraternal Order of Police
Gaudenzia Program (Pennsylvania)
Gateway Foundation
General Federation of Women's Clubs
Generations United
George Meany Center for Labor Studies
Georgia State University, Department of Psychology
Girl Scouts of the U.S.A.
Girls, Incorporated
Hadassah
Haight-Ashbury Free Clinic
Harvard Inter-Disciplinary Working Group on Drugs and Addiction
Harvard University School of Public Health
Hazelden
Heritage Foundation
Hispanic American Command Officers Association
Hispanic American Police Officers Association
Hispanic American Police Command Officer's Association
Houston's Drug Free Business Initiative
Human Rights Watch
Illinois Drug Education Alliance
Independent Order of Odd Fellows
Institute for a Drug-Free Workplace
Inter-American College of Physicians/Surgeons
Inter-American Drug Abuse Control Commission of the Organization of American States
International Association of Chiefs of Police
International Association of Junior Leagues
International Brotherhood of Police Officers
International Brotherhood of Teamsters
International Certification and Reciprocity Consortium
International City Managers Association
International Drug Strategy Institute
International Criminal Police Organization
International Narcotic Control Board
International Olympics Committee
Johns Hopkins University School of Medicine
Johnson Institute Foundation
Join Together
Junior Achievement of the National Capital Area, Inc.
Junior Chamber International, Inc.
"Just Say No" International
Kaiser Family Foundation
Kiwanis International
Knights of Columbus
Latino Council on Alcohol and Tobacco
Lawyer's Committee for Human Rights
League of United Latin American Citizens
Legal Action Center
Life Steps Foundation, Inc.
Linden Grove
Lindesmith Center
Lions Club International
Little League Foundation
Los Alamos Citizens Against Substance Abuse (LACASA)
Lutte Contra La Toxicomanie
LUZ Social Services
Major City Chiefs Organization
Maryland Underage Drinking Prevention Coalition
Mediascope
Metropolitan Atlanta Crime Commission
Milton Eisenhower Foundation
Milwaukee Council on Alcoholism and Drug Dependence
Moose International
Mothers Against Drunk Driving (MADD)
Nar-Anon Family Groups
Narcotics Anonymous
National Education Association
National 4-H Council
National Academy of Public Administration
National Alliance for Model State Drug Laws
National Alliance of State Drug Enforcement Agencies
National Alliance of State Territorial AIDS Directors
National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
National Asian Women's Health Organization
National Assembly of Voluntary Health and Social Welfare Associations
National Association for Children of Alcoholics (NACOA)
National Association for Family and Community Education
National Association for Native American Children of Alcoholics
National Association for the Advancement of Colored People
National Association of Addiction Treatment Providers
National Association of Alcoholism and Drug Abuse Counselors
National Association of Asian Pacific Islanders
National Association of Black Law Enforcement
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 Municipalities
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, Inc. (NAPPA)
National Association of Protection and Advocacy Systems
National Association of Psychiatric Health Systems
National Association of Regional Councils
National Association of School Nurses
National Association of Secondary School Principals
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Black Alcoholism and Addiction Council
National Black Caucus of Local Elected Officials
National Black Caucus of State Legislators
National Black Child Development Institute, Inc.
National Black Police Association
National Black Prosecutors
National Caucus of Hispanic School Board Members
National Center for Missing and Exploited Children
National Center for State Courts
National Center for Tobacco-Free Kids
National Coalition for the Homeless
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)
National Collegiate Athletic Association
National Committee for the Furtherance of Jewish Education
National Committee to Prevent Child Abuse
National Conference of Christians and Jews
National Conference of Puerto Rican Women
National Conference of State Legislators
National Congress of Parents and Teachers
National Consortium of TASC Programs
National Consumers League
National Council for Community Behavioral Healthcare
National Council of Catholic Men
National Council of Catholic Women
National Council of Churches
National Council of Jewish Women
National Council of Juvenile and Family Court Judges
National Council of Negro Women
National Council on Alcoholism and Drug Dependence
National Council on Disability
National Council on Patient Information and Education
National Crime Prevention Council
National Criminal Justice Association
National District Attorneys Association
National Drug Court Institute
National Drug Prevention League
National Drug Strategy Network
National Education Association
National Exchange Club
National Families in Action
National Family Partnership
National Federation of Independent Businesses
National Federation of Parents for Drug-Free Youth
National Federation of State High School Associations
National FFA Organization
National Governors' Association
National Health Council
National High School Athletic Coaches Association
National Hispanic/Latino Community Prevention Network
National Hispanic Leadership Conference
National Hispanic Radio
National Inhalant Prevention Coalition
National Institute for Women of Color
National Jewish Community Relations Advisory Council
National Latino Children's Institute
National League of Cities
National League of Counties
National Legal Aid and Defender Association
National Masonic Foundation for Children
National Medical Association
National Mental Health Association
National Minority Health Association
National Narcotics Officers' Associations Coalition
National Network of Runaway and Youth Services
National Nurses Society on Addiction
National Opinion Research Center
National Organization of Black County Officials
National Organization of Black Law Enforcement Executives
National Organization on Fetal Alcohol Syndrome
National Panhellenic Conference
National Parents and Teachers Association
National Pharmaceutical Association
National Pharmaceutical Council, Inc.
National Prevention Network
National Puerto Rican Coalition
National Recreation and Parks Association
National Rural Alcohol and Drug Abuse Network
National Rural Health Association
National School Boards Association
National Sheriffs Association
National Strategy Center
National Telemedia Council
National Treatment Accountability for Safer Communities
National Treatment Consortium
National Troopers Coalition
National Urban Coalition
National Wellness Association
National Wholesale Druggists Association
National Women's Health Resource Center
Native American Outreach Project, America Society of Internal Medicine
Neighborhood Drug Crisis Center
New York Hospital Cornell Medical Center
New York University Medical Center
Nonprescription Drug Manufacturers Association
North American Conference of Grand Masters

Northwest Center for Health and Safety
Odysey House
One Church - One Addict
Operation PAR, Inc.
Optimist International
Organization of American States
Organization of Chinese Americans, Inc.
Orthodox Union
Parents Collaborative
Parents' Resource Institute for Drug Education, Inc. (PRIDE)
Partners in Drug Abuse Rehabilitation Counseling
Partnership for a Drug-Free America
Patrician Movement
Penn State University
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)
Professional Actors Guild
Professional Directors Guild
Professional Writers Guild
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
Safe Streets
San Diego World Affairs Council
San Francisco AIDS Foundation
Scott Newman Center
Sertoma International
Siouxland Cares
Sons and Daughters in Touch
Soroptimist International of the Americas
Southern Christian Leadership Conference
State Justice Institute
Student National Medical Association
Students Against Destructive Decisions (SADD)
Substance Abuse Foundation for Education and Research (SAFER)
Substance Abuse Program Administrators Association (SAPAA)
Support Center for Alcohol and Drug Research and Education
Temple University, Department of Pharmacology, College on Problems of Drug Dependence
Texans' War on Drugs
Texas A&M University - Department of Marketing
The Center for Drug Free Living, Inc.
The Church of Jesus Christ of Latter-Day Saints
The LINKS, Inc.
The Matrix Institute on Addictions
The North American Committee
The Recovery Network
The Robert Wood Johnson Foundation
The Salvation Army
The Village, Inc.
Therapeutic Communities of America
Town Hall of Los Angeles
Travelers Aid International
Treatment Accountability for Safer Communities
Treatment Alternatives for Safe Communities (TASC)
Troy Michigan Communities Coalition
Twentieth Century Fund
Two Hundred Club of Greater Miami
U.S. Chamber of Commerce
U.S. Conference of Mayors
U.S. Hispanic Chamber of Commerce
U.S. Olympic Committee Union of American Hebrew Congregations
United Church of Christ
United Methodist Association of Health and Welfare
United Methodist Church, Central Pennsylvania Conference
United National Indian Tribal Youth, Inc.
United Nations Economic and Social Council
United Nations International Drug Control Programme
United States Catholic Conference
United States Conference of Mayors
United Synagogue of Conservative Judaism
United Way of America
University of California, Los Angeles
  Drug Abuse Research Group
  Graduate School of Management
  Neuropsychiatric Group
University of Delaware, Division of Criminal Justice
University of Kentucky
  Center for Prevention Research and
  Department of Communication
University of Maryland, Center for Substance Abuse Research (CESAR)
University of Michigan Survey Research Center
University of Nebraska Medical Center
University of North Carolina, Department of Curriculum and Instruction
University of Pennsylvania
  Health System
  Treatment Research Center
University of Southern California, Center for Prevention Policy Research
University of Washington, College of Education and Alcohol and Drug Abuse Institute
Urban Institute
Urban League
Veterans of Foreign Wars
Virginia Association of Alcoholism and Drug Abuse Counselors
Visiting Nurses Association of America
Washington Business Group on Health
Washington Office on Latin America
Wellness Council of America
World Affairs Council of San Diego
World Affairs Council of Washington, D.C.
Yale University School of Medicine
Yerkes Regional Primate Research Center, Emory University
YMCA of the USA
YWCA of the USA
Youth Service America
Youth to Youth
Zeta Phi Beta, Inc.
Zonta International

Appendix: Drug-Related Data

[NOTE: This section is being reviewed for any additional updates and for compliance with new re-authorization legislation.]

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. The Office of National Drug Control Policy's (ONDCP) Advisory Committee on Research, Data, and Evaluation coordinates the development and analysis of drug-control information in support of the *Strategy*. The 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 the Crime Control Act require ONDCP to assess.

Data Source Descriptions

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

What America's Users Spend on Illegal Drugs: 1988-1995 (Source for Tables 1, 3, and 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 1997–98 school year involved _____ students in twenty-eight states.

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program (Source for Tables 7 and 8)

The National Institute of Justice established the Drug Use Forecasting (DUF) program in 1987 to provide an objective assessment of the drug problem among those arrested and charged with crimes. In 1997, this program became the Arrestee Drug Abuse Monitoring (ADAM) program. The ADAM program collected data in 23 major metropolitan sites across the United States. Arrestees were 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 1997 data comprised 19,736 adult male arrestees, 7,547 adult female arrestees, and a smaller sample of juvenile arrestees. The ADAM system is expanding to more cities in the coming years.

Current Population Survey (Source for Table 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 federal, state, and local drug policy makers to examine drug use patterns and trends and assess health hazards associated with drug abuse. Data are available on deaths and emergency department episodes by type of drug, reason for taking the drug, demographic characteristics of the user, and metropolitan area. NIDA maintained DAWN from 1982 through 1991; SAMHSA has maintained it since 1992.

Uniform Crime Reports (Source for Table 14)

The Uniform Crime Reports (UCR) is a nationwide census of thousands of city, county, and state law enforcement agenciesThe goal of the UCR is to count in a standardized manner the number of offenses, arrests, and clearances known to police. Each law enforcement agency voluntarily reports data on crimes. Data are reported for the following nine index offenses: murder and manslaughter, forcible rape, robbery, aggravated assault, burglary, larceny, theft, motor vehicle theft, and arson. Data on drug arrests, including

arrests for possession, sale, and manufacturing of drugs, are included in the database. Distributions of arrests for drug abuse violations by demographics and geographic areas also are available. UCR data have been collected since 1930; the FBI has collected data under a revised system since 1991.

Survey of Inmates of Local Jails (Source for Table 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. In 1997, the Surveys of Inmates in State and Federal Correctional Facilities (SISFCF) was conducted.

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) 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. In 1995, NDATUS was renamed the Uniform Facility Data Set (UFDS).

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 clients who receive treatment, as well as persons who need treatment but are not in treatment.

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

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

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

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

International Narcotics Control Strategy Report (Source for Table 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.

GLOSSARY

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

ADAM--Arrestee Drug Abuse Monitoring System. Conducted by the National Institute of Justice, it provides community-level data and national estimates of drug abuse among arrestees. Formerly known as the Drug Use Forecasting (DUF) program.

AIDS--acquired immune deficiency syndrome.

ASEAN--Association of Southeast Asian Nations.

ATF -- Bureau of Alcohol, Tobacco and Firearms.

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

BJS--Bureau of Justice Statistics, part of the U.S. Department of Justice.

CADCA--Community Anti-Drug Coalitions of America. CADCA's mission is to build and strengthen the capacity of coalitions to prevent and reduce substance abuse and violence in communities across America. The organization supports coalition members through technical assistance, leadership development programs, information dissemination and by serving as a national voice on substance abuse issues.

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. One of the National Institutes of Health and

part of the Department of Health and Human Services. CSAP is the focus of the U.S. Department of Health and Human Services' efforts to prevent alcohol, tobacco, and other drug problems nationwide. CSAP provides information and assistance to national, regional, state, and community prevention efforts.

CSAT - One of the National Institutes of Health and part of the Department of Health and Human Services. CSAT's congressional mandate is to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT works cooperatively across the private and public treatment spectrum to identify, develop, and support policies, approaches, and programs that enhance and expand treatment services for individuals who abuse alcohol and other drugs.

CTAC--Counter-Drug Technology Assessment Center.

DAICC--Domestic Air Interdiction Coordination Center

D.A.R.E.--Drug Abuse Resistance Education.

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

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

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

DOD--U.S. Department of Defense.

DOJ--U.S. Department of Justice.

DOL--U.S. Department of Labor.

DOT--U.S. Department of Transportation.

DUF--Drug Use Forecasting program. Now known as ADAM.

EAP--Employee Assistance Program

EPA--U.S. Environmental Protection Agency.

FAS--fetal alcohol syndrome.

FATF--Financial Action Task Force, an international grouping of nations that fight money laundering.

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

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

FDSS--Federal-Wide Drug Seizure System.

FY--fiscal year.

GHB--Gamma-hydroxybutyrate

GREAT--Gang Resistance Education and Training.

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

HCl--hydrochloride.

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

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

HIV--human immunodeficiency virus.

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

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

ILEA--International Law Enforcement Academy.

INCSR--International Narcotics Control Strategy Report.

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

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

ISIS/RVS--Integrated Surveillance Intelligence System and Remote Video Surveillance.

JIATF--Joint Interagency Task Force.

LAAM--levomethadyl acetate hydrochloride

LSD--Lysergic acid diethylamide, a hallucinogen.

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

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

NDATUS--National Drug And Alcoholism Treatment Unit Survey.

NDCS--National Drug Control Strategy.

NHSDA--National Household Survey of Drug Abuse, the most comprehensive of the many national surveys 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.

NTIES--National Treatment Improvement Evaluation Study.

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.

OJP--Office of Justice Programs, 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 promotes private section involvement in the creation of anti-drug messages.

PME--performance measures of effectiveness.

POE--Port of Entry.

PRIDE--Parent's Resource Institute for Drug Education.

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

SDFS-- Safe and Drug-Free Schools and Communities Program

SIDS--sudden infant death syndrome.

SIFCF--Survey of Inmates in Federal Correctional Facilities.

SISCF--Survey of Inmates in State Correction Facilities.
SMART--Self Management and Resistance Training.

STD--sexually transmitted disease.

STRIDE--System To Retrieve Information from Drug Evidence, a program of the Drug Enforcement Administration.

SWBI--South West Border Initiative.

THC--Tetrahydrocannabinol, the psychoactive family of substances in marijuana.

TIPS--Treatment Improvement Protocols.

UCR--Uniform Crime Reports, a publication of the FBI.

UFDS--Uniform Facility Data Set

UN--United Nations.

UNDCP--United Nations International Drug Control Programme.

U.S.--United States.

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

USCG--United States Coast Guard.

USCS--United States Customs Service.

USG-- United States Government.

USIC--United States Interdiction Coordinator.

WtW--Welfare to Work.

XTC--a street name for MDMA.

YRBS--Youth Risk Behavior Survey.