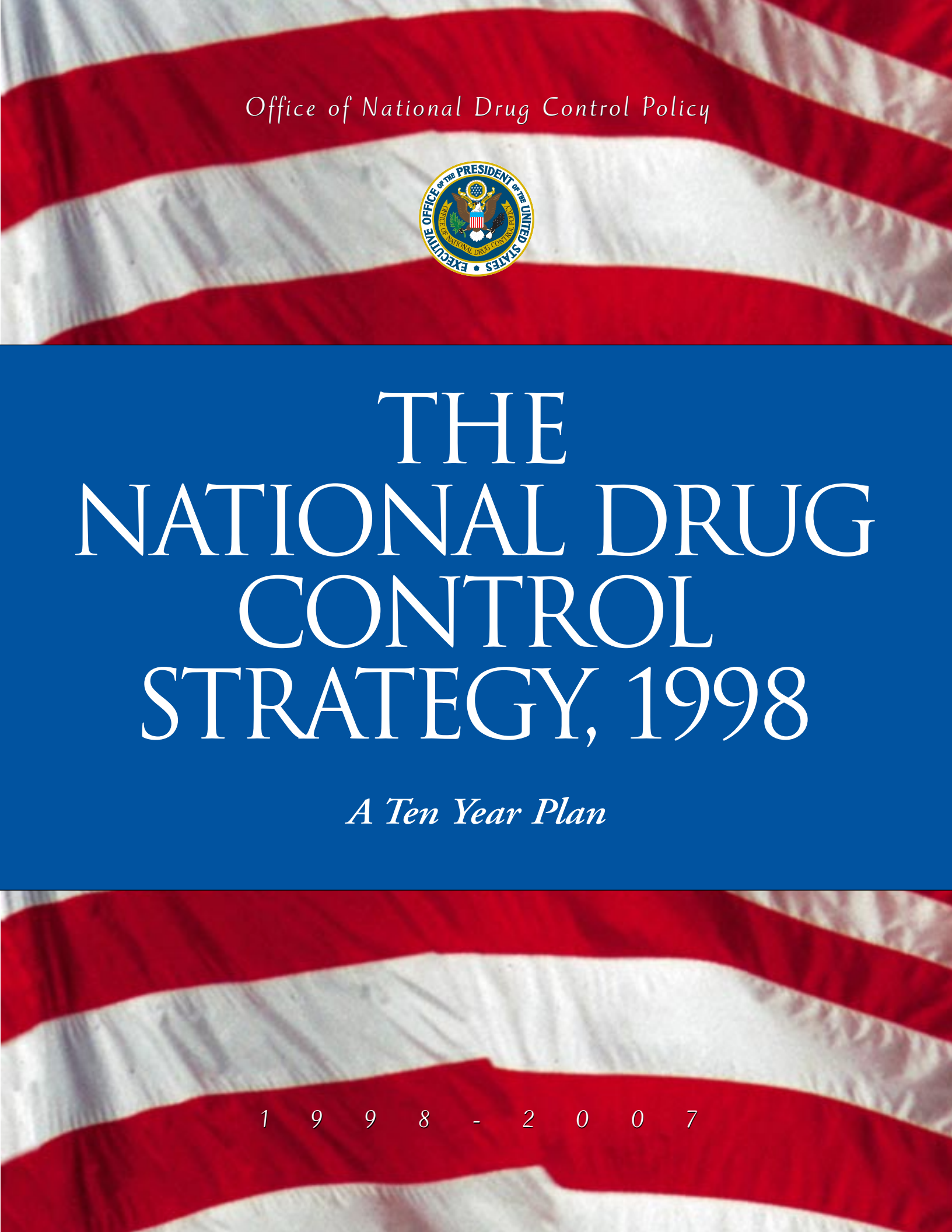


Office of National Drug Control Policy

# THE NATIONAL DRUG CONTROL STRATEGY, 1998

*A Ten Year Plan*

1998-2007

# The National Drug Control Strategy: 1998

# The President's Message

TO THE CONGRESS OF THE UNITED STATES:

On behalf of the American people, I am pleased to transmit the *1998 National Drug Control Strategy* to the Congress. The *1998 Strategy* reaffirms our bipartisan, enduring commitment to reduce drug use and its destructive consequences.

This year's *Strategy* builds upon the 1997 Strategy and is designed to reduce drug use and availability in America by half over the next 10 years—a historic new low. This plan has been developed under the leadership of General Barry McCaffrey, Director of National Drug Control Policy, in close consultation with the Congress, the more than 50 Federal agencies and departments involved in the fight against drugs, the dedicated men and women of law enforcement, and with stakeholders—mayors, doctors, clergy, civic leaders, parents, and young people—drawn from all segments of our society.

I am also proud to report that we have made real and substantial progress in carrying out the goals of the 1997 *Strategy*. Working with the Congress, we have begun the National Anti-Drug Youth Media Campaign. Now when our children turn on the television, surf the "net," or listen to the radio, they can learn the plain truth about drugs: they are wrong, they put your future at risk, and they can kill you. I thank you for your vital support in bringing this important message to America's young people.

Together, we enacted into law the Drug-Free Communities Act of 1997, which will help build and strengthen 14,000 community anti-drug coalitions. We also brought together civic groups—ranging from the Elks to the Girl Scouts and representing over 55 million Americans—to form a Civic Alliance, targeting youth drug use. By mobilizing people and empowering communities, we are defeating drugs through a child-by-child, street-by-street, and neighborhood-by-neighborhood approach.

We have also helped make our streets and communities safer by strengthening law enforcement. Through my Administration's Community Oriented Policing Services (COPs) program, we are helping put 100,000 more police officers in towns and cities across the Nation. We are taking deadly assault weapons out of the hands of drug dealers and gangs, making our streets safer for our families. We have taken steps to rid our prisons of drugs, as well as to break the vicious cycle of drugs and crime. These efforts are making a difference: violent crime in America has dropped dramatically for 5 years in a row.

Over the last year, the United States and Mexico reached agreement on a mutual *Threat Assessment* that defines the scope of the common threat we face and an Alliance that commits our great nations to defeating that threat. Soon, we will sign a bilateral *Strategy* that commits both nations to specific actions and performance benchmarks. Our work to enhance cooperation within the hemisphere and worldwide is already showing results. For example, Peruvian coca production has declined by roughly 40 percent over the last 2 years. In 1997, Mexican drug eradication rates reached record levels, and seizures increased nearly 50 percent over 1996.

We are making a difference. Drug use in America has declined by 50 percent over the last decade. For the first time in 6 years, studies show that youth drug use is beginning to stabilize, and in some respects is even declining. And indications are that the methamphetamine and crack cocaine epidemics, which in recent years were sweeping the Nation, have begun to recede.

However, we must not confuse progress with ultimate success. Although youth drug use has started to decline, it remains unacceptably high.

More than ever, we must recommit ourselves to give parents the tools and support they need to teach children that drugs are dangerous and wrong. That is why we must improve the Safe and Drug-Free Schools program, and other after school initiatives that help keep our kids in school, off drugs, and out of trouble. We must hire 1,000 new border patrol agents and close the door on drugs at our borders. We must redouble our efforts with other nations to take the profits out of drug dealing and trafficking and break the sources of supply. And we must enact comprehensive bipartisan tobacco legislation that reduces youth smoking. These and other efforts are central elements of the *1998 National Drug Control Strategy*.

With the help of the American public, and the ongoing support of the Congress, we can achieve these goals. In submitting this plan to you, I ask for your continued partnership in defeating drugs in America. Our children and this Nation deserve no less.

THE WHITE HOUSE

# Foreword

The *1998 National Drug Control Strategy* provides a comprehensive ten-year plan to reduce drug use and its consequences to historic lows. The *Strategy* focuses on shrinking America's demand for drugs, through treatment and prevention, and attacking the supply of drugs through law enforcement and international cooperation.

Preventing children from turning to drugs will safeguard the future of this country. The promise of tomorrow's astronauts, Nobel prize-winners, Olympic athletes, business leaders, and families all begin with our children. By reducing drug abuse, we secure for future generations the dreams upon which our nation was founded.

Drug treatment saves lives, strengthens families, reduces crime, and renews hope — not only for individuals struggling with addiction but also for the people who care about them. Freeing chronic users from the grip of drugs increases workplace productivity and reduces health burdens. As we restore drug-infested neighborhoods, we turn violent cities into creative communities.

By closing the door on drugs at our borders, we increase the security of all Americans. The stream of commerce and culture across our borders represents tremendous opportunity for our great nation. Expanding the exchange of industry and ideas, while stemming the flow of illegal drugs, allows us to prosper. Similarly, reaching beyond our borders to foster multinational cooperation diminishes the drug threat America faces.

For America to succeed in defeating the threat of drugs, each of us must play a role. Our nation's community leadership must provide the essential commitment. Drug treatment must expand the science of addiction and provide needed treatment capacity. Law enforcement must protect our streets, schools, and homes. Clergy can give our citizens moral guidance for rejecting the destructive temptation of drugs. Teachers, coaches, medical professionals, and mentors need to steer young people away from drugs and toward bright futures. Most of all, parents must talk honestly and frequently with children about the danger of drugs. We need to give young people the courage and judgement not only to reject drugs but to help friends do so as well.

The *National Drug Control Strategy* embodies this need for collective action. Together, we can reject drug abuse and make America a safer, healthier nation.

Barry R. McCaffrey
Director
Office of National Drug Control Policy

# The National Drug Control Strategy: 1998

## Table of Contents

# I: Drug-Control Strategy: An Overview

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

## Introduction

The first duty of government is to provide security for citizens. The Constitution of the United States articulates the obligation of the federal government to uphold the public good, providing a bulwark against all threats, foreign and domestic. Drug abuse, and the illegal use of alcohol and tobacco by youngsters under the legal age, constitute such a threat. Toxic, addictive substances are a hazard to our safety and freedom, producing devastating crime and health problems. 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 Ten-Year 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 ten-year conceptual framework to reduce illegal drug use and availability 50 percent by the year 2007. If this goal is achieved, just 3.1 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 a comprehensive approach to the regulation, manufacture, and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the production of controlled substances.

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

- **The Anti-Drug Abuse Act of 1988** established as a policy goal the creation of a drug-free America. A key provision of that Act was the establishment of the Office of National Drug Control Policy (ONDCP) to set priorities, implement a national strategy, and certify federal drug-control budgets. The law specifies that the strategy must be comprehensive and research-based, contain long-range goals and measurable objectives, and seek to reduce drug abuse, 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.

## Evolution of the National Drug Control Strategy

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

## Elements of the 1998 National Drug Control Strategy

**Democratic**: Our nation's domestic challenge is to reduce illegal drug use and its criminal, health, and economic consequences while protecting individual liberty and the rule of law. Our international challenge is to develop effective, cooperative programs that respect national sovereignty and reduce the cultivation, production, trafficking, 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: A System for Assessing the Performance of the National Drug Control Strategy*[2] details long and mid-term targets that gauge progress toward each of the *Strategy*'s goals and objectives.

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

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

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

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

**Science-based**: Facts, based in science and data collection, rather than ideology or anecdote must provide the basis for rational drug policy.

## Goals of the 1998 Strategy:

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

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

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

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

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

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

## 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 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).

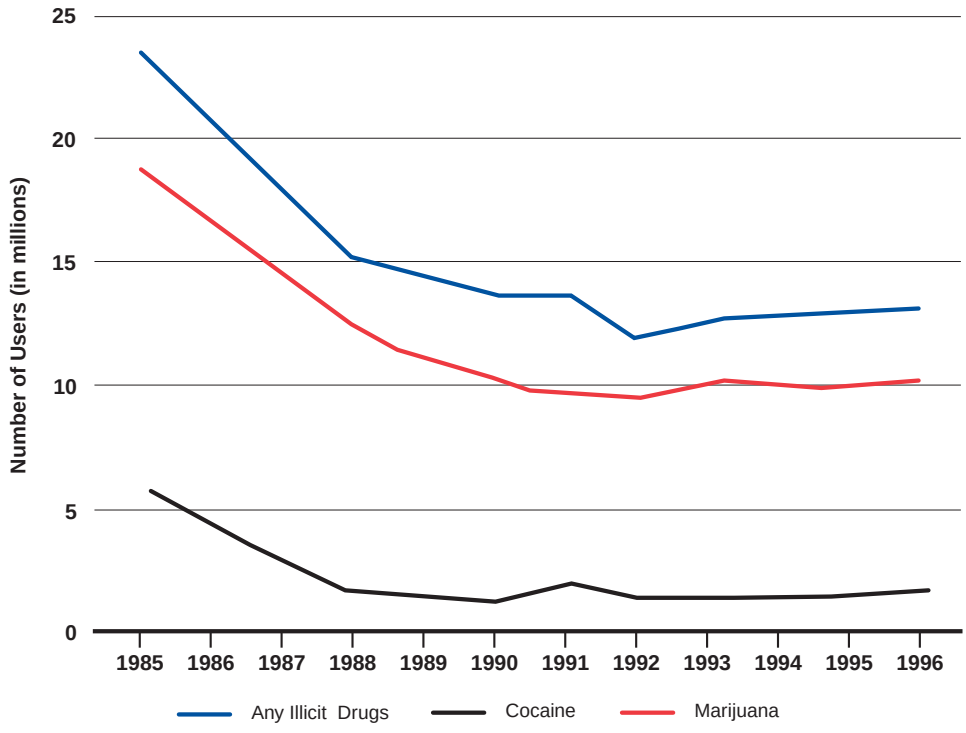
# II: America's Illegal Drug Profile

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

In 1996, overall drug use remained stable, and use among youth stopped increasing after five years of rising rates. An estimated thirteen million Americans (6.1 percent of the U.S. household population aged twelve and over) were current drug users.* This figure represents a significant change from 1979 when the number of current users was at its highest recorded level—twenty-five million (or 14.1 percent of the population).[1] Despite this dramatic drop, 34.8 percent of Americans twelve and older have used an illegal drug in their lifetime; 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.

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

Figure 2-1 **Past Month Users of Any Illicit Drugs, Cocaine, and Marijuana.**




**Source:** National Household Survey on Drug Abuse, National Institute on Drug Abuse (1985–91), Substance Abuse and Mental Health Services Administration, (1992–95)

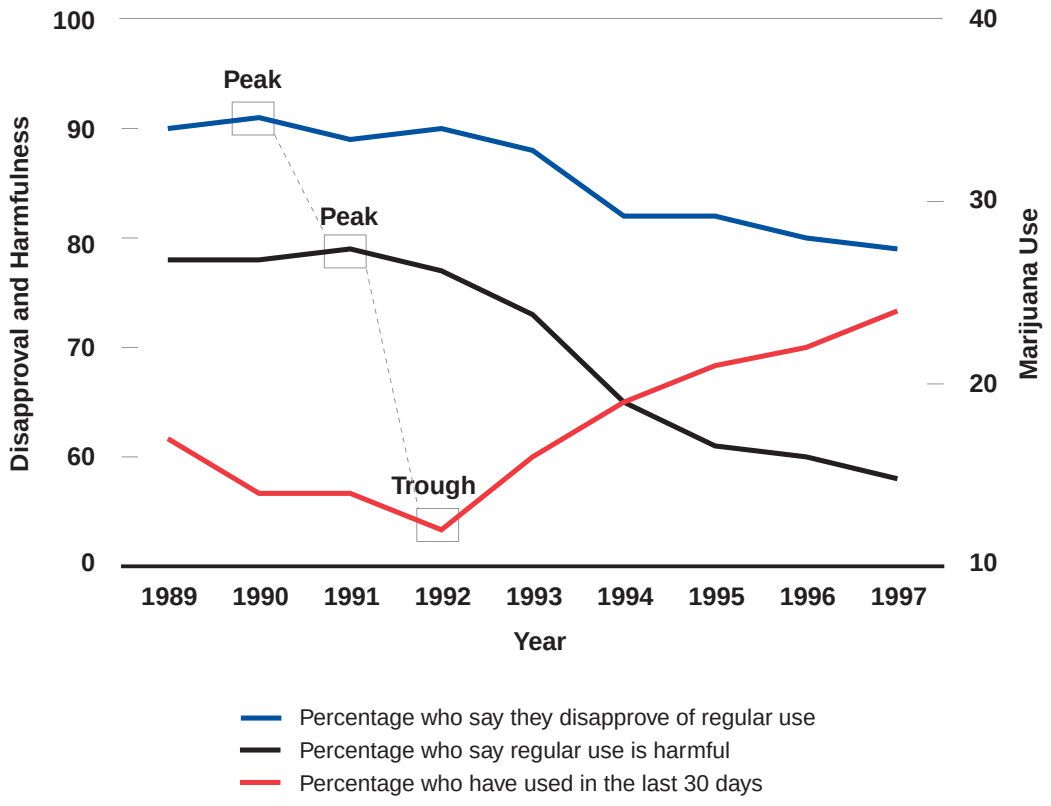
## Drug Abuse Is a Shared Problem

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

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

The University of Michigan's 1997 *Monitoring the Future (MTF)* study—a nationwide school-based report of drug use among eighth, tenth, and twelfth-grade students—records that drug-use

Figure 2-2: **Marijuana: Disapproval and Perceived Harmfulness of Regular Use Compared with Past 30-Day Use Among 12th Graders**




**Source:** *Monitoring the Future* Study, University of Michigan, 1997

rates are leveling off.[2] Since 1992, there has been a substantial increase in the use of most drugs—particularly marijuana. In 1997, for the first time in six years, the use of marijuana and other illegal drugs did not increase among eighth graders. Use of marijuana and other illegal drugs among tenth and twelfth graders also appears to have leveled off. Furthermore, attitudes regarding drugs, which are key predictors of use, began to reverse in 1997 after several years of erosion.

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

## Chronic Users Are Difficult to Count

Estimates of the size of the population that uses drugs heavily (termed chronic users) are imprecise because many individuals who are deeply involved in drugs are difficult to locate for interviews.* This problem of access tends to produce a negative bias in data gathered in conventional ways. Researchers estimate the number of chronic users at 3.6 million for cocaine and 810,000 for heroin.[5] Learning more about the demographics of chronic users is vital. Chronic users maintain the illegal drug market, commit a great deal of crime, and contribute to the spread of hepatitis and tuberculosis as well as HIV/AIDS and other sexually-transmitted diseases. Without an accurate estimate of the number of chronic users, initiatives responsive to the scale of the problem are difficult to develop.

An Office of National Drug Control Policy (ONDCP) funded large-scale feasibility study, conducted in Cook County, Illinois, underscored the difficulty of estimating the number of chronic users and the tendency of survey instruments to undercount. The Cook County study 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.[6]

## Problems Estimating Drug Availability

Information about quantities of illegal drugs imported to the United States or cultivated or produced within the United States is imprecise. So too is wholesale and retail-level price and purity data for different drugs. Estimation models for cocaine availability are the most rigorous. Domestic availability figures are derived by calculating the quantity of cocaine exported from producer countries, based on cultivation and production figures, and adjusting the figure to reflect the probable proportion bound for the United States and in-transit seizures. However, similar methodologies for estimating heroin, marijuana, methamphetamine, and other drug availability have not been developed. Domestically, the Drug Enforcement Administration's (DEA) System to Retrieve Information from Drug Evidence (STRIDE) is used to provide broad ranges for retail and

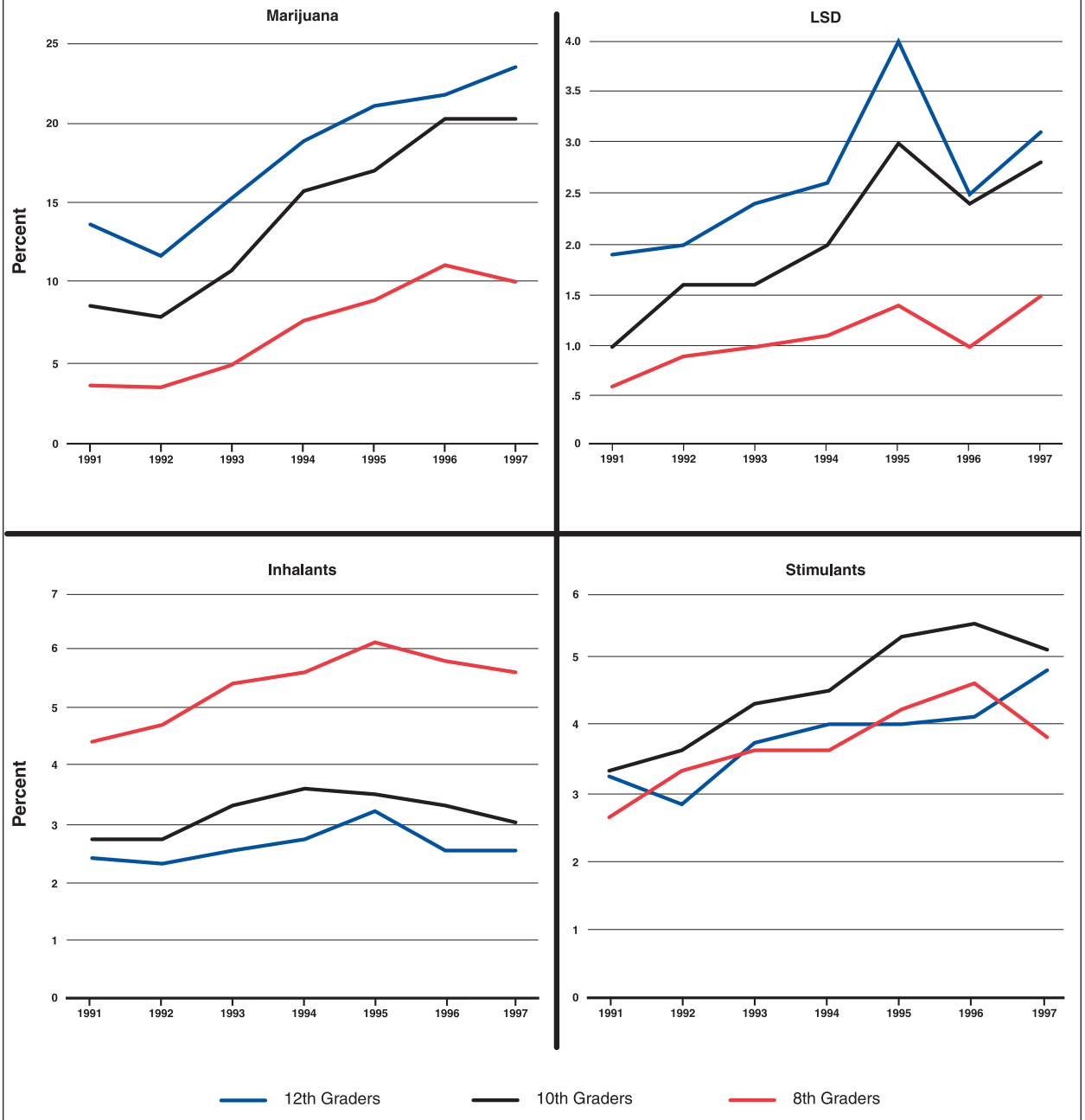
* A "chronic user" is an individual who uses illegal drugs on fifty-one or more days in the year prior to being interviewed.

wholesale purity and prices. Without accurate estimates, gauging the size of illegal markets or the effects of anti-trafficking programs is difficult. This information shortfall is being addressed by ONDCP's Advisory Committee on Research, Data, and Evaluation.

## Cocaine

**Overall usage**: In 1996, an estimated 1.7 million Americans were current cocaine users. This figure represents 0.8 percent of the household population aged twelve and over and is a substantial decline from the 1985 figure of 5.7 million (3 percent of the

Figure 2-3: **Past 30-Day Use of Selected Drugs Among 8th, 10th, and 12th Graders, 1991-97**




**Source:** Monitoring the Future Study, University of Michigan, 1997

population). The current-use rate, however, has not changed significantly in the last seven years. The number of first-time users in 1995 (652,000) was significantly lower than the number between 1977 and 1987 when more than one million Americans tried cocaine each year. Estimates of the number of chronic cocaine users vary, but 3.6 million is a widely accepted figure within the research community.[7]

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

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

## Heroin

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

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

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

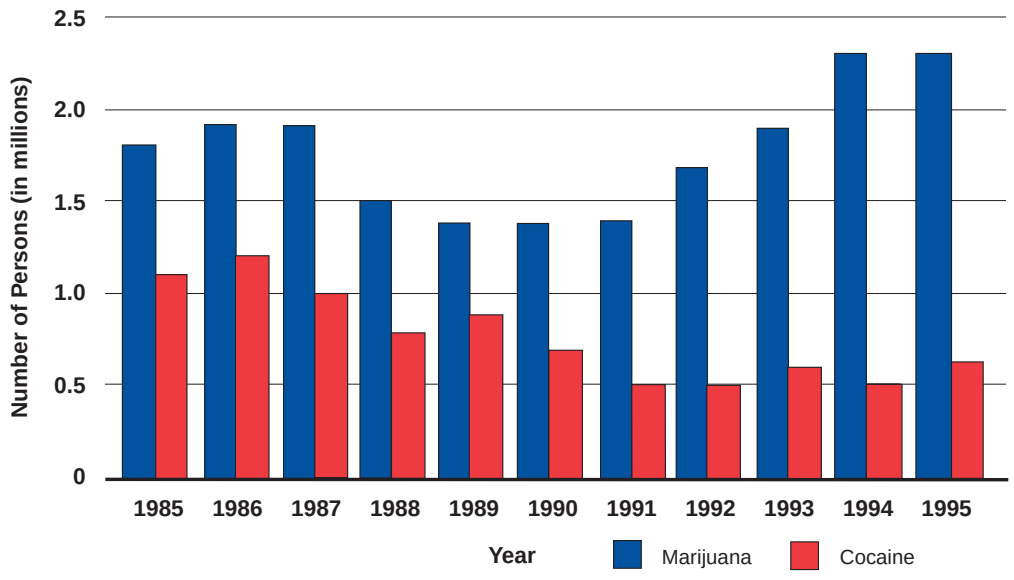
## Marijuana

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

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

**Availability**: While marijuana is the most readily available illegal drug in our nation, there is currently no methodology to determine the extent of cannabis cultivation within the United States. Consequently, there is no national survey or accepted estimate of domestic cultivation. Cannabis is frequently cultivated in remote locations and on public land to prevent observation and identification of owners. The drug is also grown commercially and privately indoors, which complicates the task of assessing cultivation. California, Hawaii, Kentucky, Tennessee, and West Virginia are major growing states. Marijuana is also imported from a wide range of regions; Colombia, Jamaica, and Mexico are major source

Figure 2-4: **Cocaine and Marijuana First Time Users, 1985-95**




**Source:** National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, 1996

countries. Eradication and seizure data suggest the magnitude of the illegal marijuana trade.[15] In 1996, three million marijuana plants were eradicated in the United States; their potential yield was 1,389 metric tons.[16] In 1997, more than 300,000 plants were eradicated in 4,400 sites in National Forests. According to the El Paso Intelligence Center, 478 metric tons were seized along the southwest border in 1996, a fifty percent increase over 1995. In 1996, marijuana typically sold at eight hundred dollars a pound.[17] The potency of some of today's marijuana crops is higher than in the early 1980s as a result of indoor cultivation and manipulation of Delta-9 tetrahydrocannabinol (THC) levels—THC is the primary psychoactive chemical in marijuana.

## Methamphetamine

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

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

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

## Other Substances

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

**Use among youth**: The 1997 *MTF* reports that inhalant use is most common in the eighth grade

where 5.6 percent used it on a past-month basis and 11.8 percent did so on a past-year basis. Inhalants can be deadly, even with first-time use, and often represent the initial experience with illegal substances. Current use of stimulants (a category that includes methamphetamine) declined among eighth graders (from 4.6 to 3.8 percent) and tenth-graders (from 5.5 percent to 5.1 percent) and increased among twelfth graders (from 4.1 to 4.8 percent). Ethnographers continue to report "cafeteria use"* of hallucinogenic or sedative drugs like ketamine, LSD, MDMA, and GHB throughout the country. Treatment providers have noted increasing poly-drug use among young people. *NHSDA* also reported that the mean age of first use of hallucinogens was 17.7 years in 1995, the lowest figure since 1976.

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

* "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.

## Underage Use of Alcohol

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

## Underage Use of Tobacco

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

## Consequences of Illegal Drugs

Illegal drugs cost our society approximately sixty-seven billion dollars each year.[21] Drug-related deaths have increased 42 percent since 1990 and numbered 14,218 in 1995.[22] Accidents, crime, domestic violence, illness, lost opportunity, and reduced productivity are the direct consequences of substance abuse. Drug and alcohol use by children often leads to other forms of unhealthy,

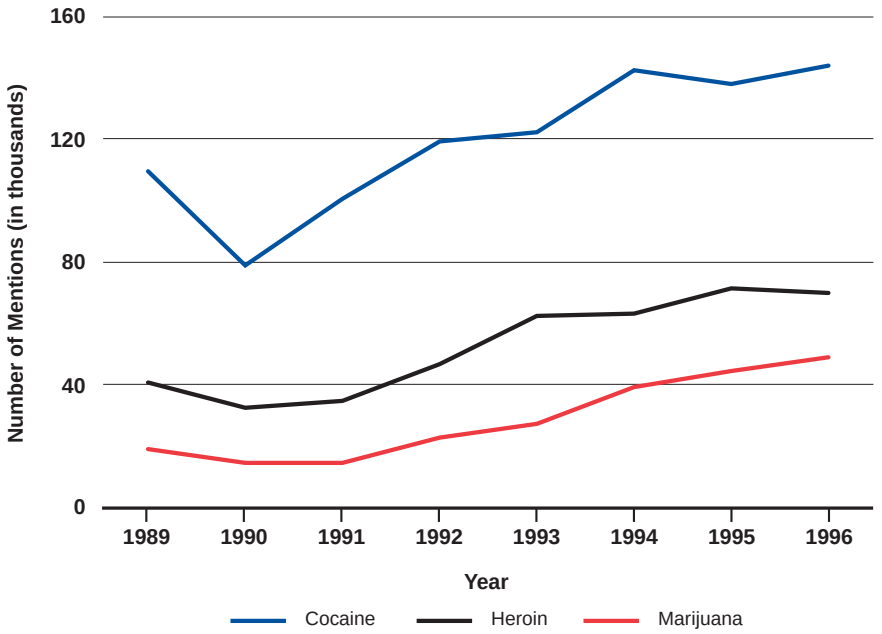
unproductive behavior including delinquency and unsafe sex. Drug abuse and trafficking hurt families, businesses, and neighborhoods; impede education; and choke criminal-justice, health, and social-service systems.

## Health Consequences

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

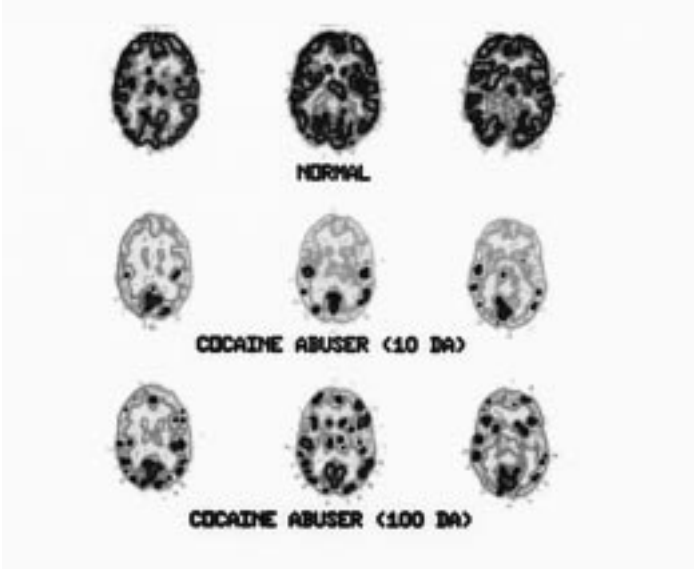
Estimated emergency mentions of both cocaine and heroin were at their highest levels since 1978. Cocaine-related cases remained about the same in 1995 (137,979) and 1996 (144,180). The increasing incidence of cocaine emergencies among persons aged thirty-five and older continued through 1996, rising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

Figure 2-5: **Trends in Drug-Related Emergency Room Mentions of Cocaine, Heroin, and Marijuana, 1989–96**




**Source:** HHS Drug Abuse Warning Network, Substance Abuse and Mental Health Services Administration 1997

Figure 2-6: **The Effects of Cocaine Abuse on Brain Metabolism**




**Source**: Brookhaven National Laboratory, 1992

**Maternal drug use affects mother, developing fetus, and children**: SAMHSA's 1996 *NHSDA* estimates that 3.2 percent of pregnant women (approximately eighty thousand) were current drug users. This rate is substantially lower than for current users among women aged fifteen to forty-four who were not pregnant and had no children (10 percent). However, women who recently gave birth (who were not pregnant and had children under two years of age) had a current-usage rate of 6.2 percent, suggesting that many women resume drug use after giving birth. Similar patterns are seen for alcohol and cigarette use.[24]

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

**Addiction**: Once viewed as essentially a moral or character defect, addiction now is understood to be a complex behavioral and medical condition with personal, social, and biological underpinnings, as well as a chronic, relapsing disease. Research shows that some individuals are at greater risk than others of developing drug-related problems and that addiction invariably alters brain chemistry.[27] Drug-seeking and use alters thinking patterns and, in essence, re-trains the brain. With heavy, frequent drug use, the change in cerebral function can be profound, and interventions to date—although effective in modifying behavior—have not demonstrated the capacity to fully restore brain chemistry. Persons of any background can become

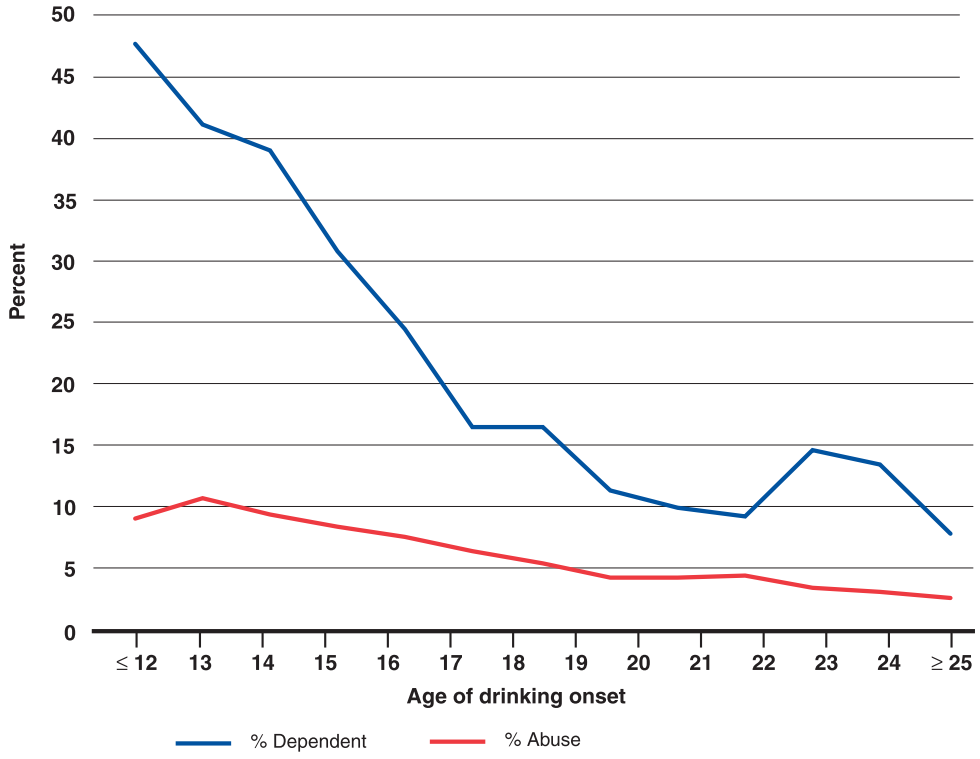
addicted to drugs. Approximately 45 percent of Americans know someone with a substance-abuse problem;[28] nearly 20 percent state that drug abuse has been a cause of trouble in their families.[29]

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

**Consequences of underage drinking**: Although alcohol is a legal drug that many American adults use without negative consequences, it holds unique dangers for underage drinkers. The younger the onset of drinking, the greater the chances of developing a clinically-defined alcohol disorder.[31] Researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) found that young people who begin drinking before age fifteen are four times more likely to become alcohol dependent and twice as likely to abuse alcohol than individuals who start drinking at age twenty-one. Underage drinking can impair physical and psychological development as well as learning.

Drinking by youth correlates with increases in other high-risk behavior, including unsafe sexual practices. Drinking greatly increases the risk of being involved in a car crash, and this chance

Figure 2-7: **Prevalence of Lifetime Alcohol Dependancy/Abuse and Age of Drinking Onset**




**Source:** National Institute on Alcohol Abuse and Alcoholism, Office of Policy Analysis, 1998

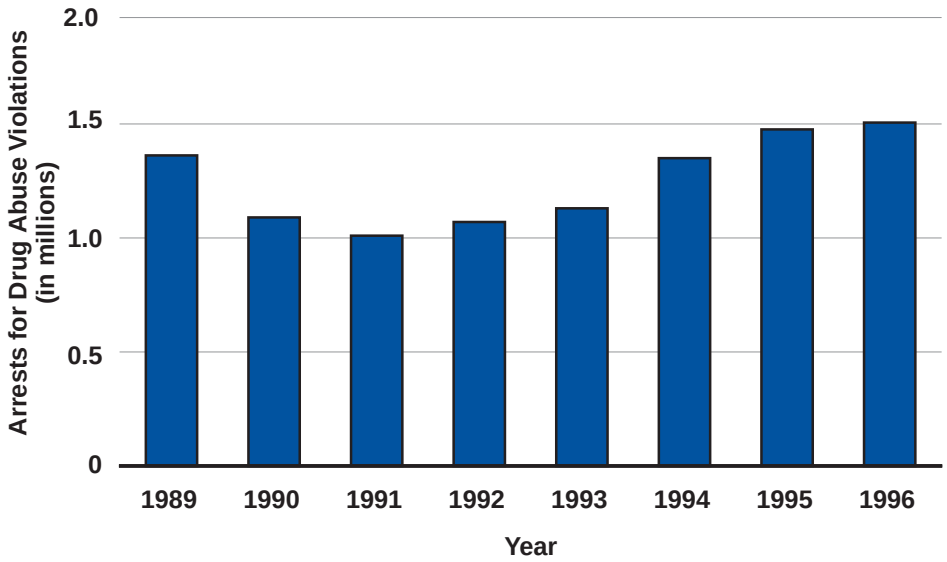
is further magnified because young persons are inexperienced with both drinking and driving. More than 2,300 youths aged fifteen to twenty died in alcohol-related crashes in 1996—33.6 percent of total traffic fatalities in this age group.[32] A survey focusing on alcohol-related problems experienced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

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

## Cost of Drug Abuse to Workplace Productivity

According to the 1996 *NHSDA*, an estimated 6.1 million current illegal drug users were employed full-time (6.2 percent of the full-time labor force aged eighteen and older) in 1996, while 1.9 million worked part-time. 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 drug-free workers. One quarter of drug users left a job voluntarily in the past year.[39]

Figure 2-8: **Drug Related Arrests**




**Source**: Uniform Crime Reports, Federal Bureau of Investigation

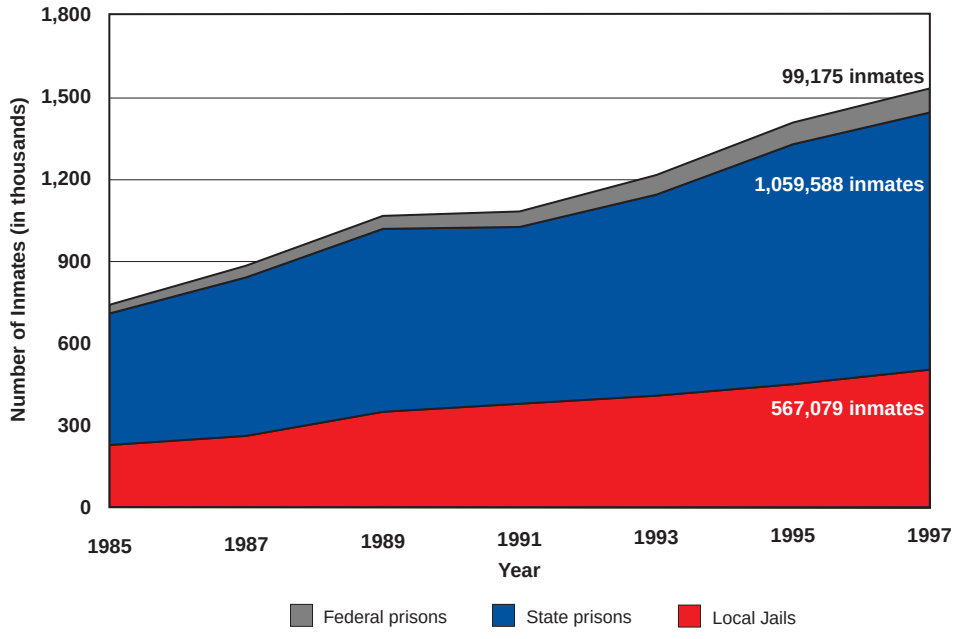
## Criminal Consequences

While crime in general continues to decline, arrests for drug-law violations are at record highs. More than 1.5 million Americans were arrested for drug-law violations in 1996. Many crimes (e.g., assault, prostitution, and robbery) are committed under the influence of drugs or may be motivated by a need to get money for drugs. In addition, drug trafficking and violence go hand in hand. Competition and disputes contribute to violence as does the location of drug markets in areas where legal and social controls on violence tend to be ineffective. The proliferation of automatic weapons also makes drug violence more deadly.

**Arrestees frequently test positive for recent drug use**: NIJ's DUF drug-testing program found that more than 60 percent of adult male arrestees tested positive for drugs in twenty out of twenty-three cities in 1996.[40] In Chicago, 84 percent of males arrested for assault tested positive.[41] For young adult males, the median rate of marijuana prevalence exceeded 64 percent in all cities, up from the 1995 figure of 53 percent.[42] Among females, arrestees charged with prostitution were most likely to test positive for drug use. In Philadelphia, for example, 94 percent of women arrested on prostitution charges tested positive for drugs.[43]

**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 155 U.S. residents was incarcerated;[44] more Americans were behind bars than on active duty in the armed forces. The increase in drug offenders accounts for nearly three-quarters of the growth in the federal prison population between 1985 and 1995 while the number of inmates in state prisons for drug-law violations increased by 478 percent over the same period. About 60 percent of federal prisoners in 1995 were sentenced for drug-law violations.[45] In fiscal year 1996, 16,251 offenders were sentenced for federal trafficking offenses while 615 were imprisoned for federal possession convictions.[46] In 1993, state correction expenses exceeded $19 billion.[47]

Figure 2–9 **Number of Persons Incarcerated in Federal and State Prisons and Local Jails, 1985–97**




**Source:** Bureau of Justice Statistics, 1997

**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 National Committee to Prevent Child Abuse survey of state child welfare agencies found substance abuse to be one of the top two problems exhibited by 81 percent of families reported for child maltreatment.[48] Women who abuse alcohol and other drugs are also more likely to become victims of domestic violence. 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]

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

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