Reducing Drug Abuse in America

An Overview of Demand Reduction Initiatives

January 1999

Foreword

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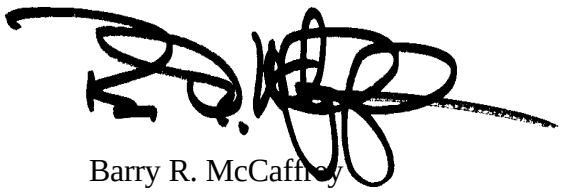
Americans are united in their belief that the drug problem represents a serious threat to our country. The campaign to reduce drug abuse in America is a comprehensive, concerted effort by all levels of government -- federal, state, and local -- as well as non-governmental organizations, the private sector, 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



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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)

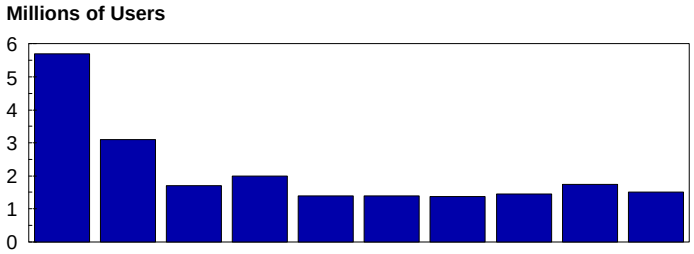
Despite this dramatic drop, 34.8 percent of Americans twelve and older have used an illegal drug in their lifetime; of these, more than 90 percent used either marijuana or hashish, and approximately 30 percent tried cocaine. Fortunately, sixty-one million Americans who once used illegal drugs have now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

From 1992 through 1996 illegal drug use increased substantially, particularly for

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

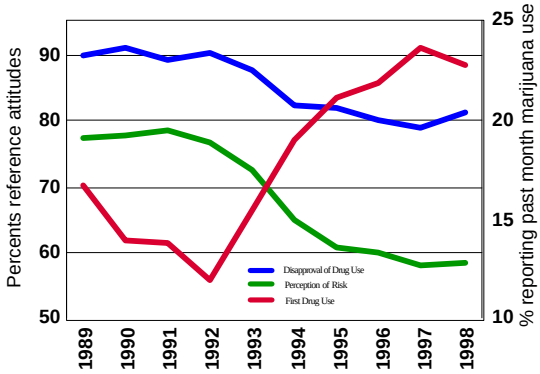
marijuana but also for such drugs as cocaine and heroin. For example, marijuana use by eighth graders nearly tripled. In addition, the period in which teen drug use was increasing was preceded by erosion of anti-drug attitudes among youth. Both the perceived harmfulness of regular illicit drug use as well as the perceived social disapproval of drug use fell significantly among all categories of youth. (Fig 2)

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.

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

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.

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 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) 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.

Heroin initiation rates have risen dramatically since 1992

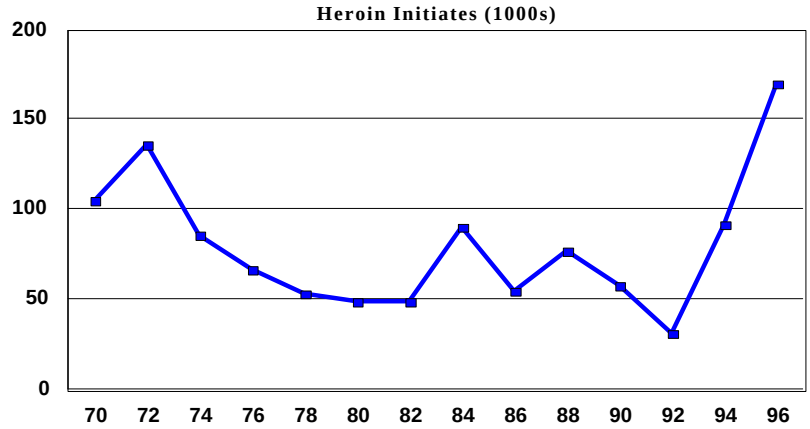


Fig 3 Source: 1997 Household Survey

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.

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.

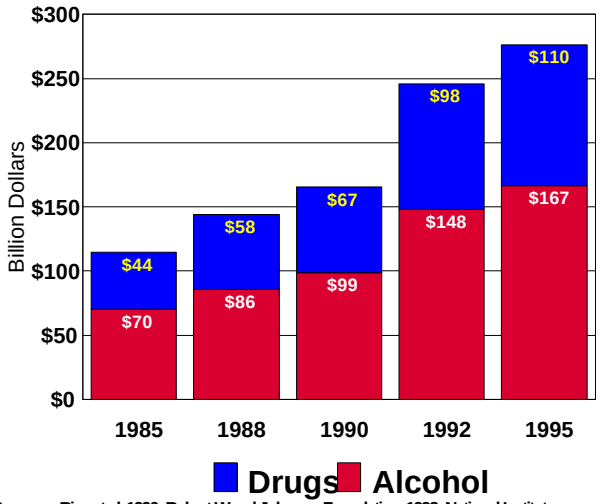
2. Methamphetamine

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

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

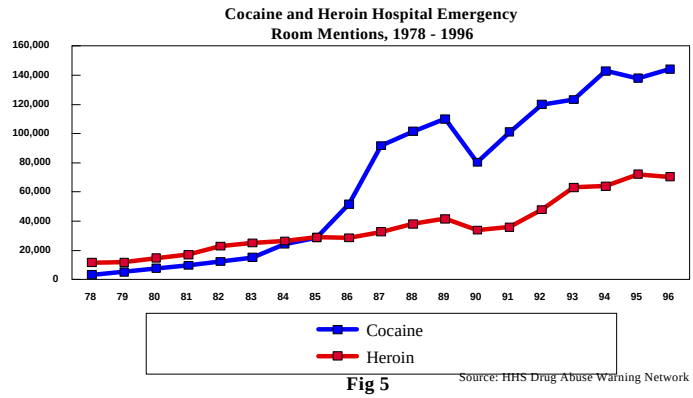


Fig 5

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 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.

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.

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.

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

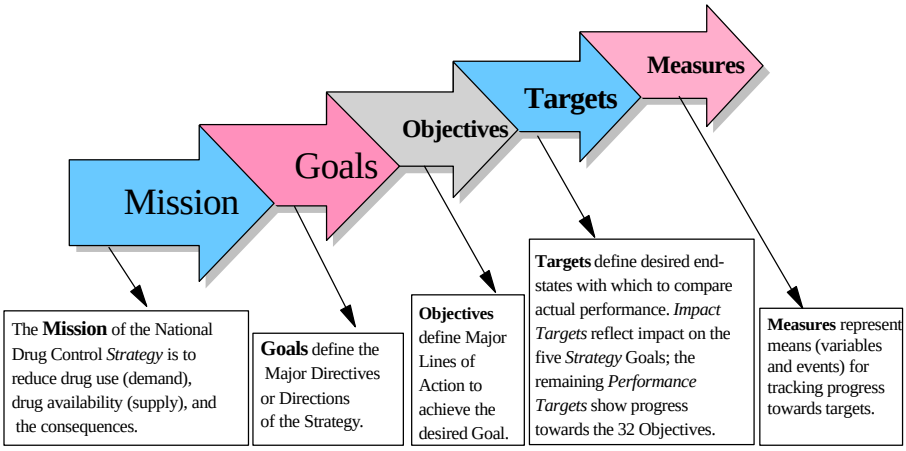


Fig 7

C. Demand Reduction Goals, Objectives and Rationale

Demand reduction is integral to three of the

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 ~~w~~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.

<u>GOAL 2:</u> 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.

attention to appropriate booster sessions during critical life transitions (e.g., middle school to high school).

Treatment Reduces Drug Use

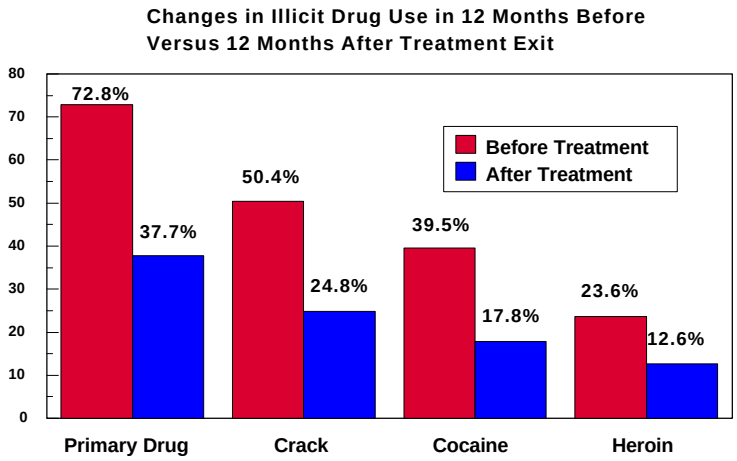


Fig 8

- 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
- 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.

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

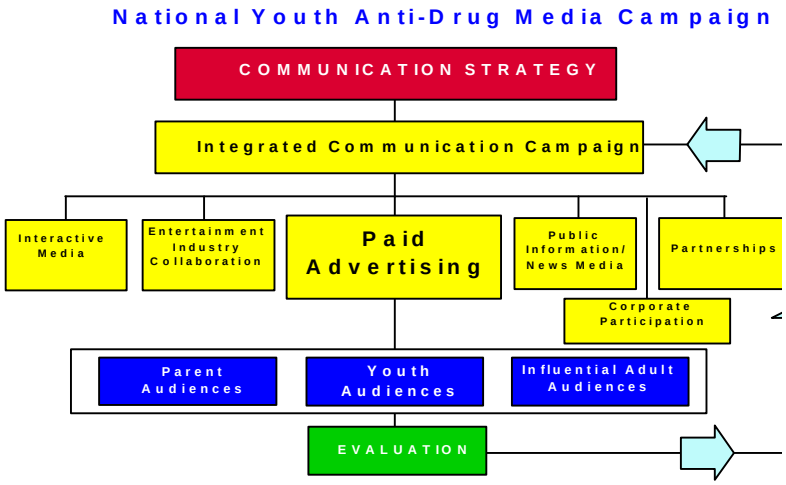


Fig 9

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.

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.

Treatment Reduces Crime

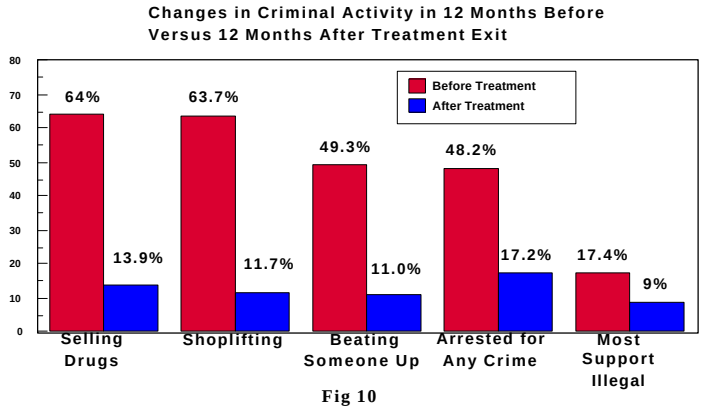


Fig 10

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 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

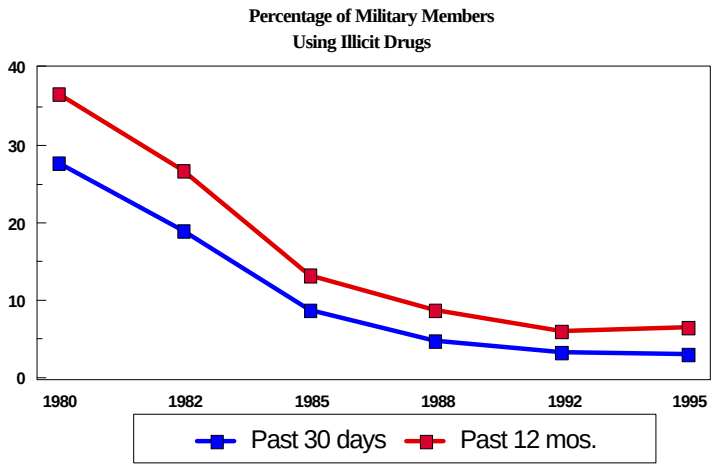


Fig 11 Source: 1995 DoD Surven of Health Related Behaviors Among Military Personnel

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.

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