



National Drug Control Strategy

The White House
February 2002

TO THE CONGRESS OF THE UNITED STATES:

I am pleased to transmit the 2002 National Drug Control Strategy, consistent with the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1705).

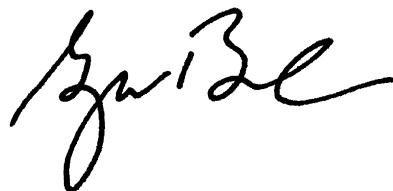
Illegal drug use threatens everything that is good about our country. It can break the bonds between parents and children. It can turn productive citizens into addicts, and it can transform schools into places of violence and chaos. Internationally, it finances the work of terrorists who use drug profits to fund their murderous work. Our fight against illegal drug use is a fight for our children's future, for struggling democracies, and against terrorism.

We have made progress in the past. From 1985 to 1992, drug use among high school seniors dropped each year. Progress was steady and, over time, dramatic. However, in recent years we have lost ground. This Strategy represents the first step in the return of the fight against drugs to the center of our national agenda. We must do this for one great moral reason: over time, drugs rob men, women, and children of their dignity and of their character.

We acknowledge that drug use among our young people is at unacceptably high levels. As a Nation, we know how to teach character, and how to dissuade children from ever using illegal drugs. We need to act on that knowledge.

This Strategy also seeks to expand the drug treatment system, while recognizing that even the best treatment program cannot help a drug user who does not seek its assistance. The Strategy also recognizes the vital role of law enforcement and interdiction programs, while focusing on the importance of attacking the drug trade's key vulnerabilities.

Previous Strategies have enjoyed bipartisan political and funding support in the Congress. I ask for your continued support in this critical endeavor.



THE WHITE HOUSE

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INTRODUCTION

In December 2001, the University of Michigan released its annual survey, *Monitoring the Future*, which measures drug use among American youth. Very little had changed from the previous year's report; most indicators were flat. The report generated little in the way of public comment.

Yet what *Monitoring the Future* had to say was deeply disturbing. Though drug use among our Nation's 8th, 10th, and 12th graders remains stable, it nevertheless is at levels that are close to record highs. More than 50 percent of our high school seniors experimented with illegal drugs at least once prior to graduation. And, during the month prior to the survey, 25 percent of seniors used illegal drugs, and 32 percent reported being drunk at least once.

This situation is not new. Indeed, drug use among our young people has hovered at unacceptably high levels for most of the past decade. As in the 1960s and 1970s, drug use has once again become all too accepted by our youth.

As self-styled drug policy "reformers" never tire of pointing out, people who use marijuana or cocaine once or twice do not invariably graduate to a life of drug addiction—just as not every teenager who drives drunk ends up in the emergency room. Yet a large percentage *do* in fact remain drug users. Recent data from Columbia University's National Center on Addiction and Substance Abuse show that roughly 60 percent of children who try cocaine and LSD during high school are still using drugs at graduation.

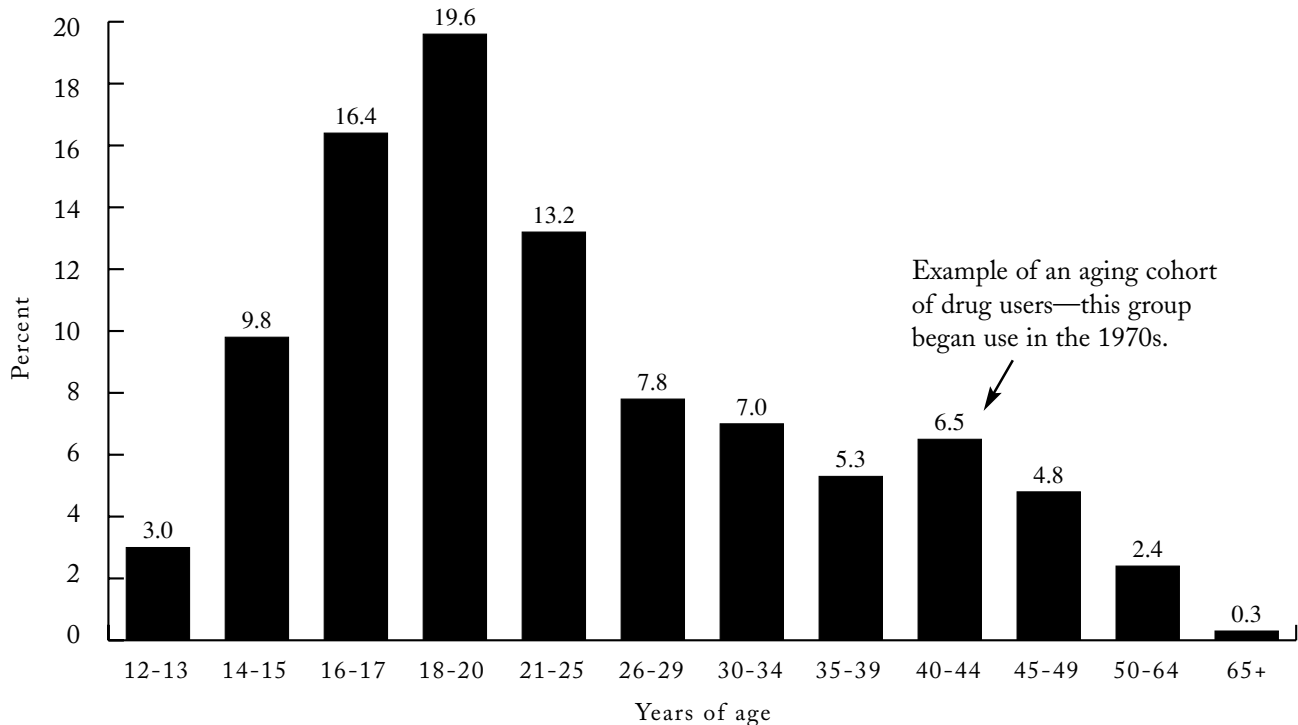
Although not establishing a causal relationship, other data from the Center show that a young

person who smokes marijuana is 85 times more likely to try cocaine. Data from another study show that the earlier people initiate drug use, the more likely they are to develop a drug problem later in life. According to the latest *National Household Survey on Drug Abuse*, adults who first used marijuana at the age of 14 or younger were 5 times more likely to be classified as drug dependent or abusers than adults who first used marijuana at age 18 or older. And if the long-term experience of many baby boomers (see Figure 1 on the following page) holds true for today's teenagers—a suspicion bolstered by recent discoveries in the field of brain imaging—the consequences of drug use among today's teenagers will be felt for decades.

Therein lies the enormous challenge for our Nation. Drug use among today's teenagers threatens to reverberate for years to come in areas as disparate as crime rates, the success of our Nation's colleges, the productivity of our industrial base, and the cohesiveness of our families.

That the individual consequences of drug use can be deadly is now well accepted—progress over decades past when drugs were held out as a door to enlightenment, or, at the least, a harmless diversion. But the consequences for society are no less serious. Although it is not fashionable to say so in some circles, tolerance of drug use is particularly corrosive for any self-governing people.

Democracies can flourish only when their citizens value their freedom and embrace personal responsibility. Drug use erodes the individual's capacity to pursue both ideals. It diminishes the individual's capacity to operate effectively in many of life's spheres—as a student, a parent, a

Figure 1: Drug Use Varies by Age but the Cohort Effect Lasts a Lifetime**Percentage Reporting Past Month Use of an Illicit Drug**

Source: 2000 National Household Survey on Drug Abuse

spouse, an employee—even as a coworker or fellow motorist. And, while some claim it represents an expression of individual autonomy, drug use is in fact inimical to personal freedom, producing a reduced capacity to participate in the life of the community and the promise of America.

President Bush has said: “We must reduce drug use for one great moral reason: Over time, drugs rob men, women, and children of their dignity and of their character. Illegal drugs are the enemies of ambition and hope. When we fight against drugs, we fight for the souls of our fellow Americans.”

Sadly, many of our fellow Americans are mired in a life of drug use. The roughly 470 hospital emergency rooms participating in the Drug Abuse Warning Network give a sense of the scope of the problem—roughly 175,000 emergency room incidents related to cocaine each year, while heroin and marijuana are each implicated in roughly 97,000 incidents. According to estimates generated from the *Household Survey*, 2.8 million Americans are “dependent” on illegal drugs, while an additional 1.5 million fall in the less severe “abuser” category. Over time, drugs will change these people from productive citizens into addicts. We need to unite as a Nation to begin the long and challenging task of transforming them back to health.

NATIONAL DRUG CONTROL STRATEGY GOALS

- Two-Year Goals:** A 10 percent reduction in current use of illegal drugs by the 12–17 age group
- A 10 percent reduction in current use of illegal drugs by adults age 18 and older
- Five-Year Goals:** A 25 percent reduction in current use of illegal drugs by the 12–17 age group
- A 25 percent reduction in current use of illegal drugs by adults age 18 and older

Progress toward all goals will be measured from the baseline established by the 2000 *National Household Survey on Drug Abuse*. All Strategy goals seek to reduce “current” use of “any illicit drug,” as defined by the *Household Survey*. Use of alcohol and tobacco products, while illegal for youths, are not included in these estimates.

Rebuilding the Consensus

Meeting the challenge of reducing illegal drug use will require more than just a range of targeted initiatives focused on key elements of the drug problem. It will take more than a 5-pronged strategy or a 15-point implementation plan because, in distinct contrast to the can-do attitude toward fighting terrorism, confidence has been undermined in the capacity of our public institutions—educational, rehabilitative, enforcement, and military—to fight drug use.

The easy cynicism that has grown up around the drug issue is no accident. Sowing it has been the deliberate aim of a decades-long campaign by proponents of legalization, critics whose mantra is “nothing works,” and whose central insight appears to be that they can avoid having to propose the unmentionable—a world where drugs are ubiquitous and where use and addiction would skyrocket—if they can hide behind the bland management critique that drug control efforts are “unworkable.”

Yet recent history shows otherwise. During the late 1980s and early 1990s, an engaged government and citizenry took on the drug issue and forced down drug use, with declines observed among 12th graders in every year between 1985 and 1992. The Federal Government supplied leadership, but so did parents and clergy, media and community groups, and state and local leaders.

The good news is that, in many cases, what worked then can work now. To make up the ground we have lost, we need only to recover the lessons of that recent past. We know that when we push against the drug problem it recedes. We will push against the drug problem; it will recede—a statement this document backs up with quantifiable, use-based goals.

Specifically, the National Drug Control Strategy will have as its objective reducing past-month, or “current” use of illegal drugs in the 12–17 age group by 10 percent over 2 years and 25 percent over 5 years. Similarly, the Strategy sets the goal of reducing current drug use among adults, those ages 18 and up, by 10 percent over 2 years and 25 percent over 5 years.

Bureaucracies are famously self-protective, but this document will depart from standard government practice by conceding that our drug fighting institutions have not worked as effectively as they should. In keeping with the goals of the President’s Management Agenda, it is our task to make these institutions perform better. Good government demands it, and it is our responsibility to future generations to ensure it.

Progress toward reducing illegal drug use has been frustrated not only by the deliberate efforts of legalization proponents, but also by well-intentioned advocates of various schools of thought concerning drug control; advocates who do not always appreciate the complexity of the drug problem or the ways in which differing drug control efforts reinforce one another.

This is partly a function of the drug problem’s wide disciplinary span, involving experts as different in training and outlook as a research scientist developing a pharmaceutical for fighting addiction and a DEA agent dismantling a methamphetamine trafficking organization. Over the years, some have advocated for an exclusive focus on supply control. Others have insisted that treatment of heavy users is the solution. Still others have argued that prevention is key.

All are partly right. What the Nation needs is an honest effort to integrate these strategies.

Reduced to its barest essentials, drug control policy has just two elements: modifying individual behavior to discourage and reduce drug use and addiction, and disrupting the market for illegal drugs. Those two elements are mutually reinforcing.

Drug treatment, for instance, is demonstrably effective in reducing crime. Law enforcement

helps “divert” users into treatment and makes the treatment system work more efficiently by giving treatment providers needed leverage over the clients they serve. Treatment programs narrow the problem for law enforcement by shrinking the market for illegal drugs. A clearer example of symbiosis is hard to find in public policy.

Similarly, prevention programs are perennially appealing because they stop drug use before it starts and, in so doing, they reduce the load on the treatment system and, ultimately, the criminal justice system. Prevention programs work best in a climate where law breaking is punished and young people are discouraged from trying illegal drugs in the first place.

These different elements of our drug control program are really two sides of the same coin. In some areas, as in the law enforcement and drug treatment systems, the connection is exceptionally strong and should be exploited. As will be described later and in more detail, this linkage offers a rare opportunity to make drug treatment available to a large pool of addicted individuals.

A variant of this linkage applies equally well to the many other people with whom the drug user comes into contact, whether a sibling, an employer, or a neighbor. Treatment works. But even the best drug treatment program cannot help a drug user who does not seek its assistance. Perhaps the greatest single challenge for our Nation in this area is to create a climate in which Americans confront drug use honestly and directly, encouraging those in need to enter and remain in drug treatment.

This Strategy seeks to apply the principles articulated above in the key areas of prevention, treatment, and supply reduction. Those sections are followed by tables summarizing the President’s

fiscal year 2003 budget request for drug control programs. That section is followed by a data appendix covering a range of drug-related topics, including patterns of drug use, information about drug treatment, trends in drug supply and total consumption, drug-related arrests, and arrests of individuals who tested positive for drugs at the time of arrest.

Integrating Budget and Performance

The President has committed the Federal Government to manage by results. Nowhere is the need for such management greater than in federal drug control efforts, in which coordinating the work of more than 50 national drug control program agencies can quickly become overwhelming for both the executive branch and Congress. This Strategy outlines two initiatives that will bring results-oriented management to drug control efforts: budgeting improvement and performance management.

In the past, the task of managing anti-drug programs has been complicated by the methods used to calculate the drug control budget. The budget information presented with the Strategy each year does not represent actual, managed dollars. With few exceptions, the dollars reported are not reflected as line items in the President's budget or in appropriations acts. Rather, they reflect percentages of total appropriations for agencies and programs, with a number of different methods used to estimate the portion dedicated to drug control.

Independent reviews, some conducted for the Office of National Drug Control Policy and some

by inspectors general in other federal agencies, have revealed that many of the estimation methods may not reflect accurately agency efforts. Even if the estimation techniques were perfect, the resulting numbers would still be difficult to use. Usually reflecting estimates generated after bottom-line decisions are made, these figures are not adequate for meaningful budget management in the executive branch or for deliberations in Congress.

Additionally, information is presented on a number of costs that are a consequence of drug use rather than expenditures aimed at reducing drug use. Because they do not reflect judgments about drug policy, they will be excluded from the drug control budget. These costs will continue to be reported as part of the annual report, *Economic Costs to Society of Drug Abuse*.

ONDCP will develop, in consultation with OMB and other federal agencies, a new methodology for identifying drug control spending. This new methodology will seek to tie all drug funding directly to actual dollars identified in the congressional presentations of drug control agencies that accompany the annual submission of the President's budget. If a line item in an agency's budget were judged to have a strong association with drug control, then 100 percent of this line item would be included in the drug budget.

Narrowing the scope of the drug control budget and presenting it in terms of real dollars will make it a more useful tool for policymakers. Resource allocation will become part of the decisionmaking process rather than information reported after decisions are made.

In addition to being more accurate, the new drug control budget will focus on agencies and programs that produce measurable results.

This will make it possible to improve accountability and, for the first time, will create a basis for comparing the results of supply and demand reduction activities and the underpinnings of a system for moving assets to areas of maximum effectiveness.

While all budget figures used in the Strategy are generated using the current methodology, a table showing an approximate outline of the new methodology is included in the Budget Summary chapter of this document.

In addition to changing the budget presentation, ONDCP will continue the work to bring accountability to drug control programs through the use of ONDCP's Performance Measures of Effectiveness System, which measures the results of federal drug control programs. In so doing, the Administration will be able to make better informed management and policy decisions about resource allocation. Working from our fundamental aim—to reduce drug use in America—the Administration will measure its success, at the policy level with drug use data, and at the program level with relevant indicators. This performance management system will help direct our efforts to effective programs and point the way to improvement for programs that underperform.

The Administration is committed to accountability in government. Drug policy will be no exception. By improving the system by which we manage drug programs, we will see results.

National Drug Control Strategy:
NATIONAL PRIORITIES

BUDGET HIGHLIGHTS

- **Safe and Drug-Free Schools Program: \$644 million**
(\$634.8 million drug-related). This program funds activities that address drug and violence prevention for young people. To improve evaluation and better direct program activities, ONDCP will work with the Department of Education to develop a useful evaluation plan that will impose program accountability while alerting schools to problem areas.
- **Drug-Free Communities Program: \$60 million.**
This program provides assistance to community groups on forming and sustaining effective community and anti-drug coalitions that fight the use of illegal drugs, alcohol, and tobacco by youth. The Administration proposes an increase of \$9.4 million over the fiscal year 2002 enacted level. Further, this request includes \$2 million for the National Community Anti-Drug Coalition Institute. The Institute will provide education, training, and technical assistance for coalition leaders and community teams and will help coalitions to evaluate their own performance.
- **National Youth Anti-Drug Media Campaign: \$180 million.**
The Media Campaign uses paid media messages to guide youth and parent attitudes about drug use and its consequences. Targeted, high impact, paid media advertisements—at both the national and local levels—seek to reduce drug use through changes in adolescents' perceptions of the danger and social disapproval of drugs.
- **Parents Drug Corps Program: \$5 million.**
This new initiative funded through the Corporation for National and Community Service will encourage parents to help children stay drug-free by training them in drug prevention skills and methods.

Stopping Use Before It Starts: Education and Community Action

Common sense tells us that preventing young people from experimenting with drugs in the first place is preferable to later—and more costly—treatment, rehabilitation, and possible incarceration.

Preventing drug use before it starts spares families the anguish of watching a relative slip into the grasp of addiction and protects society from many risks, such as those created by workers whose mental faculties are dulled by chemicals. Prevention is also the most cost-effective approach to the drug problem, sparing society the burden of treatment, rehabilitation, lost productivity, and other social pathologies—costs estimated at \$160 billion per year.

We know that prevention works. We know that, if we prevent young people from using drugs through age 18, the chance of their using drugs as adults is very small. We know that the use of alcohol by young people has been linked to a range of social pathologies, including the use of illegal drugs. We also know that prevention requires real and sustained effort by adults and peers. We know, in other words, a great deal. What we know presents us with a challenge: to face up to our shared responsibility to keep young people from ever using drugs.

Prevention programs involve schools and faith-based organizations, civic groups, and the mass media. But the single indispensable element of an effective prevention program is not a program at all. Parents and other caregivers have a tremendous influence on whether their kids use drugs. Intuition suggests this; the data confirm it. According to the Partnership for a Drug-Free

America, kids whose parents (or grandparents) teach them about the dangers of drugs are 36 percent less likely to smoke marijuana, 50 percent less likely to use inhalants, 56 percent less likely to use cocaine, and 65 percent less likely to use LSD.

But parents cannot do it alone. Schools, communities, the media, and others must offer prevention messages that are unambiguous and convey a direct message that drug use is dangerous, is wrong, and will not be tolerated.

At the level of school-based programs, drug prevention includes imparting factual, research-based drug education and teaching drug-refusal skills. Many effective prevention programs convey the dangers of underage drinking. Yet effective prevention programs go beyond merely reciting the dangers of drug use—dangers that might seem remote to many young people. A hallmark of many effective prevention programs is motivating young people to see their self-worth and purpose in society as part of the broader community. For young people, understanding one's place in society and learning to take responsibility for one's actions are at least as important as knowing the risks of smoking marijuana.

President Bush has said: “We recognize that the most important work to reduce drug use is done in America’s living rooms and classrooms, in churches and synagogues and mosques, in the workplace, and in our neighborhoods. Families, schools, communities, and faith-based organizations shape the character of young people. They teach children right from wrong, respect for law, respect for others, and respect for themselves.”

Drug use will abate only when parents, teachers, religious and civic leaders, and employers join together to reaffirm the principles of personal responsibility. Those working at the community level are making a lasting difference in our drug problem, applying Americans' renewed understanding of the importance of working together as citizens to push back against a menace that threatens us all.

they have caught up by the time of college graduation, according to data from *Monitoring the Future*. Administrators at our colleges and universities also need to do a better job of controlling underage drinking. Although not governed by the same statutes as illegal drugs, underage drinking is illegal, is at epidemic levels on many college campuses, and can have equally devastating consequences.

EFFECTIVE EDUCATION PROGRAMS: PROJECT STAR

Project STAR is a broad-based prevention program that teaches young people social skills and techniques to resist using drugs, even in the face of peer pressure. Unlike many prevention programs, Project STAR operates in the community, mass media, home, and in the schools. According to the National Institute on Drug Abuse, research findings on the project show that students who began the program in junior

high, and whose results were measured in their senior year of high school, showed significantly less use of marijuana (about 30 percent less), cigarettes (about 25 percent less), and alcohol (about 20 percent less) than children in schools that did not offer the program. The most important factor found to have affected drug use among the students was an increased perception of their friends' intolerance of drug use.

The newly reauthorized Drug-Free Communities Support Program will provide critical resources to expand prevention programs across America, including small towns, rural areas, and Native American communities, all of which have been hit hard in recent years by drug problems that have historically plagued big cities.

Community coalitions address geographic communities, but drug use can flourish in other types of communities, including our colleges and universities. It is surprising to many parents that, although college-bound high school students are less likely to use illegal drugs than their peers,

This Administration will provide national leadership and resources to those working to prevent drug abuse at the community level. For example, the National Youth Anti-Drug Media Campaign, in partnership with the Ad Council and Community Anti-Drug Coalitions of America, will spread the message that community coalitions are vital catalysts in preventing drug use. The Parents Drug Corps Program, funded through the Corporation for National and Community Service, will encourage parents to help children stay drug-free by training them in drug prevention skills and methods, and will promote cooperation nationally among a

network of parent organizations and community anti-drug coalitions.

This real work of reducing drug use is opposed by armchair theorists who want to define the problem away and normalize drug use. The outright legalization of drugs—a goal that is opposed by a solid majority of Americans—rests on the flawed premise that because some people

undermine our own prevention efforts. It is time to put the distracting argument about harm reduction behind us. We stand both for reducing drug use *and* its attendant consequences.

This is an effort in which every American has a role to play. In homes, schools, places of worship, the workplace, and civic and social organizations, we can set norms that both reaffirm the value of

COMMUNITY COALITIONS THAT SHOW RESULTS

The Fighting Back Partnership of Vallejo, California, was formed in response to the city's escalating crime rate in the late 1980s, blamed largely on gang activity and use of methamphetamine and crack cocaine. A coalition of churches, individuals, and agencies in the fields of substance abuse treatment, law enforcement, and education, as well as private businesses, took action on

three fronts: revitalizing neighborhoods, helping young people, and encouraging individuals in need to enter treatment. Today, in this racially diverse city of 118,000, neighborhood crime and drug use is down, the number of patients in substance abuse treatment has increased, calls for police assistance have declined, and residents say Vallejo is a safer, more desirable place to live.

will inevitably make bad choices, society should supply the means for those choices and pay for their consequences. Those consequences would be devastating—starting with what even proponents acknowledge would be an increase in drug *use*. Whether in their undiluted form or in other guises, such as “harm reduction,” efforts to legalize drugs represent the ultimate in disastrous social policy. This Administration will oppose them.

It goes without saying that we need to reduce the great harms associated with drug use. But it should be equally obvious that we can only do that in ways that do not increase drug use and

responsibility and good citizenship and dismiss the notion that drug use is consistent with the “pursuit of happiness” by a free and self-governing people. With national leadership and community engagement, we can—and we will—recreate the formula that helped America succeed against drugs in the past. We will bring resolve to our efforts, we will bring together coalitions of uniquely qualified individuals, and we will bring a renewed sense of purpose to the challenge of preventing drug use. And we will see drug use recede.

BUDGET HIGHLIGHTS

- **Drug Abuse Treatment Programs—SAMHSA.** The President has committed to adding \$1.6 billion to the drug treatment system over 5 years. The following enhancements for the Substance Abuse and Mental Health Services Administration (SAMHSA) will provide additional funding to increase the capacity of the treatment system:
 - **Targeted Capacity Expansion (TCE) Program: +\$109 million.** This additional funding will help SAMHSA expand the Treatment TCE program, which is designed to support a rapid, strategic response to emerging trends in substance abuse. Included in this proposal is \$50 million to be used for a new component of the TCE program. This new component would be structured to reserve funding for state-level competitions, weighted according to each state's need for treatment services.
 - **Substance Abuse Prevention and Treatment (SAPT) Block Grant: +\$60 million** (\$43 million of which will be drug related). This increase for SAMHSA's SAPT Block Grant will provide additional funding to states for treatment and prevention services. States use these funds to extend treatment services to pregnant women, women with dependent children, and racial and ethnic minorities.
- **Promoting Drug Treatment in the Criminal Justice System—**

Department of Justice: Critical to breaking the cycle of drugs and crime is providing resources that promote drug treatment and early intervention to individuals who come into contact with the criminal justice system. This initiative expands two criminal justice treatment programs that seek to reduce recidivism among these populations.

 - **Residential Substance Abuse Treatment (RSAT) Program: +\$7 million.** This enhancement will expand the RSAT program to \$77 million in fiscal year 2003. The RSAT program is a formula grant that distributes funds to states to support drug and alcohol treatment in state corrections facilities.
 - **Drug Courts Program: +\$2 million.** These additional resources will expand the Drug Courts program to \$52 million in fiscal year 2003. The Drug Courts program provides alternatives to incarceration by using the coercive power of the court to force abstinence and alter behavior through a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

Healing America's Drug Users: Getting Treatment Resources Where They Are Needed

Many people stop using drugs on their own. Some stop only when faced with consequences, such as the loss of a professional license, a job, or personal liberty. Some do not or cannot stop. Their drug use has progressed to addiction, and they need our help.

To get them that help, the Federal Government needs more reliable needs assessments at the state and local levels to guide the expansion of particular types, or modalities, of drug treatment. We need better information about what works in drug treatment and where there are shortages of capacity. We also need to work toward administration of standardized assessments and to ensure appropriate placement for those in need of treatment.

Yet for more than a decade, the public agenda in this area has been preoccupied by an exclusive focus on the question of treatment *capacity*—whether the Federal Government is spending enough to make treatment services available to those in need.

But what *is* the total need? What is the capacity of our Nation's drug treatment system? And what, by extension, is the "right" level for federal treatment funding? Remarkably, until relatively recently, policymakers were saddled with a number of crude and deficient tools for estimating treatment capacity and the number of individuals in need of treatment.

Our understanding of treatment need advanced significantly with the release, in September 2001, of new data from the *National Household Survey on*

Drug Abuse. By incorporating into the survey questions distilled from the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, we are now for the first time able to estimate that there are roughly 2.8 million "dependent" users, along with an additional 1.5 million users deemed to fall in the less severe "abuser" category.

As defined in DSM-IV, drug dependence—characterized by significant health problems, emotional problems, difficulty in cutting down on use, drug tolerance, withdrawal, and other symptoms—is more severe than drug abuse. Abuse is characterized by problems at work, home, and school; problems with family or friends; voluntary exposure to physical danger; and trouble with law enforcement. Individuals in both categories will have difficulty ending their drug use without treatment.

As currently constituted, the treatment system is not able to help all those deemed to be in need of drug treatment; according to conservative estimates, only an estimated 800,000 individuals had received drug treatment in the year prior to the survey. The President has committed to supporting a \$1.6 billion expansion in federal treatment aid over 5 years. Consistent with this pledge, the President's 2003 budget requests an increase of approximately \$100 million in federal treatment spending for the Substance Abuse and Mental Health Services Administration. (This enhancement is part of an overall treatment increase of \$224 million for fiscal year 2003.)

But the *Household Survey* contains another remarkable finding, one that argues that

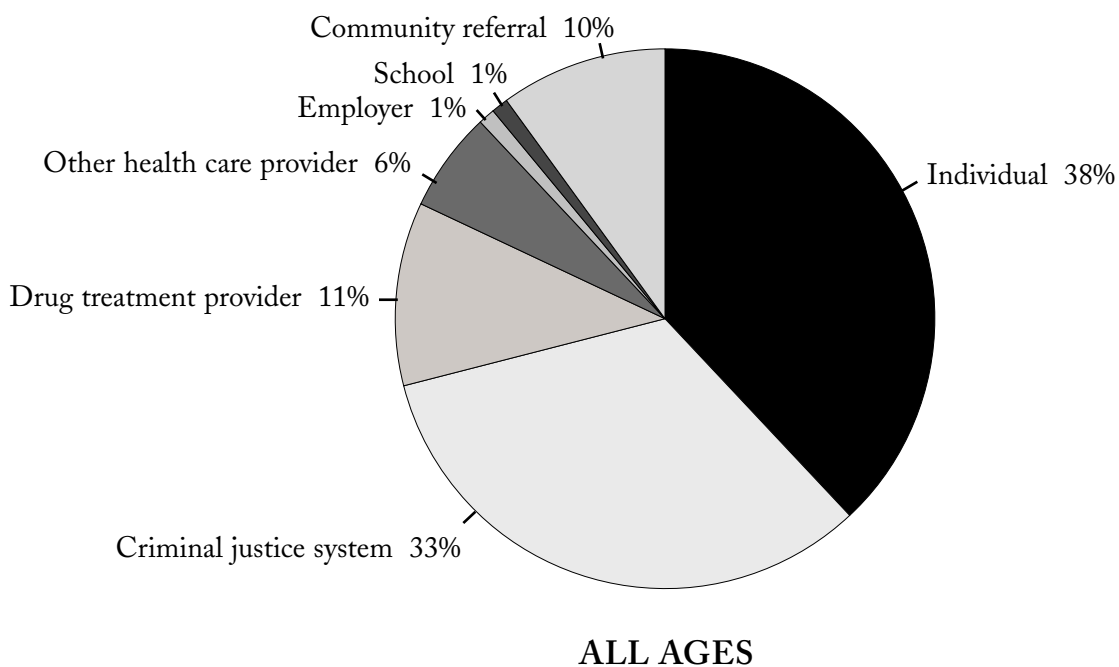
expanding the treatment system is not by itself sufficient. Frustrating the work of treatment providers, the overwhelming majority of users characterized with dependence or abuse do not see themselves as actually needing drug treatment. This tendency is particularly pronounced among adolescents and young adults. Of the estimated 3.9 million individuals who needed but did not receive treatment in 2000, fewer than 10 percent—just 381,000—reported actually *thinking* that they needed help.

There are good reasons for believing that the latter estimate is too low. The survey from which it is derived omits individuals currently in residential treatment and does not cover groups such as homeless people not living in shelters. ONDCP will convene experts to build on the

significant work that has already been done by the Department of Health and Human Services and others to attempt to determine more precisely the number of individuals currently receiving drug treatment services as well as the number of those seeking access to drug treatment. New data collection systems will aid in this process, including the National Treatment Outcome Monitoring System—currently being developed by ONDCP and the Center for Substance Abuse Treatment—which will provide vitally needed information on treatment admissions, waiting times, and treatment outcomes.

But the obvious conclusion one would draw from the data is in fact the correct one: most people who need drug treatment do not think they have a problem. To borrow a popular phrase, *they are in*

Figure 2: Drug Treatment Admissions by Source of Referral: All Ages and Ages 12–17



Note: Individual includes self-referral, and referral by a family member or by friends.
 Source: Treatment Episode Data Set (2001)

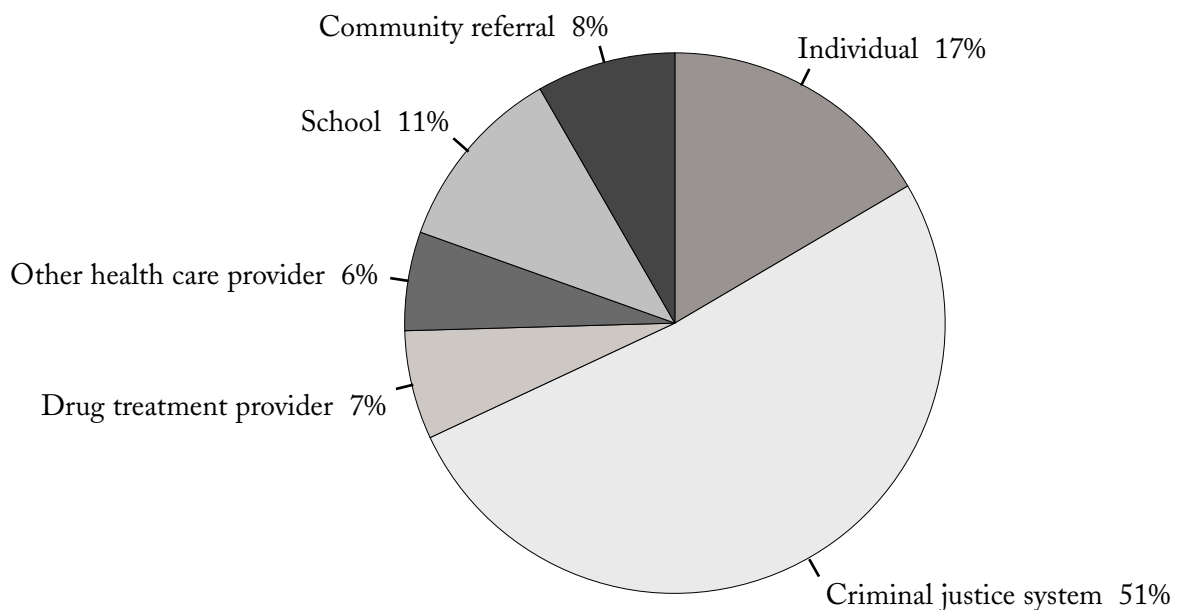
denial. If there were ever any question about the role of coercion in getting people into treatment, these findings should answer it.

Most drug users—the lucky ones, at least—are no strangers to coercion. People in need of drug treatment are fortunate if they run up against the compassionate coercion of family, friends, employers, the criminal justice system, and others. Such pressure needs no excuse; the health and safety of the addicted individual, as well as that of the community, require it.

Compassionate coercion begins with family, friends, and the community. Americans must begin to confront drug use—and therefore drug users—honestly and directly. We must encourage those in need to enter and remain in drug treatment.

Of course, drug users often conceal their involvement with illegal drugs. Yet looking back to the most recent *Household Survey* data, we know that there are more than 4 million Americans who, according to the DSM-IV definitions, suffer from a mix of difficulties that range from emotional problems to trouble with law enforcement. Drug users may be secretive, but their problems are often visible to us if we are willing to look for them.

Researchers estimate that well over half of all cocaine and heroin is purchased by individuals formally under the control of the criminal justice system—either on pretrial release, probation, or parole. Some 50–80 percent of arrestees in major cities tested positive for drugs at the time of arrest. The Bureau of Justice Statistics estimates that 150,000 state inmates are released each year



AGES 12–17

without receiving needed drug treatment, thus making the criminal justice system perhaps the most important natural ally of the drug treatment system. This Administration seeks to capitalize on the link between prison and drug treatment by expanding the Residential Substance Abuse Treatment program, a federal grant program that distributes funds to states to support drug and alcohol treatment in state corrections facilities.

At the federal level, with the goal of achieving a drug-free prison system, the Bureau of Prisons will be pushing for 100 percent inmate participation in prison treatment programs while improving treatment continuity for persons being released from confinement to community supervision. The Bureau will also seek to administer a drug urinalysis to every federal inmate within 60 days of release and will provide appropriate sanctions for a failed test.

In addition, the Administration proposes to increase federal support for the Drug Courts

program in fiscal year 2003. Drug courts use the coercive power of the judicial branch to force abstinence and alter behavior through a combination of escalating sanctions, mandatory drug testing, treatment, and effective aftercare programs. Some 782 drug courts now operate in 49 states and represent one of the most promising innovations in recent memory. Intrusive and carefully modulated programs like drug courts are often the only way to free a drug user from the grip of addiction. The Federal Government will be undertaking a longitudinal review of selected drug court programs to determine the long-term effects of drug court participation.

The criminal justice system is far from the only lever treatment providers have over drug users, a majority of whom work for a living. Companies know that drug use among their employees detracts from the bottom line, translating directly into increased absenteeism and tardiness, higher employee turnover, more damaged and stolen property, and more workers' compensation claims.

WHAT WORKS IN DRUG TREATMENT: OPERATION PAR

Operation PAR (Parental Awareness and Responsibility), serving five Florida counties, got its start in 1970 in the way many effective programs do—a parent concerned about her daughter's drug use took action. The organization's Family Support Network, an initiative designed to reduce marijuana use among youth, boasts a superior retention rate, keeping 88 percent of its clients in treatment after 10 months.

Operation PAR also provides drug treatment programs for Florida felons and boasts a 17 percent recommitment rate after 2 years for individuals completing the Long-Term Secure Drug Treatment Program. A program for juvenile offenders produces similar results.

KEY FINDINGS ABOUT DRUG TREATMENT

- Nearly 10,000 clients in community-based programs in 11 cities were compared before and after treatment on a number of key outcomes. Depending upon treatment modality, the data showed reductions in weekly use of heroin (between 44 and 69 percent), cocaine (between 56 and 69 percent), and marijuana (between 55 and 67 percent); reductions in illegal behavior (between 36 and 61 percent); and improvements in employment status (between 4 and 12 percent).
- One year following discharge from drug treatment, use of the primary drug of choice dropped 48 percent; arrests dropped 64 percent; self-reported illegal activity dropped 48 percent; and the number of health visits related to substance use declined by more than 50 percent.
- Five years after discharge, there was a 21 percent reduction in the use of any illegal drug—a 45 percent reduction in powder cocaine use, a 17 percent drop in crack cocaine use, a 14 percent decline in heroin use, and a 28 percent drop in marijuana use. Similar reductions were reported for criminal activity: a 30 percent reduction in selling drugs, a 23 percent decrease in victimizing others, and a 38 percent drop in breaking and entering, as well as a 56 percent drop in motor vehicle theft.

Sources: Drug Abuse Treatment Outcome Study, National Treatment Improvement Evaluation Study, and Services Research Outcomes Study.

Private industry, including the vast majority of Fortune 500 companies, has been quick to adopt drug-free workplace policies, including employee assistance programs (EAPs), which can require employees to participate in drug treatment programs. The success of major companies may even have had the unintended consequence of making small businesses more attractive to drug-using employees, since small companies are less likely to screen employees for drug use either before or during employment. Employees of smaller firms are also less likely to have access to EAPs.

Targeting Treatment Resources

By now, most Americans are acquainted with the idea that recovery from addiction is a lifelong challenge, yet few understand what that signifies for drug treatment programs. Simply put, for many people, ceasing a life of drug use involves more than one attempt at treatment and more than a single mode of drug treatment.

Effective treatment programs face a daunting challenge. Research has demonstrated that drug use can change the very structure and function of

HELPING FAMILIES HELP THEMSELVES

In 1995, a tiny grocery store in Manhattan's Lower East Side was the scene of a police shootout with local drug dealers that left one person dead and a police officer paralyzed. The following year, in that same corner store, La Bodega de La Familia opened its doors with an inventive plan to make drug treatment work better by helping the people *around* drug using criminal defendants—including family and friends. The strategy—helping families

help their loved ones—has been a big success. Preliminary results of a study by the Vera Institute of Justice indicate that participants in La Bodega's program significantly reduced their use of illegal drugs. Over a six-month period, past-month use of cocaine among La Bodega participants fell from 42 percent to just 10 percent (compared to a drop of 27 percent to 21 percent for a control group).

the brain, diminishing the capacity to make judgments, control impulses, and meet responsibilities. Advances in brain imaging techniques are enabling scientists to observe real-time neurochemical changes occurring in the brain as it processes information or responds to stimuli—including illegal drugs or drug treatment medications.

Brain imaging techniques reveal that illegal drugs like MDMA, better known as Ecstasy, modify brain chemistry by damaging neurons and altering the functions responsible for the release of serotonin, a brain chemical responsible for regulating memory and other cognitive functions, such as verbal reasoning and the ability to sustain attention. Additional studies suggest that the toxic effects of drug use persist long after an individual discontinues use.

While roughly half of all treatment is funded through private or other non-federal means, policymakers pondering questions about treatment spending have found their work simplified by a

calculus of self-interest. Briefly, the costs incurred in providing drug treatment are dwarfed by the costs of *not* providing treatment. Supporting drug treatment—helping drug users break the cycle of addiction—therefore makes sense on fiscal grounds as well as being the right thing to do.

Treatment capacity is an important question, and the President's \$1.6 billion initiative to increase the system's capacity was previously discussed. Yet the exclusive focus on treatment capacity has diverted attention from other important questions, such as how to direct current treatment resources more effectively, as well as how to improve the quality and availability of aftercare services.

In considering the federal role in expanding the treatment system, the sheer diversity of approaches aimed at freeing individuals from addiction argues for a greater focus on our ability to direct those in need to the most appropriate type, or modality, of drug treatment. This Administration takes a major step in that direction with a request for an increase of

RALLYING FAITH-BASED ORGANIZATIONS

When attempting to bring about a personal transformation of a drug user whose life has spun out of control, it only makes sense to call upon the life-transforming power of faith. The role of religion and spirituality in both preventing and treating substance abuse is documented in the results of a two-year study titled *So Help Me God: Substance Abuse, Religion and Spirituality*, by the National Center on Addiction and

Substance Abuse at Columbia University. The report found that participation in spiritually-based treatment programs increases the odds of maintaining abstinence and concluded that “religion and spirituality can play a powerful role in the prevention and treatment of substance abuse, and in the maintenance of sobriety.”

\$109 million for the Treatment Targeted Capacity Expansion (TCE) program—grants that are awarded to the cities, towns, counties, and states most in need. The program also targets high-priority groups for treatment, such as adolescents, pregnant women, and racial and ethnic minorities.

Treatment programs take many forms. They vary from an 18-month, inpatient therapeutic community in the rural Catskills, where clients learn discipline and basic life skills, to an outpatient clinic in Los Angeles, where heroin addicts line up for a daily dose of methadone and periodic counseling, to a long-term, faith-based program in Portland, Oregon, that uses the power of faith as an essential part of the treatment process.

The most intensive aspects of treatment typically are relatively short lived, and treatment must be followed by an aftercare component if long-term abstinence is to be a realistic expectation. For an increasing number of people, that abstinence is coerced—by family, friends, an employer, or the

criminal justice system. For tens of thousands, the key to staying away from drugs is a Twelve Step program, such as Narcotics Anonymous, an American success story that is modeled after the Alcoholics Anonymous movement, and which began developing in the 1940s. The success of NA and programs like it stems in large part from a single-minded emphasis on abstinence and the support of other individuals who also face the challenge of sustaining recovery for the rest of their lives.

BUDGET HIGHLIGHTS

- **Border Control and Enforcement: +\$76.3 million**

(+\$11.4 million of which is drug related). This enhancement of the U.S. Border Patrol includes hiring an additional 570 agents to enforce national borders and to combat international drug trafficking.

- **Southwest Border Drug Prosecutions: \$50 million.**

The President's fiscal year 2003 Budget maintains funding of \$50 million for the Southwest Border Drug Prosecution Initiative. This program provides critical support to counties along the Southwest Border for the costs of detaining and prosecuting drug cases referred to them by U.S. Attorneys.

- **Andean Counterdrug Initiative (ACI): \$731 million.**

The fiscal year 2003 Budget requests an increase of \$106 million over funding enacted for the ACI account in fiscal year 2002. This request includes resources to continue enforcement, border control, crop reduction, alternative development, institution building, and administration of justice and human rights programs. For Colombia, funding will be used for several broad categories including operations and maintenance of air assets provided with Plan Colombia supplemental funding; Colombian National Police and Army Counternarcotics Brigade operational support; and herbicide application programs. Additional funding will support critical Agency for International Development-implemented humanitarian, social, economic, and alternative development programs; support vulnerable groups; and provide resources for justice-sector reform projects.

Disrupting the Market: Attacking the Economic Basis of the Drug Trade

Few areas of public policy boast linkages as clear as those that exist between the availability and use of illegal drugs. Simply put, the demand for drugs tends to vary with their price and availability. Disrupting this market relationship provides policymakers with a clear lever to reduce use.

For decades, the “supply effect” was understood more on the basis of anecdote than hard science. One oft-cited example involves heroin use by American servicemen during the Vietnam war. Southeast Asia offered cheap, potent heroin, which American servicemen used in sufficient numbers to provoke widespread alarm in Washington and the creation of an unprecedented program to administer drug tests on those returning from the war. As it turned out, this prudent strategy was partly for naught. Returning to a world where heroin was expensive, impure, and difficult to obtain, the vast majority of servicemen simply stopped using it. At first, supply had fostered demand. Later, for many, lack of supply would curtail demand.

The supply effect helps explain why some countries are so much more successful than others in controlling drug use among their citizens. Even countries with well-managed law enforcement systems can be overrun if geography conspires to make it difficult to interdict illegal drugs at the border or beyond.

Consider Malaysia, a nation with an effective drug control force and strict sanctions for drug trafficking (including a mandatory death sentence for certain drug crimes). Malaysia’s chief misfortune is one over which it has little control—

being located astride trafficking routes from nearby Burma and Thailand, making heroin cheap and plentiful. As a result, Malaysia’s population has a serious problem with intravenous heroin addiction.

It seems obvious that availability is a precondition for use. Yet availability is a relative term—what really matters to the drug user is that the market for illegal drugs produces availability *at a price*. Understanding of this fact has been obscured by images in the popular culture of crazed addicts who will do anything for a fix. Whatever compulsion drives them, most addicts are in fact quite conscious of and sensitive to the price and purity of the drugs they consume. Addicts must spend almost all their money on illegal drugs; rising prices for drugs such as cocaine and heroin do not magically enable them to beg, borrow, or steal more. (Conversely, the arrival of a ubiquitous, low-cost drug like crack cocaine can be a tremendous spur to consumption.) Above all, even heavy users of drugs are rational consumers, and the market signal conveyed by a drop in availability (or a dispiriting series of “rip-off” transactions) may be a powerful spur to enter a drug treatment program.

Recent research suggests that casual users, even teenagers, are susceptible to supply effects. A research paper, *Marijuana and Youth*, funded by the Robert Wood Johnson Foundation, concludes that changes in the price of marijuana “contributed significantly to the trends in youth marijuana use between 1982 and 1998, particularly during the contraction in use from 1982 to 1992.” That contraction was a product of many factors, including a concerted effort among

federal agencies to disrupt domestic production; these factors contributed to a doubling of the street price of marijuana in the space of a year.

It should not come as a surprise that drug users respond to market forces. The drug trade is in fact a vast market, one that faces numerous and often overlooked obstacles that may be used as pressure points.

Major drug-trafficking organizations and their suppliers face the colossal management challenge of supervising the cultivation of hundreds of thousands of acres of drug crops and importing thousands of tons of illicit chemicals into remote production areas that are often controlled by guerrilla armies. Traffickers must then move hundreds of tons of illegal drugs across continents and through intermediaries and a maze of specialized border smuggling organizations, then into the waiting hands of mid-level distributors in a foreign country where senior managers will never risk setting foot.

Even success—the shipment of illegal drugs to the United States—brings its own set of challenges, including the unlikely problem of money. The drug trade relies on the international banking system to launder billions of dollars each year, an increasingly uncertain proposition at a time when financial transactions are coming under increasing scrutiny. Where it is unable to infiltrate local banking systems, the drug trade must resort to reverse smuggling, in bulk form, enormous quantities of cash, which often weigh two to three times as much as the drugs that were smuggled in. Each of these processes involves a series of finely honed systems. Every finely honed system has its weaknesses. The drug trade's complexity and sheer vastness will prove to be its greatest weakness.

As we mount law enforcement programs here at home and with our international partners abroad,

the Federal Government will be guided by this understanding of the illegal drug trade as a market. To effectively manage our efforts, we will better define the market by estimating the flow of illicit drugs from their sources to our streets. We will gauge our success by our ability to reduce the supply of drugs.

Disrupting Markets at Home

Domestically, disrupting drug markets will involve the cooperative, combined efforts of federal, state, and local law enforcement—each of which contributes in crucial ways. Effective drug supply reduction efforts will focus on intercepting drugs at the border and dismantling the drug networks that transport and distribute drugs and illicit proceeds from their sale throughout the United States.

Driving up the price of drugs such as cocaine and marijuana will require us to target the top of the trafficking pyramid using sophisticated cooperative mechanisms such as the Special Operations Division, a DEA-managed, multiagency operations center that includes participants from the Department of Justice and the U.S. Treasury. The virtue of this program is that it manages the challenging task of exploiting sensitive information in a manner that protects intelligence sources and methods, while making major strides in creating an environment in which federal law enforcement agencies can share information.

The Organized Crime Drug Enforcement Task Force (OCDETF) program was created in 1982 to focus resources on dismantling and disrupting major drug-trafficking organizations and their

money-laundering operations. Today, the Justice Department part of OCDETF has matured into a nationwide structure of task forces—including federal prosecutors and federal, state and local law enforcement agents—in nine regions receiving a total of \$338.6 million in fiscal year 2002, and focusing entirely on drug law enforcement. Yet, over the past several years, only 1 in 10 OCDETF investigations has included a financial investigation, and only 21 percent of these investigations have reached the leadership level of drug organizations, according to Justice Department figures. The Attorney General has refocused the OCDETF program to ensure that law enforcement efforts are directed at the most significant drug-trafficking organizations responsible for distributing most of the drugs in the United States. Under the OCDETF program, law enforcement will strategically identify the most sophisticated trafficking organizations, eliminate their leadership, take down their transportation and distribution operations, and dismantle their financial infrastructure. The effectiveness of the OCDETF program will be measured by its impact in reducing the supply of drugs in the United States.

The High Intensity Drug Trafficking Areas (HIDTA) program is administered by ONDCP in 28 HIDTA regions around the country. Over the coming months, ONDCP will consult with the Attorney General; the Secretary of the Treasury; heads of law enforcement agencies at the federal, state, and local levels; and relevant governors and mayors to see how best to ensure that the HIDTA program focuses on high-value trafficking targets and financial infrastructure.

Collaborative efforts like the Treasury Department's Financial Crimes Enforcement Network (FinCEN) must play a leading role in helping federal, state and local law enforcement uncover the financial crimes of drug traffickers.

The Treasury Department, as part of the National Money Laundering Strategy, has intensified the efforts of High Intensity Money Laundering and Related Financial Crimes Areas (HIFCAs), jointly managed with the Department of Justice. Federal law enforcement and regulatory efforts will focus on major money-laundering enterprises in these areas.

Over the long term, however, everything federal law enforcement does requires a public consensus that the laws they enforce are fair and that they enforce those laws in a fair manner. That consensus has eroded to an alarming extent in recent years. Law enforcement has been the target of a campaign that derides its work as sending users and low-level dealers to prison with sentences that are excessively harsh. Reams of data—including the most current information on federal convictions—argue otherwise.

According to the United States Sentencing Commission, the median quantity involved in cocaine-trafficking cases is 1,999 grams for powder, and 68.7 grams for crack cocaine—more than 600 “rocks” of crack. The relevant figures for heroin and marijuana are 512 grams and 56,110 grams, respectively—enough, in either case, for tens of thousands of doses. The notion that the federal criminal justice system is causing the arrest of legions of small-time drug offenders is thus revealed to be unsupportable, as is the claim that federal law enforcement agencies are busily locking up individuals for possession of—as opposed to trafficking in—illegal drugs. In fiscal year 2000, the most recent year for which we have data, there were just 232 federal possession convictions for cocaine, marijuana, and heroin combined.

The sentencing structure has fostered among some a perception of racial injustice within the criminal justice system. Clearly, the government must create and administer laws in a fair and

equitable fashion, but it is equally important that the public perceive that the government is doing so because if some believe that a law discriminates against a certain population, it hinders the ability of the government to enforce that law for the benefit of all in society. This Administration is committed to working with all interested parties to ensure that our criminal justice system is both fair and perceived as fair.

Going to the Source

While the bulk of our drug control program is based at home, there are elements of an effective drug control program that can only be pursued abroad. Internationally, we and our allies will attack the power and pocketbook of those international criminal and terrorist organizations that threaten our national security. We will support our international partners in their efforts to attack the drug trade within their borders, and we will work through international financial and banking institutions to combat drugs and terrorism-related money-laundering activities. In addition, we will work to strengthen democratic institutions and the rule of law in allied nations under attack from the illegal drug trade. Making it clear to traffickers that there is no safe haven from justice, we will work with our foreign counterparts to support their prosecutorial efforts and will prosecute foreign traffickers using the extraterritorial application of U.S. law.

We will continue to target the supply of illegal drugs in the source countries. The illicit industry that cultivates coca and produces, transports, and markets cocaine is vulnerable to effective law enforcement action. Coca, the raw material for cocaine, is produced in commercial quantities exclusively in the Andean region of South America.

Much of the heroin consumed in the United States is produced in the Andean region as well.

The coca industry thrives in areas devoid of effective law enforcement control. Yet with a meaningful government presence, capable law enforcement, and the political will to confront entrenched corruption and powerful political groups, the cocaine industry can be disrupted. Historically, international supply reduction efforts have reduced the cultivation of opium poppy and coca crops in a number of countries including Bolivia, Ecuador, Guatemala, Pakistan, Panama, Peru, and Thailand. In each of these cases, some combination of alternative development, eradication, enforcement, and interdiction programs was successfully adapted to local conditions.

Democracy is under pressure in the Andean region, in large measure because money generated by narcotics production and trafficking is available to well-armed antidemocratic groups. Past successes in crop control in Bolivia and Peru have been partially offset by coca cultivation increases in Colombia. Now, nearly 90 percent of the cocaine and the majority of the heroin arriving in the United States come from Colombia, mostly originating in southern Colombia where government control is weakest.

To date, government presence and security remain limited, at best, in southern Colombia. Aerial eradication has not been delivered continuously or intensely enough, and it has not been sufficient to change the economic equation in Colombia's Putumayo region. Coca remains the most lucrative crop in the southern growing areas, and growers, although willing to sign up for alternative development programs as a hedge, have little incentive to follow through with voluntary eradication without the pervasive threat of involuntary eradication and interdiction. As the

CONSEQUENCES OF DRUG USE

Economic Costs to Society. The total economic cost to society of illegal drug use in 2000 was an estimated \$160 billion, a 57 percent increase from 1992. The three major components of the total cost are health care costs (\$14.9 billion), productivity losses (\$110.5 billion), and other costs (\$35.2 billion), including the cost of goods and services lost to crime, the criminal justice system, and social welfare.

Expenditures for Illegal Drugs. Americans spent approximately \$64 billion for illegal drugs in 2000—more than 8 times the total federal outlays for research on HIV/AIDS, cancer, and heart disease. Domestic drug

users expended more than half that amount (\$35 billion) on cocaine. Expenditures for heroin and marijuana use totaled about \$10 billion each; methamphetamine expenditures totaled \$5 billion.

Drug-Related Deaths. The Centers for Disease Control and Prevention (CDC) estimate that 19,102 people died in 1999 (or 52 such deaths per day) as the direct result of drug-induced causes. Although current CDC data are not directly comparable with prior-year estimates, there was a steady increase in drug-induced deaths between 1990 and 1998—from 9,463 to 16,926.

Government of Colombia begins to make inroads against the massive increase in coca production in areas under illegal armed group control, drug traffickers will look for new sources of supply.

The United States stands ready to support Peru and Bolivia, as well as Ecuador and other countries in the region, to ensure that coca production does not migrate as a result of pressure being exerted in Colombia. The Administration requests \$731 million in dedicated funds in the fiscal year 2003 budget for the Andean Counterdrug Initiative to be applied in Bolivia, Brazil, Colombia, Ecuador, Panama, Peru, and Venezuela. About half the assistance is for Colombia's neighbors; the remainder is for sustaining ongoing programs in Colombia. Similarly, roughly half the assistance is dedicated to interdiction and eradication efforts; the remainder will go to alternative development

and institution-building programs, such as anticorruption and judicial system programs. An example of the latter is the *Casas de Justicia* program, which already has extended courtroom dispute resolution services to 18 underserved communities.

Roughly two-thirds of the U.S.-bound cocaine produced in the Andean region enters the United States across our border with Mexico. The recent extradition of major traffickers, including Everardo Arturo Paez Martinez, is evidence that the bilateral drug control relationship has improved since the beginning of the Fox and Bush administrations. Nonetheless, Mexico faces serious implementation difficulties because of corruption and underdeveloped institutions. Our primary strategy in working with the Government of Mexico will be to focus on disrupting and dismantling major transnational drug-trafficking organizations. The extent of our

mutual interest in such a strategy is underscored by estimates that cocaine consumption in that country has been rising sharply in recent years.

The terrorist attacks of September 11 have created a new awareness of our domestic vulnerability and highlight the need for an examination of how we do business at our borders. The Administration is currently reviewing a range of options for better controlling our borders to stop drugs from entering the United States.

In the Caribbean, we face a lack of Caribbean nation resources to take an aggressive stance against drug trafficking. In this area, we will focus on increasing maritime cooperation to interdict the flow of drugs, improving national capabilities to resist drug trafficking, providing assistance to strengthen regional counterdrug forces, and supporting anti-money laundering initiatives.

We will also employ more agile interdiction packages, such as the combination of a ship, an armed helicopter, and an extended-range pursuit boat currently utilized in the Coast Guard's Operation New Frontier. The success of New Frontier—which can use nonlethal force including warning shots and disabling fire—has changed the calculus of maritime smugglers in areas where it has been deployed. We will develop similarly effective interdiction packages, including the use of U.S. Customs Service P-3 aircraft, to disrupt trafficker operations in other areas of the Caribbean.

In Central Asia, we face a different set of challenges. Under the Taliban, Afghanistan became the source of more than 70 percent of the world's opium. After announcing a ban on opium production, the Taliban profited greatly from increased prices for stockpiled opium under their control. As Afghanistan is reconstructed, U.S. objectives include ensuring that illegal drug

income will never again finance regional instability or the threat of international terrorism.

Afghanistan's interim Foreign Minister has already made a public pronouncement indicating that the provisional government will move to eradicate drug production and trafficking. Nonetheless, crops are already being planted, and a significant drug harvest this spring could allow the drug trade to continue. Development assistance to Afghanistan should be designed to provide an incentive to steer away from a drug-crop economy, and law enforcement should provide sanctions to be employed against drug producers and traffickers. These actions will be particularly challenging during the early days of reconstruction and will require continuing involvement and encouragement from the international donor community.

The illegal drug proceeds of the Taliban represent just part of a global problem in which drug revenue helps fuel terrorist violence; 12 of the 28 international terrorist groups listed by the U.S. Department of State are alleged to be involved to some degree in drug trafficking. In Colombia, all three of the major terrorist groups are involved in the drug trade as a source of operational funding. This underscores the need to ensure that cooperative international law enforcement operations target those trafficking organizations that directly or indirectly help bankroll international terrorism.

The drug trade is a transnational market; disrupting it will require a cooperative international response. As in our other international efforts, we will also seek out international coalitions and trusted allies to combat drug production and trafficking. We will support regional, bilateral, and multilateral efforts that fight the drug-trafficking industry, and the destructive market that it purveys.

National Drug Control Strategy:

APPENDIXES

National Drug Control Budget Summary

Drug Control Funding: Agency Summary,

FY 2001–FY 2003 (Budget Authority in Millions)

	FY 2001 Final BA	FY 2002 Enacted	FY 2003 Request
Department of Agriculture			
Agricultural Research Service	4.8	4.8	4.8
U.S. Forest Service	5.8	6.8	6.8
Women, Infants & Children	16.1	17.5	19.0
Total, Agriculture	26.7	29.1	30.6
Corporation for National & Community Service	9.4	9.4	14.4
D.C. Court Services and Offender Supervision	58.6	86.4	82.3
Department of Defense			
Counterdrug Operations	1,047.1	997.6	998.8
Plan Colombia	103.3	10.9	0.0
Total, Defense	1,150.3	1,008.5	998.8
Intelligence Community Management Account	34.0	42.8	34.0
Department of Education	634.1	659.5	634.8
Dept. of Health and Human Services			
Administration for Children and Families	83.0	89.6	90.7
Centers for Disease Control and Prevention	223.6	225.4	224.9
Centers for Medicare and Medicaid Services	500.0	560.0	620.0
Health Resources & Services Administration	45.8	47.2	47.2
Indian Health Service	59.9	62.0	63.3
National Institutes of Health (NIDA & NIAAA)	822.7	933.0	994.1
Substance Abuse and Mental Health Services Admin.	1,655.0	1,766.5	1,820.1
Total, HHS	3,389.9	3,683.7	3,860.2

	FY 2001 Final BA	FY 2002 Enacted	FY 2003 Request
Dept. of Housing and Urban Development	309.3	9.0	9.0
Department of the Interior			
Bureau of Indian Affairs	23.2	23.3	23.4
Bureau of Land Management	5.0	5.0	5.0
U.S. Fish & Wildlife Service	1.7	1.0	1.0
National Park Service	9.5	9.5	9.6
Total, Department of Interior	39.5	38.8	39.0
The Judiciary	756.8	819.7	921.1
Department of Justice			
Assets Forfeiture Fund	439.9	360.0	430.0
U.S. Attorneys	228.2	244.6	254.4
Bureau of Prisons	2,341.5	2,525.1	2,443.0
Community Policing	374.7	427.4	653.3
Criminal Division	35.1	37.8	38.7
Drug Enforcement Administration	1,480.4	1,605.4	1,698.5
Federal Bureau of Investigation	707.5	415.5	421.4
Federal Prisoner Detention	375.5	429.4	463.9
Immigration and Naturalization Service	525.0	538.0	713.4
Interagency Crime and Drug Enforcement	325.2	338.6	362.1
INTERPOL	0.3	0.3	0.3
U.S. Marshals Service	223.8	255.1	277.8
Office of Justice Programs	1,016.6	962.6	309.2
Tax Division	0.4	0.4	0.4
Total, Department of Justice	8,074.1	8,140.1	8,066.5
Department of Labor	78.8	79.2	79.4
ONDCP			
Operations	24.7	25.3	25.5
High Intensity Drug Trafficking Areas	208.3	226.4	206.4
Counterdrug Technology Assessment Center	36.0	42.3	40.0
Special Forfeiture Fund	233.1	239.4	251.3
Total, ONDCP	502.1	533.3	523.1

	FY 2001 Final BA	FY 2002 Enacted	FY 2003 Request
Small Business Administration	3.5	3.0	3.0
Department of State			
Bureau of International Narcotics & Law Enforcement			
International Narcotics Control	279.3	197.5	152.2
Plan Colombia / Andean Counterdrug Initiative	0.0	625.0	731.0
Subtotal, INL	279.3	822.5	883.2
Emergencies in the Diplomatic and Consular Service	1.7	1.0	2.5
Public Diplomacy	8.8	9.1	9.5
Total, Department of State	289.8	832.6	895.2
Department of Transportation			
U.S. Coast Guard	745.4	540.4	629.2
Federal Aviation Administration	19.9	19.1	20.3
National Highway Traffic Safety Administration	30.5	31.9	32.2
Total, Department of Transportation	795.8	591.4	681.7
Department of the Treasury			
Bureau of Alcohol, Tobacco, and Firearms	164.9	185.4	199.1
U.S. Customs Service	707.7	994.8	995.9
Federal Law Enforcement Training Center	31.9	35.5	30.3
Financial Crimes Enforcement Network	10.8	12.3	13.2
Interagency Crime and Drug Enforcement	103.2	107.6	107.6
Internal Revenue Service	51.5	39.1	42.0
U.S. Secret Service	21.7	26.2	30.8
Treasury Forfeiture Fund	170.2	145.9	145.9
Total, Department of the Treasury	1,262.0	1,546.8	1,564.7
Department of Veterans Affairs	680.9	709.4	741.8
Total Federal Drug Budget	18,095.7	18,822.8	19,179.7

(Detail may not add to totals due to rounding)

Restructuring the National Drug Control Budget

To bring greater accountability to drug control efforts, the Administration proposes a significant restructuring of the National Drug Control Budget. The drug budget includes close to 50 budget accounts totaling over \$19 billion for 2003. Recent independent analyses of these budgets commissioned by ONDCP, as well as ongoing required reviews by department inspectors general, have identified weaknesses in these budget presentations. Many of these issues are associated with the drug budget methodologies used by agencies to estimate drug spending. Drug budget methodologies are imprecise and often have only a weak association with core drug control missions. Reform of the national drug control budget is needed.

In the coming months, the Administration will develop a new methodology for reporting the drug budget. The principal guidelines that will be used to develop these estimates are:

- All funding displayed in the drug budget should be readily identifiable line items displayed in the budget of the President or agency Congressional budget justifications accompanying the budget.
- The overall budget presentation should be simplified by eliminating several supporting agencies from the drug budget tabulation. Only agencies with a primary drug law enforcement or demand reduction mission would be displayed in the drug budget. This change would limit the budget to those agencies or accounts that have been, or should be, the principal focus of drug control policy. Agencies that provide a minimal contribution to the national drug control program would be excluded from the revised drug budget presentation.

Application of these principles is likely to reduce dramatically federal resources deemed to represent drug control funding, without affecting the overall federal commitment to reducing drug use. Consistent with these principles, a pro forma display of the drug budget on a revised basis is presented in the accompanying table. The details of this proposal will be shared with key stakeholders in the coming months, and after consultation with Congress and drug control agencies, the President's fiscal year 2004 budget will show the changes in full. This new structure for the drug budget will better serve policymakers and the public by focusing on programs genuinely directed at reducing drug use.

Pro Forma Proposed National Drug Control Budget

(Budget Authority in Millions)

Agency/Account	FY 01	FY 02	FY 03	Change FY02-03
Defense	970.4	847.6	848.9	1.3
Education (Safe & Drug-Free Schools)	644.3	679.3	644.3	(35.0)
Health and Human Services				
Substance Abuse & Mental Health Services Administration	2,175.0	2,305.8	2,371.0	65.2
National Institute on Drug Abuse	783.6	890.9	948.5	57.6
Justice				
Drug Enforcement Administration	1,480.4	1,605.4	1,698.5	93.1
Interagency Crime & Drug Enforcement	325.2	338.6	362.1	23.5
Immigration & Naturalization Service	201.7	210.1	328.5	118.4
Office of Justice Programs	214.8	255.5	240.2	(15.3)
Office of National Drug Control Policy	502.1	533.3	523.1	(10.2)
State	279.3	859.0	883.2	24.2
Transportation (U.S. Coast Guard)	745.4	540.4	629.2	88.8
Treasury				
Customs Service	714.7	1,004.0	1,004.4	0.4
Interagency Crime & Drug Enforcement	103.2	107.6	107.6	0.0
Veterans Affairs	680.9	709.4	741.8	32.4
Other Presidential Initiatives*	3.5	53.0	58.0	5.0
Total, Federal Drug Control Budget	9,824.6	10,939.9	11,389.3	449.4

* For SBA's Drug-Free Workplace programs, \$3.5 million is included for FY 2001 and \$3.0 million is included for FYs 2002 and 2003. For Corporation for National Service's Parents Drug Corps program, this includes \$5 million for FY 2003. For the COPS Southwest Border Prosecutor initiative, this includes \$50 million for FYs 2002 and 2003.

Acknowledgments

Consultation

The Office of National Drug Control Policy Reauthorization Act of 1998 requires the Director of ONDCP to consult with a variety of experts and officials while developing and implementing the National Drug Control Strategy. Specified consultants include the heads of the National Drug Control Program agencies, Congress, state and local officials, citizens and organizations with expertise in demand and supply reduction, and appropriate representatives of foreign governments. In 2001, ONDCP consulted with both houses of Congress and 21 federal agencies. At the state and local level, 58 Governors and Governors-elect were consulted as well as the National Governors' Association, the U.S. Conference of Mayors, and the National Association of Counties. ONDCP also solicited input from a broad spectrum of nonprofit organizations, community anti-drug coalitions, chambers of commerce, professional associations, research and educational institutions and religious organizations. The views of the following individuals and organizations were solicited during the development of the National Drug Control Strategy.

Members of the Senate

Daniel K. Akaka – HI
Joseph R. Biden – DE
Jeff Bingaman – NM
Christopher Bond – MO
Sam Brownback – KS
Jim Bunning – KY
Ben Nighthorse Campbell – CO
Maria Cantwell – WA
Jean Carnahan – MO
Thomas R. Carper – DE
Max Cleland – GA
Hillary Rodham Clinton – NY
Thad Cochran – MS
Susan M. Collins – ME
Mark Dayton – MN
Mike DeWine – OH
Christopher J. Dodd – CT
Bryon L. Dorgan – ND
Richard J. Durbin – IL
John Edwards – NC
Michael B. Enzi – WY
Russell D. Feingold – WI
Dianne Feinstein – CA
Bill Frist – TN
Bob Graham – FL
Charles E. Grassley – IA
Judd Gregg – NH
Tom Harkin – IA
Orrin G. Hatch – UT
Tim Hutchinson – AR
Kay Bailey Hutchison – TX
James M. Jeffords – VT
Edward M. Kennedy – MA
Herb Kohl – WI
Jon L. Kyl – AZ
Mary L. Landrieu – LA
Patrick J. Leahy – VT

Carl Levin – MI
 Joseph P. Lieberman – CT
 Mitch McConnell – KY
 Barbara A. Mikulski – MD
 Patty Murray – WA
 Jack Reed – RI
 Pat Roberts – KS
 Charles E. Schumer – NY
 Jeff Sessions – AL
 Richard C. Shelby – AL
 Arlen Specter – PA
 Ted Stevens – AK
 Fred D. Thompson – TN
 Strom Thurmond – SC
 Robert G. Torricelli – NJ
 George V. Voinovich – OH
 John W. Warner – VA
 Paul D. Wellstone – MN

J.D. Hayworth – AZ
 John N. Hostettler – IN
 Steny H. Hoyer – MD
 Duncan L. Hunter – CA
 Henry J. Hyde – IL
 Johnny Isakson – GA
 Ernest J. Istook – OK
 Jack Kingston – GA
 Mark Steven Kirk – IL
 Jim Kolbe – AZ
 Tom Latham – IA
 Ron Lewis – KY
 Frank LoBiondo – NJ
 Carrie Meek – FL
 John L. Mica – FL
 Dan Miller – FL
 Sue Myrick – NC
 George R. Nethercutt – WA
 Anne Meagher Northup – KY
 Doug Ose – CA
 John E. Peterson – PA
 Rob Portman – OH
 David E. Price – NC
 Harold Rogers – KY
 Mike Rogers – MI
 Ileana Ros-Lehtinen – FL
 Steven R. Rothman – NJ
 Bernard Sanders – VT
 Janice D. Schakowsky – IL
 Pete Sessions – TX
 Don Sherwood – PA
 Robert R. Simmons – CT
 Lamar S. Smith – TX
 Mark Souder – IN
 John E. Sununu – NH
 John E. Sweeney – NY
 W. J. “Billy” Tauzin – LA
 Todd Tiahrt – KS
 Jim Turner – TX
 Peter J. Visclosky – IN
 Zach Wamp – TN
 J.C. Watts – OK
 Curt Weldon – PA
 Roger F. Wicker – MS
 Heather Wilson – NM
 Frank R. Wolf – VA

Members of the House of Representatives

Robert B. Aderholt – AL
 Thomas H. Allen – ME
 Cass Ballenger – NC
 Bob Barr – GA
 Joe Barton – TX
 Judy Biggert – IL
 Rod R. Blagojevich – IL
 Henry Bonilla – TX
 Dan Burton – IN
 Ken Calvert – CA
 Howard Coble – NC
 Elijah E. Cummings – MD
 Danny K. Davis – IL
 Jo Ann Davis – VA
 Nathan Deal – GA
 Ernie L. Fletcher – KY
 Benjamin A. Gilman – NY
 Robert W. Goodlatte – VA
 Porter J. Goss – FL
 Kay Granger – TX
 Melissa Hart – PA
 J. Dennis Hastert – IL

Federal Agencies

Department of Agriculture
 Department of Defense
 Department of Education
 Department of Health and Human Services
 Department of Housing and Urban Development
 Department of the Interior
 Department of Justice
 Department of Labor
 Department of State
 Department of Transportation
 Department of the Treasury
 Department of Veterans Affairs
 Civil Air Patrol
 Corporation for National and Community Service
 Small Business Administration
 Bureau of Alcohol, Tobacco, and Firearms
 Drug Enforcement Administration
 Federal Bureau of Investigation
 Joint Task Force 6
 National Institute on Drug Abuse
 Substance Abuse and Mental Health Services
 Administration
 U.S. Customs Service
 U.S. Forest Service
 U.S. Marshals Service
 U.S. Secret Service

Governors

Lincoln C. Almond – RI
 Juan Babauta – MP
 Roy E. Barnes – GA
 Jeb Bush – FL
 Sila M. Calderón – PR
 Benjamin J. Cayetano – HI
 Gray Davis – CA
 Howard Dean – VT
 Donald T. DiFrancesco – NJ (outgoing)
 Michael F. Easley – NC
 John Engler – MI
 Mike Foster, Jr. – LA

Jim Geringer – WY
 James S. Gilmore III – VA (outgoing)
 Parris N. Glendening – MD
 Bill Graves – KS
 Kenny C. Guinn – NV
 Carl T.C. Gutierrez – GU
 Jim Hodges – SC
 John Hoeven – ND
 Bob Holden – MO
 Mike Huckabee – AR
 Jane Dee Hull – AZ
 William J. Janklow – SD
 Mike O. Johanns – NE
 Gary E. Johnson – NM
 Frank Keating – OK
 Dirk Kempthorne – ID
 Angus S. King, Jr. – ME
 John A. Kitzhaber – OR
 Tony Knowles – AK
 Michael O. Leavitt – UT
 Gary Locke – WA
 Judy Martz – MT
 Scott McCallum – WI
 James E. McGreevey – NJ
 Ruth Ann Minner – DE
 Ronnie Musgrove – MS
 Frank O'Bannon – IN
 Bill Owens – CO
 George E. Pataki – NY
 Paul E. Patton – KY
 Rick Perry – TX
 John G. Rowland – CT
 George H. Ryan – IL
 Mark Schweiker – PA
 Jeanne Shaheen – NH
 Don Siegelman – AL
 Don Sundquist – TN
 Jane Swift – MA
 Bob Taft – OH
 Tauese P.F. Sunia – AS
 Pedro P. Tenorio – MP (outgoing)
 Charles W. Turnbull – VI
 Thomas J. Vilsack – IA
 Jesse Ventura – MN
 Mark Warner – VA
 Robert E. Wise, Jr. – WV

Private Individuals and Organizations

100 Black Men of America, Inc.
 Abt Associates, Inc.
 Addiction Research and Treatment Corporation
 AFL-CIO
 Alcohol and Drug Problems Association of North America
 Alliance for Consumer Education
 America Cares, Inc.
 American Correctional Association
 American Enterprise Institute
 American Federation of Government Employees
 American Federation of Teachers
 American Medical Association
 American Methadone Treatment Association, Inc.
 American Police Command Officers Association
 American Psychological Association
 American Public Health Association
 American Public Welfare Association
 American Society of Addiction Medicine
 Appalachian State University of North Carolina
 Arizona Department of Education
 Ken Barun
 Peter Bell
 Boy Scouts of America
 Boys and Girls Clubs of America
 Brookings Institution
 Caliber Associates
 California Narcotics Officers Association
 Californians for Drug-Free Youth
 Carnegie Mellon University
 Carnevale Associates, LLC
 Catholic Charities U.S.A.
 Center for Media Education, Inc.
 Center for Media Literacy
 Center for Problem-Solving Courts
 Center for Science in the Public Interest
 Century Foundation
 Child Welfare League of America, Inc.
 Church of Jesus Christ of Latter Day Saints
 Civic Solutions
 Colorado Department of Human Services
 Columbia University
 Community Anti-Drug Coalitions of America
 Congress of National Black Churches
 Corporate Community
 Bob Cote
 Council of State Governments
 Barry Crane
 D.A.R.E. America
 Direct Impact
 Drug and Alcohol Service Providers
 Organization of Pennsylvania (DASPOP)
 Drug Free America Foundation, Inc.
 Drug Free Pennsylvania
 Drug Watch International
 Dupont Associates, PA
 Employee Assistance Professionals Association
 Employee Health Programs, Inc.
 Empower America
 Entertainment Industries Council, Inc.
 Family Research Council
 Federal Law Enforcement Officers Association
 Florida Chamber of Commerce
 Fraternal Order of Police
 Georgia State University Department of Psychology
 Girl Scouts of the U.S.A.
 Heritage Foundation
 Hispanic American Police Command
 Officer's Association
 Institute for a Drug-Free Workplace
 Institute for Social Research
 Institute for Youth Development
 Institute on Global Drug Policy
 International Brotherhood of Police Officers
 International City/County Management Association
 Iowa Board of Parole
 Jewish Council for Public Affairs
 Johnson Institute Foundation
 Join Together
 Joint Center for Political and Economic Studies
 Kiwanis International
 Legal Action Center
 Melvyn Levitsky
 Lewin Group
 John Linder
 Los Alamos Citizens Against Substance Abuse
 (LACASA)

Major City Chiefs Organization
 Maximizing Adolescent Potentials
 Miami Coalition
 Milton Eisenhower Foundation
 William Mockler
 Mothers Against Drunk Driving (MADD)
 Nashville Center for Family Life
 National Alliance of State Drug Enforcement Agencies
 National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
 National Association of Alcoholism and Drug Abuse Counselors
 National Association of Attorneys General
 National Association of Children of Alcoholics (NACOA)
 National Association of Counties
 National Association of County Behavioral Health Directors
 National Association of Drug Court Professionals
 National Association of Elementary School Principals
 National Association of Native American Children of Alcoholics (NANACOA)
 National Association of Neighborhoods
 National Association of Police Organizations
 National Association of Secondary School Principals
 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
 National Association of Student Assistance Professionals
 National Black Child Development Institute, Inc.
 National Center on Addiction and Substance Abuse at Columbia University (CASA)
 National Center for Missing and Exploited Children
 National Center for State Courts
 National Center for Tobacco-Free Kids
 National Coalition of Hispanic Health and Human Services Organizations
 National Conference of State Legislators
 National Council of Juvenile and Family Court Judges
 National Crime Prevention Council
 National Criminal Justice Association
 National District Attorneys Association
 National Drug Prevention League
 National Families in Action
 National Family Partnership
 National Federation of State High School Associations
 National Governors' Association
 National Hispanic/Latino Community Prevention Network
 National Inhalant Prevention Coalition
 National Institute of Citizen Anti-drug Policy (NICAP)
 National Legal Aid and Defenders Association
 National Masonic Foundation for Children
 National Mental Health Association
 National Narcotics Officers' Association Coalition
 National Opinion Research Center
 National Organization of Black Law Enforcement Executives
 National Parents and Teachers Association
 National Pharmaceutical Council, Inc.
 National Research Council Committee on National Statistics
 National School Boards Association
 National Sheriffs Association
 National Treatment Accountability for Safer Communities
 National Treatment Consortium
 National Troopers Coalition
 National Development and Research Institutes (NDRI)
 New York University School of Medicine
 Northwestern University Department of Economics and Institute for Policy Research
 Operation PAR, Inc.
 Oregon Partnership
 Orthodox Union
 Parents' Resource Institute for Drug Education, Inc. (PRIDE)
 Partnership for a Drug-Free America
 Phoenix House
 Physicians for Prevention (PFP)
 Police Executive Research Forum
 Police Foundation
 Prevention, Intervention, and Treatment Coalition for Health
 Prevention Think Tank
 RAND Drug Policy Research Center

Research Triangle Institute
Robert Wood Johnson Foundation
Robert Wood Johnson Medical School
Department of Psychiatry
Laurie Robinson
Safe Streets
Sally Satel
Scott Newman Center
Southern Christian Leadership Conference
Substance Abuse Program Administrators
Association (SAPAA)
Support Center for Alcohol and Drug Research
and Education
Texas Commission on Alcohol and Drug Abuse
Therapeutic Communities of America
Treatment Accountability for Safer Communities
Troy Community Coalition for the Prevention of
Drug and Alcohol Abuse
Union of American Hebrew Congregations
United Methodist Church Washington
Episcopal Area
U.S. Conference of Mayors
United Synagogue of Conservative Judaism
University of Arizona
University of California, Los Angeles
Neuropsychiatric Institute
University of Chicago
University of Delaware Center for Drug and
Alcohol Studies
University of Florida Brain Institute
University of Kentucky Center for Prevention
Research
University of Maryland School of Public Affairs
University of Texas at Austin Institute for
Advanced Technology
Urban Institute Justice Policy Center
Washington Business Group on Health
Workers Assistance Program
Yale School of Public Health
YMCA of America

Drug-Related Data

Up-to-date information on the availability and prevalence of illegal drugs and the criminal, health, and social consequences of their use is vital to the implementation of the National Drug Control Strategy. Such information is also important for measuring the effectiveness of federal, state, and local drug-control programs. The Office of National Drug Control Policy's (ONDCP) Advisory Committee on Research, Data, and Evaluation; Subcommittee on Data, Research, and Interagency Coordination coordinates the development and analysis of drug-control information in support of the Strategy. The Office of National Drug Control Policy Reauthorization Act of 1998 defines ONDCP's reporting requirements to include "an assessment of current drug use (including inhalants) and availability, impact of drug use, and treatment availability." The legislation, quoted here directly, specifies that this assessment shall include the following:

- i** estimates of drug prevalence and frequency of use as measured by national, State, and local surveys of illicit drug use and by other special studies of:
 - I** casual and chronic drug use;
 - II** high-risk populations, including school dropouts, the homeless and transient, arrestees, parolees, probationers, and juvenile delinquents; and
 - III** drug use in the workplace and the productivity lost by such use;
- ii** an assessment of the reduction of drug availability against an ascertained baseline, as measured by:
 - I** the quantities of cocaine, heroin, marijuana, methamphetamine, and other drugs available for consumption in the United States;
 - II** the amount of marijuana, cocaine, heroin, and precursor chemicals entering the United States;
 - III** the number of hectares of marijuana, poppy, and coca cultivated and destroyed domestically and in other countries;
 - IV** the number of metric tons of marijuana, heroin, cocaine, and methamphetamine seized;
 - V** the number of cocaine and methamphetamine processing laboratories destroyed domestically and in other countries;
 - VI** changes in the price and purity of heroin and cocaine, changes in the price of methamphetamine, and changes in tetrahydrocannabinol level of marijuana;
 - VII** the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and
 - VIII** the effectiveness of Federal technology programs at improving drug detection capabilities in interdiction, and at United States ports of entry;

- iii an assessment of the reduction of the consequences of drug use and availability, which shall include estimation of:
 - I the burden drug users placed on hospital emergency departments in the United States, such as the quantity of drug-related services provided;
 - II the annual national health care costs of drug use, including costs associated with people becoming infected with the human immunodeficiency virus and other infectious diseases as a result of drug use;
 - III the extent of drug-related crime and criminal activity; and
 - IV the contribution of drugs to the underground economy as measured by the retail value of drugs sold in the United States;
- iv a determination of the status of drug treatment in the United States, by assessing:
 - I public and private treatment capacity within each State, including information on the treatment capacity available in relation to the capacity actually used;
 - II the extent, within each State, to which treatment is available;
 - III the number of drug users the Director estimates could benefit from treatment; and
 - IV the specific factors that restrict the availability of treatment services to those seeking it and proposed administrative or legislative remedies to make treatment available to those individuals; and
- v a review of the research agenda of the Counter-Drug Technology Assessment Center to reduce the availability and abuse of drugs.

Data are available for many of the areas listed above; however, there are specific areas for which measurement systems are not yet fully operational. The tables presented in this appendix contain the most current drug-related data on the areas the 1998 ONDCP Reauthorization Act requires ONDCP to assess.

Data Source Descriptions

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

What America's Users Spend on Illegal Drugs: 1988–2000

(Source for Tables 1, 3, 32, 39, and 40)

This report estimates total U.S. expenditures on illicit drugs based on available drug price, purity, and demand data. Data are provided on estimated numbers of users' yearly and weekly expenditures for drugs, which is combined with drug price/purity data to calculate trends in total national drug expenditures and consumption. Abt Associates, Inc., first wrote the report for ONDCP in 1993. It was updated in 1995, 1997, 2000, and 2001. For each update, estimates for all years are adjusted due to changes in the database, methodology improvements, and assumption adjustments. See the source report for details.

National Household Survey on Drug Abuse

(Source for Tables 2, 4, 31, 49, and 50)

The NHSDA measures the prevalence of drug and alcohol use among household members aged twelve and older. Topics include drug use, health, and demographics. In 1991, the NHSDA was expanded to include college students in dormitories, persons living in homeless shelters, and civilians living on military bases. The NHSDA was administered by the National Institute on Drug Abuse (NIDA) from 1974 through 1991; the Substance Abuse and Mental Health Services Administration (SAMHSA) has administered the survey since 1992. The data collection methodology was changed from paper-and-pencil interviews (PAPI) to computer-assisted interviews (CAI) in 1999, and the sample was expanded almost fourfold to permit state-level estimates and more detailed subgroup analyses, including racial/ethnic subgroups and single-year age categories. This change in method represents a break in trend data after 1998.

Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth

(Source for Tables 5 and 6)

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

Youth Risk Behavior Survey

(Source for Tables 7–9, 11, 74, and 75)

The Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System (YRBSS), maintained by the Centers for Disease Control and Prevention (CDC). The YRBSS currently has the following three complementary components: (1) national school-based surveys, (2) state and local school-based surveys, and (3) a national household-based survey. Each of these components provides unique information about various sub-populations of adolescents in the United States.

The school-based survey was initiated in 1990, and the household-based survey was conducted in 1992. The school-based survey is conducted biennially in odd-numbered years throughout the decade among national probability samples of 9th through 12th graders from public and private schools. Schools with a large proportion of black and Hispanic students are over-sampled to provide stable estimates for these subgroups. The 1992 Youth Risk Behavior Supplement was administered to one in-school youth and up to two out-of-school youths in each family selected for the National Health Interview Survey. In 1992, 10,645 youth ages 12–21 were included in the YRBS sample. The purpose of the supplement was to provide information on a broader base of youth, including those not currently attending school, than usually is obtained with surveys and to obtain accurate information on the demographic characteristics of the household in which the youth reside. Another component of the YRBSS is the national Alternative High School Youth Risk Behavior Survey (ALT-YRBS). Conducted in 1998, ALT-YRBS results are based on a nationally representative sample of 8,918 students enrolled in alternative high schools who are at high risk for failing or dropping out of regular high school, or have been expelled from regular high school because of illegal activity or behavior problems.

The Monetary Value of Saving a High-Risk Youth

(Source for Tables 12 and 13)

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

Substance Abuse Among Probationers and Inmates

(Source for Table 14)

Conducted by the Bureau of Justice Statistics, Office of Justice Programs, Department of Justice, the 1997 Survey on Inmates in State and Federal Correctional Facilities comprises 14,285 interviews for the state survey and 4,041 for the federal survey using computer-assisted personal interviewing (published in December 1998). The survey is conducted every 5–6 years. The first national survey of adults on probation was conducted in 1995 by BJS and provides information on drug use from personal

interviews with a national representative sample of more than 2,000 adult probationers under active supervision (published in March 1998). About 417,000 jail inmates were surveyed in 1998 as part of the survey of inmates in local facilities. The 1998 survey included a special addendum on drug testing, sanctions, and interventions.

Homelessness: Programs and the People They Serve

(Source for Tables 15–17)

The National Survey of Homeless Assistance Providers and Clients provides a full picture of homeless service users in late 1996. It provides updated information about the providers of homeless assistance services and the characteristics of homeless clients who use these services. Information from this survey was intended for use by federal agencies responsible for administering homeless assistance programs and other interested parties. The U.S. Bureau of the Census carried out the data collection on behalf of the sponsoring agencies. The survey, released in December 1999, provides the first opportunity since 1987 to update the national picture of homelessness in a comprehensive and reliable way.

The Economic Costs of Drug Abuse in the United States

(Source for Tables 18 and 19)

ONDCP commissioned the study *The Economic Costs of Drug Abuse in the United States, 1992–1998* to update a previous study conducted by NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) that was released in 1998 and that had been based on 1992 data. The study also includes cost projections for 1999 and 2000. The report, conducted by The Lewin Group, uses a cost-of-illness methodology and was released by ONDCP in January 2002.

National Vital Statistics Report

(Source for Table 20)

Data on drug-induced deaths are based on information from all death certificates filed (2.3 million in 1997) in the 50 states and the District of Columbia. Information from the states is provided to the National Center for Health Statistics (NCHS), a component of CDC. NCHS tabulates causes of death attributable to drug-induced mortality, including drug psychoses; drug dependence; nondependent drug use, not including alcohol and tobacco; accidental poisoning by drugs, medicaments, and biologicals; suicide by drugs, medicaments, and biologicals; assault from poisoning by drugs and medicaments; and poisoning by drugs, medicaments, and biologicals, undetermined whether accidentally or purposely inflicted. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mothers' drug use. The International Classification of Diseases, Version 10 (ICD-10) was implemented in 1999 following conventions defined by the World Health Organization to replace Version 9 (ICD-9), in use since 1979. Because of the change in coding causes of death and the resulting trend discontinuity, death data for 1998 were recalculated by NCHS to provide a benchmark for comparison of ICD-9 and ICD-10 results.

Drug Abuse Warning Network

(Source for Tables 21 and 68–72)

The Drug Abuse Warning Network (DAWN) provides data on drug-related emergency department episodes and medical examiner cases. DAWN assists federal, state, and local drug policy makers to examine drug use patterns and trends and assess health hazards associated with drug use. Data are available on deaths and emergency department episodes by type of drug, reason for taking the drug, demographic characteristics of the user, and metropolitan area. NIDA maintained DAWN from 1982 through 1991; SAMHSA has maintained it since 1992.

HIV/AIDS Surveillance Reports

(Source for Tables 22 and 23)

The HIV/AIDS Surveillance Reports are published semi-annually by CDC and contain tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category.

Reported Tuberculosis in the United States

(Source for Table 24)

The TB Surveillance Reports are published annually by CDC and contain tabular and graphic information about reported tuberculosis cases collected from 59 reporting areas (the 50 states, the District of Columbia, New York City, U.S. dependencies and possessions, and independent nations in free association with the United States).

The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas, with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, and drug resistance). The reports also include information on injection drug use and non-injection drug use among TB cases.

Summary of Notifiable Diseases

(Source for Table 25)

This publication contains summary tables of the official statistics for the reported occurrence of nationally notifiable diseases in the United States, including hepatitis. These statistics are collected and compiled from reports to the National Notifiable Diseases Surveillance System, which is operated by CDC in collaboration with the Council of State and Territorial Epidemiologists. These data are finalized and published in CDC's *Morbidity and Mortality Weekly Review Summary of Notifiable Diseases, United States* for use by state and local health departments; schools of medicine and public health; communications media; local, state, and federal agencies; and other agencies or persons interested in following the trends of reportable diseases in the United States. The annual publication of the summary also documents which diseases are considered national priorities for notification and the annual number of cases of such diseases.

Uniform Crime Reports

(Source for Tables 26 and 27)

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

Survey of Inmates of Local Jails

(Source for Table 28)

The Survey of Inmates of Local Jails provides nationally representative data on inmates held in local jails, including those awaiting trials or transfers and those serving sentences. Survey topics include inmate characteristics, offense histories, drug use, and drug treatment. The Bureau of Justice Statistics has conducted the survey every 5–6 years since 1972. About 417,000 jail inmates were surveyed in 1998 as part of the survey of inmates in local facilities. The 1998 survey included a special addendum on drug testing, sanctions, and interventions.

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities

(Sources for Table 28)

The Survey of Inmates in Federal Correctional Facilities (SIFCF) and Survey of Inmates in State Correctional Facilities (SISCF) provide comprehensive background data on inmates in federal and state correctional facilities, based on confidential interviews with a sample of inmates. Topics include current offenses and sentences, criminal histories, family and personal backgrounds, gun possession and use, prior alcohol and drug treatment, and educational programs and other services provided in prison. The SIFCF and SISCF were sponsored jointly in 1991 by BJS and the Bureau of Prisons and conducted by the U.S. Bureau of the Census. Similar surveys of state prison inmates were conducted in 1974, 1979, and 1986. The most recent SIFCF and SISCF were conducted in 1997.

National Prisoner Statistics Program

(Source for Table 28)

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

Uniform Facility Data Set/National Drug and Alcoholism Treatment Unit Survey (Source for Tables 29, 30, and 51)

The Uniform Facility Data Set (UFDS) measures the location, scope, and characteristics of drug and alcohol treatment facilities throughout the United States. The survey collects data on unit ownership, type, and scope of services provided; sources of funding; number of clients; treatment capacities; and utilization rates. Data are reported for a point prevalence date in the fall of the year in which the survey is administered. Many questions focus on the 12 months before that date. The UFDS, then called the National Drug and Alcoholism Treatment Unit Survey (NDATUS), was administered jointly by NIDA and the National Institute of Alcohol Abuse and Alcoholism from 1974 to 1991. Since 1992, SAMHSA has administered UFDS.

Closing the Drug Abuse Treatment Gap (Source for Table 31)

The Department of Health and Human Services (DHHS) issued a report to the President on an inventory of drug treatment need and capacity. The report includes national and state estimates of the drug treatment gap based on the NHSDA and proposes a comprehensive plan to close the gap. This table reports estimates of the number of individuals who needed, in the past year, treatment for an illicit drug problem, by demographic characteristics.

Estimation of Cocaine Availability, 1996–1998 (Source for Table 32)

ONDCP is developing a flow model for cocaine, called the Sequential Transition and Reduction (STAR) Model. The STAR model is anchored to two annual estimates of cocaine availability: Andean cultivation estimates and U.S. domestic consumption estimates. Between these endpoints, other cocaine availabilities are calculated by sequentially transitioning from one stage to another. For example, from net cultivation, the model calculates leaf production by applying leaf yield figures and reductions due to leaf seizures and consumption.

The Price of Illicit Drugs, 1981–2000 (Source for Table 33)

This study commissioned by ONDCP reports national-level drug price and purity trends for the three major drugs: cocaine, heroin, and methamphetamine. National-level price trends for marijuana are also provided, but purity trends are not, because THC content is not provided by DEA's database. DEA's *System To Retrieve Information on Drug Evidence* (STRIDE) is the primary source of data for this study, providing lab analyses of street-level drug purchases. Regional price and purity trends are weighted by DAWN data to calculate a national-level estimate.

Federal-Wide Drug Seizure System

(Source for Table 34)

The Federal-Wide Drug Seizure System (FDSS) is an online computerized system that stores information about drug seizures made by and with the participation of DEA, FBI, Customs Service, Border Patrol, and Coast Guard. The FDSS database includes drug seizures by other federal agencies (such as the Forest Service) to the extent that custody of the drug evidence was transferred to one of the five agencies identified above. The FDSS has been maintained by the DEA since 1988.

Eradicated Domestic Cannabis by Plant Type, 1982–2001

(Source for Table 35)

DEA's Domestic Cannabis Eradication and Suppression Program provides resources to state and local law enforcement for cannabis eradication. The data tabulated in this table are from state and local law enforcement reporting of the results of their efforts.

International Narcotics Control Strategy Report

(Source for Tables 36–38 and 41–47)

The International Narcotics Control Strategy Report (INCSR) provides the President with information on the steps taken by the main illicit drug-producing and transiting countries to prevent drug production, trafficking, and related money laundering during the previous year. The INCSR helps determine how cooperative a country has been in meeting legislative requirements in various geographic areas. Drug supply figures, such as seizures and cultivation estimates, are forwarded from each host nation, through the American Embassy, to this U.S. Department of State report.

Estimation of Heroin Availability, 1995–1999

(Source for Table 40)

This research was supported by ONDCP's Office of Programs, Budget, Research, and Evaluation. Beginning with domestic heroin consumption estimates and source distribution data from DEA's Heroin Signature Program, seizure figures are added to measure the amount of heroin entering the United States from various source regions. These estimates are closely correlated to potential heroin production estimates for South America and Mexico.

DEA Information 7 Reports

(Source for Table 48)

Only a fraction of MDMA seizures are analyzed by DEA's field laboratories. Those federal seizures where DEA has an interest in the case but that are not analyzed are logged into a DEA database. The data form completed for each of those seizures is referred to as a "DEA Information 7 Report."

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program**(Source for Tables 52–66)**

The National Institute of Justice established the Drug Use Forecasting (DUF) program in 1987 to provide an objective assessment of the drug problem among those arrested and charged with crimes. In 1997, this program became the Arrestee Drug Abuse Monitoring (ADAM) program. The ADAM program collected data in 35 major metropolitan sites across the United States in 1998, up from 23 in 1997. Arrestees are interviewed and asked to provide urine specimens that are tested for evidence of drug use. Urinalysis results can be matched to arrestee characteristics to help monitor trends in drug use. The sample size of the data set varies from site to site. Most sites collect data from 300–700 adult male arrestees, 100–300 female arrestees (at 32 sites), and 150–300 juvenile male arrestees (at 13 sites).

El Paso Intelligence Center**(Source for Table 67)**

The El Paso Intelligence Center (EPIC) maintains the National Clandestine Laboratory Seizure Database containing information obtained from federal, state, and local law enforcement. EPIC was established in 1974 as a Southwest Border intelligence service center. Today, EPIC still concentrates primarily on drug movement and immigration violations. Staffing at the DEA-led center has increased to more than 300 analysts, agents, and support personnel from 15 federal agencies, the Texas Department of Public Safety, and the Texas Air National Guard. Information sharing agreements with other federal law enforcement agencies, the Royal Canadian Mounted Police, and each of the 50 states ensure that EPIC support is available to those who need it. Real-time information is maintained at EPIC via different federal databases, and EPIC's own internal database.

The European School Survey Project on Alcohol and Other Drugs: Alcohol and Other Drug Use Among Students in 30 European Countries**(Source for Table 73)**

The European School Survey Project on Alcohol and Other Drugs (ESPAD) was jointly published by the Swedish Council for Information on Alcohol and Other Drugs, CAN Council of Europe, Co-Operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (the Pompidou Group). Under this project, data on drug use prevalence were collected from annual school surveys in up to 30 different European countries and the United States in 1995 and 1999. The target age of youth surveyed was 15, or approximately 10th grade, and the substances focused on included alcohol, tobacco, and other drugs. The group plans to repeat the surveys every fourth year.

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DRUG USER EXPENDITURES

Table 1. Total U.S. Expenditures on Illicit Drugs, 1988–2000 (\$ Billions)

Year	Cocaine	Heroin	Marijuana	Meth- amphetamine	Other drugs	Total
1988	\$107.0	\$26.1	\$12.1	\$5.8	\$3.3	\$154
1989	\$88.4	\$24.3	\$11.0	\$5.8	\$2.8	\$132
1990	\$69.9	\$22.5	\$15.0	\$5.7	\$2.2	\$115
1991	\$57.1	\$20.3	\$14.0	\$3.7	\$2.3	\$97
1992	\$49.9	\$17.2	\$14.6	\$4.8	\$1.5	\$88
1993	\$45.0	\$13.8	\$12.0	\$5.1	\$1.5	\$77
1994	\$42.8	\$13.2	\$12.2	\$7.6	\$2.6	\$78
1995	\$40.0	\$13.2	\$10.2	\$9.2	\$2.7	\$75
1996	\$39.2	\$12.8	\$9.5	\$10.1	\$2.7	\$74
1997	\$34.7	\$11.4	\$10.5	\$9.3	\$2.5	\$68
1998	\$34.9	\$11.1	\$10.8	\$8.0	\$2.3	\$67
1999	\$35.6	\$10.1	\$10.6	\$5.8	\$2.6	\$65
2000*	\$35.3	\$10.0	\$10.5	\$5.4	\$2.4	\$64

*Estimates for 2000 are projections.

Note: Amounts are in constant 2000 dollars.

Source: Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000*, (in press).

DRUG USE

Table 2. Trends in Selected Drug Use Indicators, 1979–2000¹ (Estimated Number and Percent Prevalence)

Year	Current use of any illicit drug ²	Current cocaine use ²	Occasional (less than monthly) cocaine use	Current marijuana use ²	Lifetime heroin use	Any adolescent ³ illicit drug use ²	Lifetime adolescent ³ inhalant use ⁴
Users (thousands)							
1979	25,400	4,700	—	23,800	2,300	4,100	—
1982	—	4,500	—	21,500	1,800	2,800	—
1985	23,300	5,700	7,100	18,600	1,800	3,200	—
1988	15,000	3,100	5,100	12,400	1,700	1,900	—
1990	13,500	1,700	3,700	10,900	1,500	1,600	—
1991	13,400	2,000	3,800	10,400	2,400	1,400	—
1992	12,000	1,400	3,000	9,700	1,700	1,300	—
1993	12,300	1,400	2,700	9,600	2,100	1,400	—
1994	12,600	1,400	2,400	10,100	2,100	1,800	1,500
1995	12,800	1,500	2,500	9,800	2,500	2,400	1,600
1996	13,000	1,700	2,600	10,100	2,400	2,000	1,300
1997	13,900	1,500	2,600	11,100	2,000	2,600	1,600
1998	13,600	1,800	2,400	11,000	2,400	2,300	1,400
1999-CAI	13,829	1,552	1,926	10,458	3,054	2,265	2,118
2000-CAI	14,027	1,213	1,732	10,714	2,779	2,264	2,079
Rate of use (%)							
1979	14.1	2.6	—	13.2	1.3	16.3	—
1982	—	2.4	—	11.5	1.0	—	—
1985	12.1	3.0	3.7	9.7	0.9	13.2	—
1988	7.7	1.6	2.6	6.2	0.9	8.1	—
1990	6.7	0.9	1.8	5.4	0.8	7.1	—
1991	6.6	1.0	1.9	5.1	1.2	5.8	—
1992	5.8	0.7	1.5	4.7	0.8	5.3	—
1993	5.9	0.7	1.3	4.6	1.0	5.7	—
1994	6.0	0.7	1.2	4.8	1.0	8.2	7.0
1995	6.1	0.7	1.2	4.7	1.2	10.9	7.4
1996	6.1	0.8	1.2	4.7	1.1	9.0	5.9
1997	6.4	0.7	1.2	5.1	0.9	11.4	7.2
1998	6.2	0.8	1.1	5.0	1.1	9.9	6.1
1999-PAPI	7.0	0.8	—	5.4	—	9.0	—
1999-CAI	6.3	0.7	0.9	4.7	1.4	9.8	9.1
2000-CAI	6.3	0.5	0.8	4.8	1.2	9.7	8.9

— Data not available.

¹In 1999, the survey methodology changed from a paper-and-pencil interview (PAPI) to a computer-assisted interview (CAI). A PAPI supplement conducted in 1999 provides estimates that are comparable to previous years. Estimates based on the new CAI methodology are not directly comparable to previous years.

²Data for past-month (current) use.

³Ages 12–17 years.

⁴Prior to a 1994 questionnaire change; data did not allow separate reporting for this age group.

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

Sources: National Institute on Drug Abuse (1979–1991), and Substance Abuse and Mental Health Services Administration (1992–2000), *National Household Survey on Drug Abuse*.

Table 3. Estimated Number of Chronic and Occasional Users of Cocaine and Heroin, 1988–2000 (Thousands)

Year	Cocaine users		Heroin users	
	Occasional ¹	Chronic ²	Occasional ¹	Chronic ²
1988	6,000	3,984	170	1,341
1989	5,300	3,824	150	1,266
1990	4,600	3,558	140	1,119
1991	4,478	3,379	359	1,015
1992	3,503	3,269	304	955
1993	3,332	3,081	230	945
1994	2,930	3,032	281	932
1995	3,082	2,866	428	923
1996	3,425	2,828	455	910
1997	3,487	2,847	597	904
1998	3,216	2,800	253	901
1999	3,216	2,755	253	898
2000*	3,035	2,707	253	898

Note: Data in this table are preliminary composite estimates derived from the *National Household Survey on Drug Abuse* (NHSDA) and the *Arrestee Drug Abuse Monitoring (ADAM)* program (see W. Rhodes "Synthetic Estimation Applied to the Prevalence of Drug Use," *Journal of Drug Issues* 23(2):297–321, 1993, for a detailed description of the methodology). The NHSDA was not administered in 1989. Estimates for 1989 are the average for 1988 and 1990.

*Estimates for 2000 are projections.

¹"Occasional" is defined as using drugs fewer than 10 days per month.

²"Chronic" is defined as more than 10 days per month.

Source: Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000*, (in press).

Table 4. Drug Use by Current Employment Status,¹ 1995–2000² (Percent Prevalence)

	Full-time	Part-time	Unemployed	Other ³
Past month use of any illicit drug				
1995	5.5	9.0	14.3	3.1
1996	6.2	8.6	12.5	3.0
1997	6.5	7.7	13.8	3.0
1998	6.4	7.4	18.2	2.8
1999 CAI	6.1	6.3	6.2	3.3
2000 CAI	6.3	7.8	15.4	3.5
Past month use of marijuana				
1995	4.2	7.5	12.6	1.9
1996	4.9	6.2	10.0	2.3
1997	5.0	6.6	12.2	2.4
1998	5.1	6.5	15.1	2.0
1999 CAI	4.7	6.6	12.1	2.2
2000 CAI	4.8	6.3	13.3	2.5
Past month use of cocaine				
1995	0.7	0.8	2.1	0.4
1996	0.9	1.1	2.4	0.4
1997	0.7	0.9	2.4	0.3
1998	0.9	0.5	3.4	0.4
1999 CAI	0.8	0.8	2.9	0.3
2000 CAI	0.6	0.9	2.0	0.3

¹Data on current employment are for persons age 18 and older.

²In 1999, the survey methodology changed from a paper-and-pencil interview to a computer-assisted interview (CAI). Estimates based on the new CAI methodology are not directly comparable to previous years.

³Retired, disabled, homemaker, student, or "other."

Source: Substance Abuse and Mental Health Services Administration, *National Household Survey on Drug Abuse* (1995–2000).

Table 5. Trends in 30-Day Prevalence of Selected Drugs Among 8th, 10th, and 12th Graders, Monitoring the Future Study, 1991–2001 (Percent Prevalence)

Selected drug/grade	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2000-2001 Change
Marijuana/hashish												
8 th grade	3.2	3.7	5.1	7.8	9.1	11.3	10.2	9.7	9.7	9.1	9.2	+0.1
10 th grade	8.7	8.1	10.9	15.8	17.2	20.4	20.5	18.7	19.4	19.7	19.8	0.0
12 th grade	13.8	11.9	15.5	19.0	21.2	21.9	23.7	22.8	23.1	21.6	22.4	+0.8
Inhalants¹												
8 th grade	4.4	4.7	5.4	5.6	6.1	5.8	5.6	4.8	5.0	4.5	4.0	-0.5
10 th grade	2.7	2.7	3.3	3.6	3.5	3.3	3.0	2.9	2.6	2.6	2.4	-0.1
12 th grade ²	2.4	2.3	2.5	2.7	3.2	2.5	2.5	2.3	2.0	2.2	1.7	-0.5
Hallucinogens												
8 th grade	0.8	1.1	1.2	1.3	1.7	1.9	1.8	1.4	1.3	1.2	1.2	0.0
10 th grade	1.6	1.8	1.9	2.4	3.3	2.8	3.3	3.2	2.9	2.3	2.1	-0.2
12 th grade	2.2	2.1	2.7	3.1	4.4	3.5	3.9	2.8	3.5	3.5	3.2	+0.6
LSD												
8 th grade	0.6	0.9	1.0	1.1	1.4	1.5	1.5	1.1	1.1	1.0	1.0	0.0
10 th grade	1.5	1.6	1.6	2.0	3.0	2.4	2.8	2.7	2.3	1.6	1.5	-0.2
12 th grade	1.9	2.0	2.4	2.6	4.0	2.5	3.1	3.2	2.7	1.6	2.3	+0.7s
Cocaine												
8 th grade	0.5	0.7	0.7	1.0	1.2	1.3	1.1	1.4	1.3	1.2	1.2	-0.1
10 th grade	0.7	0.7	0.9	1.2	1.7	1.7	2.0	2.1	1.8	1.8	1.3	-0.4
12 th grade	1.4	1.3	1.3	1.5	1.8	2.0	2.3	2.4	2.6	2.1	2.1	-0.1
Stimulants												
8 th grade	2.6	3.3	3.6	3.6	4.2	4.6	3.8	3.3	3.4	3.4	3.2	-0.3
10 th grade	3.3	3.6	4.3	4.5	5.3	5.5	5.1	5.1	5.0	5.4	5.6	+0.2
12 th grade	3.2	2.8	3.7	4.0	4.0	4.1	4.8	4.6	4.5	5.0	5.6	+0.2
Alcohol (any use)³												
8 th grade	25.1	26.1	24.3	25.5	24.6	26.2	24.5	23.0	24.0	22.4	21.5	-0.9
10 th grade	42.8	39.9	38.2	39.2	38.8	40.4	40.1	38.8	40.0	41.0	39.0	-2.0
12 th grade	54.0	51.3	48.6	50.1	51.3	50.8	52.7	52.0	51.0	50.0	49.8	-0.3

Notes: Level of significance of difference between the two most recent classes: $s=.05$. Any inconsistency between the 2000–2001 change estimate and the respective prevalence estimates is due to rounding.

Approximate Ns	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
8 th grade	17,500	18,600	18,300	17,300	17,500	17,800	18,600	18,100	16,700	17,300	16,200
10 th grade	14,800	14,800	15,300	15,800	17,000	15,600	15,500	15,000	13,600	14,600	14,000
12 th grade	15,000	15,800	16,300	15,400	15,400	14,300	15,400	15,200	13,600	13,300	12,800

¹ Unadjusted for underreporting of amyl and butyl nitrites.

² Data for 12th graders only are based on five of six questionnaire forms; N is five-sixths of N indicated.

³ For all grades: For 1993, the question text was changed slightly in one-half of the forms to indicate that a “drink” meant “more than a few sips.” For 1993, N is one-half of N indicated for all groups. Data after 1993 were based on all forms for all grades.

Source: Institute for Social Research, University of Michigan, *Monitoring the Future* study (December 2001).

Table 6. Trends in Harmfulness of Drugs as Perceived by 8th, 10th, and 12th Graders, Monitoring the Future Study, 1991–2001

Drug Behavior	Percentage saying “great risk” ¹											2000–2001 Change
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	
8th grade												
How much do you think people risk harming themselves (physically or in other ways), if they . . .												
Try marijuana once or twice	40.4	39.1	36.2	31.6	28.9	27.9	25.3	28.1	28.0	29.0	27.7	-1.3
Smoke marijuana occasionally	57.9	56.3	53.8	48.6	45.9	44.3	43.1	45.0	45.7	47.4	46.3	-1.2
Smoke marijuana regularly	83.8	82.0	79.6	74.3	73.0	70.9	72.7	73.0	73.9	74.8	72.2	-2.5
Try crack once or twice ²	62.8	61.2	57.2	54.4	50.8	51.0	49.9	49.3	48.7	48.5	48.6	+0.2
Take crack occasionally ²	82.2	79.6	76.8	74.4	72.1	71.6	71.2	70.6	70.6	70.1	70.0	-0.1
Try cocaine powder once or twice ²	55.5	54.1	50.7	48.4	44.9	45.2	45.0	44.0	43.3	43.3	43.9	+0.6
Take cocaine powder occasionally ²	77.0	74.3	71.8	69.1	66.4	65.7	65.8	65.2	65.4	65.5	65.8	+0.4
Approximate N	17,437	18,662	18,366	17,394	17,501	17,926	18,765	18,100	16,700	17,300	16,200	
10th grade												
How much do you think people risk harming themselves (physically or in other ways), if they . . .												
Try marijuana once or twice	30.0	31.9	29.7	24.4	21.5	20.0	18.8	19.6	19.2	18.5	17.9	-0.5
Smoke marijuana occasionally	48.6	48.9	46.1	38.9	35.4	32.8	31.9	32.5	33.5	32.4	31.2	-1.2
Smoke marijuana regularly	82.1	81.1	78.5	71.3	67.9	65.9	65.9	65.8	65.9	64.7	62.8	-1.9
Try crack once or twice	70.4	69.6	66.6	64.7	60.9	60.9	59.2	58.0	57.8	56.1	57.1	+1.0
Take crack occasionally	87.4	86.4	84.4	83.1	81.2	80.3	78.7	77.5	79.1	76.9	77.3	+0.4
Try cocaine powder once or twice	59.1	59.2	57.5	56.4	53.5	53.6	52.2	50.9	51.6	48.8	50.6	+1.7
Take cocaine powder occasionally	82.2	80.1	79.1	77.8	75.6	75.0	73.9	71.8	73.6	70.9	72.3	+1.5
Approximate N	14,719	14,808	15,298	15,880	17,006	15,670	15,640	15,000	13,600	14,600	14,000	
12th grade												
How much do you think people risk harming themselves (physically or in other ways), if they . . .												
Try marijuana once or twice	27.1	24.5	21.9	19.5	16.3	15.6	14.9	16.7	15.7	13.7	15.3	+1.6
Smoke marijuana occasionally	40.6	39.6	35.6	30.1	25.6	25.9	24.7	24.4	23.9	23.4	23.5	+0.1
Smoke marijuana regularly	78.6	76.5	72.5	65.0	60.8	59.9	58.1	58.5	57.4	58.3	57.4	-0.9
Try crack once or twice	60.6	62.4	57.6	58.4	54.6	56.0	54.0	52.2	48.2	48.4	49.4	+1.0
Take crack occasionally	76.5	76.3	73.9	73.8	72.8	71.4	70.3	68.7	67.3	65.8	65.4	-0.4
Try cocaine powder once or twice	53.6	57.1	53.2	55.4	52.0	53.2	51.4	48.5	46.1	47.0	49.0	+2.0
Take cocaine powder occasionally	69.8	70.8	68.6	70.6	69.1	68.8	67.7	65.4	64.2	64.7	63.2	-1.5
Approximate N	2,549	2,684	2,759	2,591	2,603	2,449	2,579	2,500	2,300	2,130	2,173	

Note: $s=.05$; Any inconsistency between the 2000–2001 change estimate and the respective prevalence estimates is due to rounding.

¹Answer alternatives were: (1) no risk, (2) slight risk, (3) moderate risk, (4) great risk, and (5) can't say, drug unfamiliar.

²8th and 10th grade: Beginning in 1997, data based on two-thirds of N indicated due to changes in questionnaire forms.

Source: Institute for Social Research, University of Michigan, *Monitoring the Future* study (December 2001).

Table 7. Percentage of High School Students Who Used Selected Drugs by Sex, Race/Ethnicity, and Grade, Youth Risk Behavior Survey, 1990, 1991, 1993, 1995, 1997, and 1999

Drug Use Behavior and Year	Sex		Race/Ethnicity			Grade Level				All Groups
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9 th	10 th	11 th	12 th	
Lifetime marijuana										
1990	—	—	—	—	—	20.6	27.9	34.7	42.2	31.4
1991	—	—	—	—	—	—	—	—	—	31.0
1993	36.8	28.6	32.7	33.6	35.4	24.4	28.8	36.0	40.8	32.8
1995	46.2	39.4	40.5	47.2	49.2	33.8	41.4	45.8	47.0	42.4
1997	50.7	42.9	45.4	52.2	49.5	38.8	45.9	50.3	52.4	47.1
1999	51.0	43.4	45.9	48.6	51.0	34.8	49.1	49.7	58.4	47.2
Current marijuana ¹										
1990	—	—	—	—	—	9.5	13.5	13.9	18.5	13.9
1991	—	—	—	—	—	—	—	—	—	15.0
1993	20.6	14.6	17.3	18.6	19.4	13.2	16.5	18.4	22.0	17.7
1995	28.4	22.0	24.6	28.6	27.8	20.9	25.6	27.6	26.2	25.3
1997	30.2	21.4	25.0	28.2	28.6	23.6	25.0	29.3	26.6	26.2
1999	30.8	22.6	26.4	26.4	28.2	21.7	27.8	26.7	31.5	26.7
Lifetime cocaine use ²										
1990	—	—	—	—	—	3.6	5.8	7.6	9.3	6.6
1991	—	—	—	—	—	—	—	—	—	6.0
1993	5.5	4.2	4.6	1.6	11.3	4.2	3.7	5.1	6.1	4.9
1995	8.8	5.0	6.5	2.0	16.0	5.7	7.5	7.2	7.4	7.0
1997	9.1	7.2	8.0	1.9	14.4	6.7	7.5	9.1	9.2	8.2
1999	10.7	8.4	9.9	2.2	15.3	5.8	9.9	9.9	13.7	9.5
Current cocaine use ¹										
1990	—	—	—	—	—	1.0	2.4	2.5	2.3	2.1
1991	—	—	—	—	—	—	—	—	—	2.0
1993	2.3	1.4	1.6	1.0	4.6	1.6	1.4	2.1	2.1	1.9
1995	4.3	1.8	2.6	1.3	7.5	3.1	2.5	3.6	3.1	3.1
1997	4.0	2.4	3.1	0.7	6.2	3.9	2.6	3.1	3.5	3.3
1999	5.2	2.9	4.1	1.1	6.7	3.4	3.7	4.5	4.8	4.0
Lifetime use of illegal steroids										
1990	—	—	—	—	—	—	—	—	—	—
1991	—	—	—	—	—	—	—	—	—	3.0
1993	3.1	1.2	1.9	2.4	3.0	2.1	2.0	2.2	2.3	2.2
1995	4.9	2.4	3.8	1.6	4.7	4.1	3.6	3.9	2.9	3.7
1997	4.1	2.0	3.1	1.5	3.4	4.3	3.0	2.7	2.5	3.1
1999	5.2	2.2	4.1	2.2	4.1	4.7	3.6	3.0	3.3	3.7
Lifetime injected drug use										
1990	—	—	—	—	—	—	—	—	—	—
1991	—	—	—	—	—	—	—	—	—	—
1993	1.9	0.8	1.3	0.9	1.5	1.4	1.4	1.3	1.2	1.4
1995	3.0	1.0	2.0	1.1	2.2	2.8	2.2	1.7	1.6	2.0
1997	2.6	1.5	1.8	1.0	2.2	3.0	2.5	1.6	1.5	2.1
1999	2.8	0.7	1.6	0.9	1.8	1.6	1.2	2.0	2.3	1.8
Episodic heavy drinking ³										
1990	—	—	—	—	—	27.7	35.7	39.6	44.0	36.9
1991	—	—	—	—	—	—	—	—	—	31.0
1993	33.7	26.0	32.6	19.1	33.4	22.0	26.2	31.3	39.1	30.0
1995	36.2	28.6	35.6	18.8	37.7	24.5	30.3	34.9	39.0	32.6
1997	37.3	28.6	37.7	16.1	34.9	25.7	29.9	37.5	39.3	33.4
1999	34.9	28.1	35.8	16.0	32.1	21.1	32.2	34.0	41.6	31.5
Current cigarette ¹										
1990	—	—	—	—	—	—	—	—	—	—
1991	28.0	27.0	—	—	—	—	—	—	—	28.0
1993	29.8	30.5	33.7	15.4	28.7	27.8	28.0	31.1	34.5	30.5
1995	35.4	34.3	38.3	19.2	34.0	31.2	33.1	35.8	38.2	34.8
1997	37.7	34.7	39.7	22.7	34.0	33.4	35.3	36.6	36.9	36.4
1999	34.7	34.9	38.6	19.7	32.7	27.6	34.7	36.0	42.8	34.8

— Data not available.

¹Used one or more times during the past 30 days.²Ever tried any form of cocaine, including powder, crack, or freebase.³Drank five or more drinks of alcohol on at least one occasion on one or more days during the last 30 days.Sources: "Tobacco, Alcohol and Other Drug Use Among High School Students—United States," *Morbidity and Mortality Weekly Report*, 40 (45) (1990): 776–84; 41 (37) (1991): 698–703; "Youth Risk Behavior Surveillance—United States (1993, 1995, 1997, and 1999)," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 8. Percentage of High School Students Who Reported Engaging in Drug-Related Behaviors on School Property by Sex, Race/Ethnicity, and Grade, Youth Risk Behavior Survey, 1990, 1991, 1993, 1995, 1997, and 1999

Drug Use Behavior and Year	Sex		Race/Ethnicity			Grade Level				All Groups
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9 th	10 th	11 th	12 th	
Used marijuana on school property ¹										
1993	7.8	3.3	5.0	7.3	7.5	4.4	6.5	6.5	5.1	5.6
1995	11.9	5.5	7.0	12.3	12.9	8.7	9.8	8.6	8.0	8.8
1997	9.0	4.6	5.8	9.1	10.4	8.1	6.4	7.9	5.7	7.0
1999	10.1	4.4	6.5	7.2	10.7	6.6	7.6	7.0	7.3	7.2
Offered, sold, or was given an illegal drug on school property ²										
1993	28.5	19.1	24.1	17.5	34.1	21.8	23.7	27.5	23.0	24.0
1995	38.8	24.8	31.7	28.5	40.7	31.0	35.0	32.8	29.1	32.1
1997	37.4	24.7	31.0	25.4	41.1	31.4	33.4	33.2	29.0	31.7
1999	34.7	25.7	28.8	25.3	36.9	27.6	32.1	31.1	30.5	30.2
Tried marijuana before age 13										
1993	—	—	—	—	—	—	—	—	—	—
1995	10.2	4.8	5.6	11.1	12.6	9.2	9.1	6.7	5.4	7.6
1997	12.2	6.7	7.5	11.0	13.2	14.9	10.4	8.3	5.8	9.7
1999	14.5	8.0	9.4	14.8	13.8	12.7	12.6	9.5	9.5	11.3
Tried cocaine before age 13 ³										
1993	—	—	—	—	—	—	—	—	—	—
1995	1.8	0.5	0.9	1.3	1.7	1.3	1.3	1.4	0.9	1.2
1997	1.3	0.8	0.9	0.4	1.4	1.8	1.3	1.0	0.3	1.1
1999	—	—	—	—	—	—	—	—	—	—

— Data not available.

¹One or more times during the 30 days preceding the survey.

²During the 12 months preceding the survey.

³Including powder, crack, and freebase forms of cocaine.

Source: "Youth Risk Behavior Surveillance—United States (1993, 1995, 1997, and 1999)," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 9. Percentage of Alternative High School Students Who Used Selected Drugs by Sex, Race/Ethnicity, and Grade, 1998

Drug use behavior	Sex		Race/Ethnicity			Grade Level				All Groups
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9 th	10 th	11 th	12 th	
Lifetime marijuana	88.0	82.1	89.4	77.7	84.0	81.0	85.3	86.0	86.8	85.4
Current marijuana ¹	58.2	46.7	56.7	47.2	50.6	51.2	52.9	55.7	51.2	53.0
Lifetime cocaine use ²	38.6	33.0	43.8	5.7	46.4	32.7	36.4	37.8	36.5	36.1
Current cocaine use ¹	17.1	13.1	17.7	3.6	19.4	14.8	16.6	15.9	14.1	15.3
Lifetime crack or freebase use	23.5	19.4	26.2	3.5	26.8	20.9	22.9	24.2	18.9	21.6
Lifetime use of illegal steroids	9.8	7.4	10.5	6.6	6.9	12.0	9.6	6.9	7.6	8.7
Lifetime injected drug use	6.8	4.4	7.0	4.1	4.5	7.6	5.6	5.4	4.9	5.7
Episodic heavy drinking ³	55.4	42.9	58.7	28.4	52.4	43.8	48.1	51.5	51.7	49.8
Current cigarette use ¹	67.7	59.8	78.6	43.3	53.0	64.5	64.3	64.8	62.2	64.1

— Data not available.

¹Used one or more times during the past 30 days.

²Ever tried any form of cocaine, including powder, crack, or freebase.

³Drank five or more drinks of alcohol on at least one occasion on one or more days during the past 30 days.

Source: "Youth Risk Behavior Surveillance—National Alternative High School Youth Risk Behavior Survey, United States, 1998," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 10. Annual High School Dropout Rates¹ for Grades 10–12 by Sex, Race, and Hispanic Origin, 1980–2000

Year	All races ² , both sexes						Male			Female			White			Black			Hispanic Origin ³		
	Total students	High school dropouts		Total students	High school dropouts		Total students	High school dropouts		Total students	High school dropouts		Total students	High school dropouts		Total students	High school dropouts		Total students	High school dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1980	10,891	658	6.0	5,445	362	6.6	5,448	296	5.4	9,177	517	5.6	1,496	124	8.3	646	74	11.5			
1981	10,868	639	5.9	5,379	322	6.0	5,487	316	5.8	9,067	478	5.3	1,516	146	9.6	717	77	10.7			
1982	10,611	577	5.4	5,310	305	5.7	5,301	271	5.1	8,769	444	5.1	1,553	121	7.8	692	65	9.4			
1983	10,331	535	5.2	5,130	294	5.7	5,200	241	4.6	8,531	410	4.8	1,498	103	6.9	691	68	9.8			
1984	10,041	507	5.0	4,986	268	5.4	5,054	238	4.7	8,221	410	5.0	1,524	88	5.8	706	77	10.9			
1985	9,704	504	5.2	4,831	259	5.4	4,874	245	5.0	7,967	384	4.8	1,422	110	7.7	729	71	9.7			
1986	9,829	421	4.3	4,910	213	4.3	4,917	208	4.2	8,011	333	4.2	1,449	68	4.7	764	91	11.9			
1987	9,802	403	4.1	4,921	215	4.4	4,879	187	3.8	7,979	299	3.7	1,463	93	6.4	769	43	5.6			
1988	9,590	461	4.8	4,960	256	5.2	4,628	206	4.5	7,727	362	4.7	1,468	93	6.3	730	77	10.5			
1989	8,974	404	4.5	4,519	203	4.5	4,453	199	4.5	7,243	286	3.9	1,384	106	7.7	762	59	7.7			
1990	8,679	347	4.0	4,356	177	4.1	4,323	170	3.9	6,984	266	3.8	1,303	66	5.1	811	65	8.0			
1991	8,612	348	4.0	4,380	167	3.8	4,231	180	4.3	6,856	254	3.7	1,366	85	6.2	809	59	7.3			
1992	8,939	384	4.3	4,580	175	3.8	4,357	207	4.8	7,077	292	4.1	1,422	70	4.9	917	72	7.9			
1993 ⁴	9,430	404	4.3	4,787	211	4.4	4,640	192	4.1	7,442	306	4.1	1,499	80	5.4	1,061	69	6.5			
1993	9,021	382	4.2	4,570	199	4.4	4,452	183	4.1	7,152	290	4.1	1,447	78	5.3	943	60	6.4			
1994	9,922	497	5.0	5,048	249	4.9	4,873	247	5.1	7,862	371	4.7	1,559	96	6.1	1,179	109	9.2			
1995	10,106	544	5.4	5,161	297	5.8	4,946	247	5.0	7,926	402	5.1	1,598	97	6.1	1,251	145	11.6			
1996	10,249	485	4.7	5,175	240	4.6	5,072	244	4.8	8,005	361	4.5	1,704	107	6.3	1,195	100	8.4			
1997	10,645	454	4.3	5,330	251	4.7	5,313	203	3.8	8,402	355	4.2	1,678	80	4.8	1,377	119	8.6			
1998	10,791	479	4.4	5,486	237	4.3	5,305	243	4.6	8,487	371	4.4	1,759	88	5.0	1,368	115	8.4			
1999	11,067	520	4.7	5,659	243	4.3	5,411	277	5.1	8,665	380	4.4	1,794	107	6.0	1,482	105	7.1			
2000	10,773	488	4.5	5,417	280	5.2	5,356	208	3.9	8,540	371	4.3	1,706	96	5.6	1,465	100	6.8			

¹Numbers in thousands; civilian noninstitutionalized population.

²All races³ includes whites, blacks, and other races not shown separately.

³Hispanics may be of any race.

⁴r = Revised, controlled to 1990 census-based population estimates; previous 1993 data controlled to 1980 census-based estimates.

Source: U.S. Bureau of the Census, Education and Social Stratification Branch, *Current Population Survey* (1980–2000).

Table 11. Past-Month Drug Use for Youth Aged 12–21, by Age, Dropout Status, Type of Drug Used, and Race/Ethnicity: 1992 Youth Risk Behavior Survey (Percent Prevalence)

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

*Low precision, no estimate reported.

— No respondents.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, *National Health Interview Survey/Youth Risk Behavior Survey* (1992).

Table 12. The Lifetime Costs of Dropping Out of High School (1993 \$)

	Total costs	Present value (2% discount rate)	Present value (10% discount rate)
Lost wage/productivity	\$360,000	\$186,500	\$15,300
Fringe benefits	\$90,000	\$46,600	\$3,800
Nonmarket losses	\$113,000–450,000	\$58,300–233,200	\$4,900–19,200
Total	\$563,000–900,000	\$291,000–466,000	\$24,000–38,300

Note: Numbers may not add to totals due to rounding.

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

Table 13. Summary of the Monetary Value of Saving a High-Risk Youth (\$ Thousands)

	Total costs	Present value with 2% discount rate	Present value with 10% discount rate
Career criminal	1,200–1,500	1,000–1,300	650–850
Heavy drug user	435–1,051	333–809	159–391
High school dropout	563–900	291–466	24–38
LESS duplication (crimes committed by heavy drug users)	(252–696)	(196–540)	(96–264)
Total	1,900–2,700	1,500–2,000	700–1,000

Note: Numbers may not add to totals due to rounding.

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

Table 14. Substance Abuse among Probationers, State Prison Inmates, and Federal Prison Inmates

	Number	Ever Used (%)	Used Regularly (%)*	Used Month Prior to Offense (%)	Used at Time of Offense (%)
Probation (1995) ¹	2,065,896	69.4	43.4	31.8	13.5
State prison inmates (1997) ²	1,059,607	83.0	69.6	56.5	32.6
Federal prison inmates (1997) ²	88,018	72.9	57.3	44.8	22.4
Jail inmates (1998) ^{3**}	417,000	70.3	65.5	55.0	35.6

*Regular use defined as once a week or more for at least a month.

¹Substance Abuse of Adults on Probation, 1995 (March 1998).

²Substance Abuse Among State and Federal Prisoners, 1997 (December 1998).

³Drug Use, Testing, and Treatment in Jails, 1998 (May 2000).

**Note: Includes convicted and non-convicted inmates. Other figures include convicted jail inmates only. Based on personal interviews.

Source: Bureau of Justice Statistics, Office of Justice Programs, Department of Justice, *1995 Survey of Adults on Probation* and *1997 Survey on Inmates in State and Federal Correctional Facilities*.

Table 15. Alcohol, Drug, and Mental Health (ADM) Problems Among Homeless Clients, 1996

ADM combination	Past month (%)	Past year (%)	Lifetime (%)
Any ADM problem	66	74	86
Alcohol problem	38	46	62
Drug problem	26	38	58
Mental health problem	39	45	57
Specific Combinations			
Alcohol problem only	13	12	9
Drug problem only	7	7	6
Mental health problem only	17	15	10
Alcohol and drug problems	7	10	15
Alcohol and mental health problems	10	10	15
Drug and mental health problems	5	7	8
Alcohol, drug, and mental health problems	8	14	30
No ADM problems	34	26	14

Source: Interagency Council on the Homeless, U.S. Department of Housing and Urban Development, *Homelessness: Programs and the People They Serve* (1999).

Table 16. Characteristics Perceived by Respondents to Prevent Exit From Homelessness, 1996

	Percent
Insufficient income	30
Lack of job	24
No suitable housing	11
Addiction to alcohol or drugs	9
Other	24

Percentages may not sum to 100 due to rounding.

Source: Interagency Council on the Homeless, U.S. Department of Housing and Urban Development, *Homelessness: Programs and the People They Serve* (1999).

Table 17. Substance Use Experiences by Homeless Status, 1996

	Currently homeless (%) (N=2,938)	Formerly homeless clients (%) (N=677)	Other service users (%) (N=518)
Started drinking three or more alcoholic beverages a week:			
Before age 15	36	29	13
Between ages 15 and 17	29	28	33
Started using illegal drugs:			
Before age 15	31	28	27
Between ages 15 and 17	32	21	22

Source: Interagency Council on the Homeless, U.S. Department of Housing and Urban Development, *Homelessness: Programs and the People They Serve* (1999).

DRUG USE CONSEQUENCES

Table 18. Estimated Costs to Society of Drug Abuse, 1992–2000 (\$ Millions)

Year	Health care costs	Productivity losses	Other costs	Total
1992	10,820	69,421	21,912	102,154
1993	11,114	77,972	22,410	111,496
1994	11,279	82,685	24,440	118,404
1995	11,305	88,085	27,120	126,510
1996	11,428	92,423	27,444	131,295
1997	12,085	94,470	30,526	137,082
1998	12,862	98,467	32,083	143,411
1999 ¹	13,860	104,353	34,295	152,508
2000 ¹	14,899	110,491	35,274	160,664

¹Figures for 1999 and 2000 are projections based on observable trends for 1992 through 1998.

Source: Office of National Drug Control Policy. *The Economic Costs of Drug Abuse in the United States, 1992-2000* (September 2001).

Table 19. Estimated Productivity Losses Due to Drug Abuse, 1992–2000 (\$ Millions)

Year	Premature death	Drug abuse related illness	Institutionalization/hospitalization	Productivity loss of victims of crime	Incarceration	Crime careers	Total
1992	14,575	14,205	1,477	2,059	17,907	19,198	69,421
1993	21,095	13,766	1,502	2,488	19,366	19,755	77,972
1994	21,905	15,845	1,683	2,554	21,095	19,603	82,685
1995	22,943	17,737	1,872	2,377	22,983	20,172	88,085
1996	19,697	20,270	1,533	2,332	24,833	23,758	92,423
1997	16,771	19,916	1,662	2,293	27,221	26,608	94,470
1998	16,611	23,143	1,786	2,165	30,133	24,627	98,467
1999 ¹	17,439	24,298	1,849	2,118	32,793	25,856	104,353
2000 ¹	18,256	25,435	1,915	2,217	35,601	27,066	110,491

¹Figures for 1999 and 2000 are projections based on observable trends for 1992–1998.

Source: Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States, 1992–1998* (September 2001).

Table 20. Number of Deaths and Death Rates from Drug-Induced Causes,¹ by Sex and Race: U.S., 1979–1999²

Year	Both sexes	Male	Female	White	All non-white	Black ³
Number						
1979	7,101	3,656	3,445	6,116	985	897
1980	6,900	3,771	3,129	5,814	1,086	1,006
1981	7,106	3,835	3,271	5,863	1,243	1,152
1982	7,310	4,130	3,180	5,991	1,319	1,212
1983	7,492	4,145	3,347	6,187	1,305	1,194
1984	7,892	4,640	3,252	6,309	1,583	1,480
1985	8,663	5,342	3,321	6,946	1,717	1,600
1986	9,976	6,284	3,692	7,948	2,028	1,906
1987	9,796	6,146	3,650	7,547	2,249	2,101
1988	10,917	7,004	3,913	8,409	2,508	2,395
1989	10,710	6,895	3,815	8,336	2,374	2,236
1990	9,463	5,897	3,566	7,603	1,860	1,703
1991	10,388	6,593	3,795	8,204	2,184	2,037
1992	11,703	7,766	3,937	9,360	2,343	2,148
1993	13,275	9,052	4,223	10,394	2,881	2,688
1994	13,923	9,491	4,432	10,895	3,028	2,780
1995	14,218	9,909	4,309	11,173	3,045	2,800
1996	14,843	10,093	4,750	11,903	2,940	2,682
1997	15,973	10,991	4,982	12,863	3,110	2,816
1998	16,926	11,462	5,464	13,811	3,115	2,831
1998 ICD-10	20,227	13,697	6,529	16,504	3,722	3,383
1999 ICD-10	19,102	12,873	6,229	15,694	3,408	3,094
Rate per 100,000 population						
1979	3.2	3.4	3.0	3.2	3.2	3.4
1980	3.0	3.4	2.7	3.0	3.4	3.8
1981	3.1	3.4	2.8	3.0	3.8	4.2
1982	3.2	3.7	2.7	3.0	3.9	4.4
1983	3.2	3.6	2.8	3.1	3.8	4.3
1984	3.3	4.0	2.7	3.1	4.5	5.2
1985	3.6	4.6	2.7	3.4	4.8	5.6
1986	4.2	5.4	3.0	3.9	5.5	6.6
1987	4.0	5.2	2.9	3.7	6.0	7.2
1988	4.5	5.9	3.1	4.1	6.5	8.1
1989	4.3	5.7	3.0	4.0	6.0	7.4
1990	3.8	4.9	2.8	3.6	4.6	5.6
1991	4.1	5.4	2.9	3.9	5.3	6.5
1992	4.6	6.2	3.0	4.4	5.6	6.8
1993	5.1	7.2	3.2	4.8	6.7	8.4
1994	5.3	7.5	3.3	5.0	6.9	8.5
1995	5.4	7.7	3.2	5.1	6.8	8.4
1996	5.6	7.8	3.5	5.4	6.5	8.0
1997	6.0	8.4	3.6	5.8	6.7	8.3
1998	6.3	8.7	4.0	6.2	6.6	8.2
1998 ICD-10	7.5	10.4	4.8	7.4	7.9	9.8
1999 ICD-10	7.0	9.7	4.5	7.0	7.1	8.9

¹Causes of death attributable to drug-induced mortality under ICD-9 include drug psychoses (292); drug dependence (304); nondependent use of drugs not including alcohol and tobacco (305.2–305.9); accidental poisoning by drugs, medicaments, and biologicals (E850–E858); suicide by drugs, medicaments, and biologicals (E950.0–E950.5); assault on poisoning by drugs and medicaments (E962.0); and poisoning by drugs, medicaments, and biologicals, undetermined whether accidentally or purposely inflicted (E980.0–E980.5). Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mothers' drug use.

²In 1999, cause of death coding was revised to ICD-10. Modified figures for 1998 were calculated based on comparability ratios for drug-induced deaths according to ICD-9 and ICD-10. The new coding scheme yields 19.5 percent more drug-induced deaths compared to the old system using 1998 data. The implementation of ICD-10 represents a break in the trend data.

³Black is a subgroup of All non-white.

Sources: Murphy, S.L., "Deaths: Final Data for 1998," *National Vital Statistics Reports*, 48 (11) Hyattsville, MD: Centers for Disease Control and Prevention/National Center for Health Statistics (2000) for 1979–1998 ICD-9 data; and Hoyert, D.L., Arias, E., Smith, B.L., et al., "Deaths: Final Data for 1999," *National Vital Statistics Reports*, 49 (8), Hyattsville, MD: Centers for Disease Control and Prevention/National Center for Health Statistics (2001) for 1998–1999 ICD-10 data.

Table 21. Trends in Drug-Related Emergency Room Episodes and Selected Drug Mentions, 1988–2000

Year	Emergency room episodes and drug mentions				
	Total drug episodes	Total drug mentions	Total cocaine mentions	Total heroin mentions	Total marijuana mentions
1988	403,578	668,153	101,578	38,063	19,962
1989	425,904	713,392	110,013	41,656	20,703
1990	371,208	635,460	80,355	33,884	15,706
1991	393,968	674,861	101,189	35,898	16,251
1992	433,493	751,731	119,843	48,003	23,997
1993	460,910	796,762	123,423	63,232	28,873
1994	518,521	900,317	142,878	64,013	40,183
1995	513,633	901,206	135,801	70,838	45,271
1996	514,347	907,561	152,433	73,846	53,789
1997	527,058	943,937	161,087	72,010	64,744
1998	542,544	982,856	172,014	77,645	76,870
1999	554,932	1,015,206	168,763	84,409	87,150
2000	601,776	1,100,539	174,896	97,287	96,446

Source: *Drug Abuse Warning Network*, National Institute on Drug Abuse (1988–1991) and Substance Abuse and Mental Health Services Administration (1992–2000).

Table 22. Estimated Number of Persons Living With AIDS¹ by Sex and Exposure Category, 1993–1999

Sex	Exposure Category							Total	Percent drug-related ³
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemophilia/coagulation disorder	Heterosexual contact	Receipt of blood transfusion ²	Risk not reported or identified		
Male adult/adolescent									
1993	86,443	34,400	13,854	1,620	6,109	893	989	144,309	33.4%
1994	94,694	40,046	14,884	1,699	7,903	914	940	161,081	34.1%
1995	100,938	44,345	15,687	1,729	9,760	963	937	174,361	34.4%
1996	110,272	46,763	16,453	1,740	12,174	1,035	974	191,410	34.0%
1997	121,991	53,812	17,698	1,788	14,907	1,140	1,023	212,248	33.6%
1998	132,441	58,118	18,682	1,825	17,627	1,253	1,080	231,022	33.2%
1999	143,108	62,418	19,553	1,853	20,495	1,375	1,151	249,951	32.7%
Female adult/adolescent									
1993	N/A	13,844	N/A	92	11,822	755	373	26,886	51.4%
1994	N/A	16,244	N/A	108	15,131	843	376	32,702	49.6%
1995	N/A	18,352	N/A	137	18,478	888	379	38,234	47.9%
1996	N/A	20,357	N/A	164	22,566	980	416	44,484	45.7%
1997	N/A	22,661	N/A	201	26,974	1,088	483	51,396	44.0%
1998	N/A	24,457	N/A	229	31,187	1,203	504	57,578	42.4%
1999	N/A	26,122	N/A	248	35,445	1,318	548	63,682	41.0%

N/A Not applicable.

¹Excludes pediatric (<13 years old) AIDS cases. These numbers do not represent actual cases of persons living with AIDS. Rather, they are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases are adjusted for reporting delays and for redistribution of cases initially reported with no identified risk but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available.

²Includes receipt of blood components or tissue.

³Proportion includes injection drug users and MSM who are injection drug users.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, 2000*; 12 (2) 2001, Table 27.

Table 23. Estimated Number of Deaths of Persons with AIDS¹ by Sex and Exposure Category, 1993–1999

Sex	Exposure Category							Total	Percent drug-related ³
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemophilia/coagulation disorder	Heterosexual contact	Receipt of blood transfusion ²	Risk not reported or identified		
Male adult/adolescent									
1993	23,904	9,298	3,184	356	1,591	314	170	38,818	32.1%
1994	25,398	10,387	3,503	348	2,010	307	147	42,100	33.0%
1995	24,914	10,786	3,436	331	2,388	262	102	42,220	33.6%
1996	16,847	8,527	2,585	248	2,108	216	68	30,601	36.3%
1997	8,695	5,369	1,445	137	1,473	107	45	17,271	39.4%
1998	6,983	4,416	1,242	115	1,214	83	29	14,081	40.1%
1999	6,069	4,041	1,124	98	1,230	70	27	12,660	40.7%
Female adult/adolescent									
1993	N/A	3,124	N/A	17	2,656	239	76	6,132	51.2%
1994	N/A	3,600	N/A	27	3,478	225	56	7,486	48.1%
1995	N/A	3,812	N/A	30	3,988	234	56	8,119	46.9%
1996	N/A	3,279	N/A	30	3,434	174	33	6,950	47.1%
1997	N/A	2,146	N/A	21	2,301	94	20	4,582	46.8%
1998	N/A	1,891	N/A	15	2,008	74	15	4,004	47.2%
1999	N/A	1,891	N/A	16	1,989	73	19	3,989	47.4%

N/A Not applicable.

¹Excludes pediatric (<13 years old) AIDS cases. These numbers do not represent actual deaths of persons with AIDS. Rather, they are point estimates adjusted for delays in the reporting of deaths and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available.

²Includes receipt of blood components or tissue.

³Proportion includes injection drug users and MSM who are injection drug users.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, 2000*, 12 (2) 2001, Table 30.

Table 24. Reported Tuberculosis Cases and Percent of Cases in Injecting and Noninjecting Drug Users, 1996–2000

Tuberculosis Cases	1996	1997	1998	1999	2000
Total	21,337	19,851	18,361	17,531	16,377
Number with information on injecting drug use	18,467	17,678	16,849	16,331	15,495
Percent with information on injecting drug use	86.5	89.1	91.8	93.2	94.6
Injecting drug users (%) ¹	3.8	3.3	2.9	2.6	2.5
With information on noninjecting drug use (number)	18,265	17,555	16,730	16,232	15,454
Percent with information on noninjecting drug use	85.6	88.4	91.1	92.6	94.4
Noninjecting drug users (%) ¹	7.7	7.8	7.7	7.1	7.5

¹Injecting drug use within past 12 months. Percentages shown only for reporting areas with information reported for ≥ 75% of cases.

Source: Centers for Disease Control and Prevention, *Reported Tuberculosis in the United States, 1996, 1997, 1998, 1999, and 2000*.

Table 25. Reported Hepatitis Cases, 1995–1999

	1995	1996	1997	1998	1999
Number of reported cases					
Hepatitis A	31,582	31,032	30,021	23,229	17,047
Hepatitis B	10,805	10,637	10,416	10,258	7,694
Hepatitis C	4,576	3,716	3,816	3,518	3,111
Reported cases per 100,000 Population					
Hepatitis A	12.13	11.70	11.22	8.59	6.25
Hepatitis B	4.19	4.01	3.90	3.80	2.82
Hepatitis C	1.78	1.41	1.43	1.30	1.14

Source: Centers for Disease Control and Prevention. Summary of Notifiable Diseases, United States, 1999. *Morbidity and Mortality Weekly Report* 48 (53), 2001.

Table 26. Total Crime, Violent Crime, and Property Crime, 1989–2000

Year	Total crime index		Violent crime index ¹		Murder victims		Property crime ²	
	Number ³	Rate ⁴	Number ³	Rate ⁴	Total ³	Related to narcotic drug laws ³	Number ³	Rate ⁴
1989	14,251,400	5,741.0	1,646,040	663.1	21,500	1,402	12,605,400	5,077.9
1990	14,475,613	5,820.3	1,820,127	731.8	23,438	1,367	12,655,486	5,088.5
1991	14,872,883	5,897.8	1,911,767	758.1	24,703	1,353	12,961,116	5,139.7
1992	14,438,191	5,660.2	1,932,274	757.5	23,760	1,302	12,505,917	4,902.7
1993	14,144,794	5,484.4	1,926,017	746.8	24,526	1,295	12,218,777	4,737.6
1994	13,989,543	5,373.5	1,857,670	713.6	23,326	1,239	12,131,873	4,660.0
1995	13,862,727	5,275.9	1,798,792	684.6	21,606	1,031	12,063,935	4,591.3
1996	13,493,863	5,086.6	1,688,540	636.5	19,645	843	11,805,323	4,450.1
1997	13,194,751	4,930.0	1,636,096	611.3	18,209	786	11,558,475	4,318.7
1998	12,485,714	4,619.3	1,533,887	567.5	16,914	679	10,951,827	4,051.8
1999	11,635,378	4,266.5	1,426,044	523.0	15,522	581	10,208,334	3,743.6
2000	11,605,751	4,124.0	1,424,289	506.1	15,517	669	10,181,462	3,617.9

¹Violent crime includes the following four offenses: murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault.

²Property crime includes the following offenses: burglary, larceny-theft, motor vehicle theft, and arson.

³Offenses reported to law-enforcement agencies.

⁴Per 100,000 population.

Source: Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States: Uniform Crime Reports* (1990–2001).

Table 27. Total Estimated Arrests and Drug Arrests, 1989–2000

Year	Total arrests ¹	Arrests for all drug abuse violations		Distribution of arrests for drug abuse violations ²					
				Heroin/cocaine ³		Marijuana		Other drugs	
		Number	Percent	Sale ⁴	Possession	Sale ⁴	Possession	Sale ⁴	Possession
1989	14,340,900	1,361,700	9.4	19.1	34.7	6.2	23.1	7.0	9.8
1990	14,195,100	1,089,500	7.6	21.0	33.3	6.1	23.9	4.5	11.2
1991	14,211,900	1,010,000	7.1	22.5	32.8	6.1	22.4	4.8	11.5
1992	14,075,100	1,066,400	7.5	20.6	32.4	6.6	25.5	4.6	10.4
1993	14,036,300	1,126,300	8.0	19.2	31.1	6.2	27.6	4.3	11.6
1994	14,648,700	1,351,400	9.2	16.8	30.3	5.8	29.8	4.1	13.2
1995	15,119,800	1,476,100	9.7	14.7	27.8	5.8	34.1	4.4	13.3
1996	15,168,100	1,506,200	9.9	14.2	25.6	6.3	36.3	4.3	13.3
1997	15,284,300	1,583,600	10.3	10.3	25.4	5.6	38.3	4.7	15.8
1998	14,528,300	1,559,100	10.7	11.0	25.6	5.4	38.4	4.8	14.8
1999	14,031,070	1,532,200	10.9	10.0	24.5	5.5	40.5	4.1	15.4
2000	13,980,297	1,579,566	10.9	19.0	24.2	5.6	40.9	3.0	13.6

¹Arrest totals are based on all reporting agencies and estimates for unreported areas from Section IV table entitled "Total Estimated Arrests, United States."

²Percentages may not add to 100 because of rounding.

³Includes heroin or cocaine and their derivatives.

⁴Includes sale/manufacture of drugs.

Source: Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States: Uniform Crime Reports*, (1990–2001).

Table 28. Adult Drug Offenders in Custody of State or Federal Prisons, 1989–2000

Year	All Offenders			Prisoners who are drug offenders (%)		Estimated ¹ number of drug offenders		
	State	Federal	Total State and Federal	Federal	State	State	Federal	State and Federal
1989	629,995	53,387	683,382	49.9	19.1	120,300	26,600	147,000
1990	684,544	58,838	743,382	53.5	21.7	148,500	31,500	180,000
1991	728,605	63,930	792,535	55.9	21.3	155,200	35,700	190,900
1992	778,495	72,071	850,566	58.9	22.1	172,000	42,500	214,500
1993	828,566	80,815	909,381	59.2	22.1	183,100	47,800	230,900
1994	904,647	85,500	990,147	60.5	22.4	202,600	51,700	254,300
1995	989,004	89,538	1,078,542	59.9	22.7	224,500	53,600	278,100
1996	1,032,440	95,088	1,127,528	60.0	22.7	234,400	57,100	291,500
1997	1,059,588	99,175	1,176,922	62.6	20.7	219,300	62,100	281,400
1998 ²	1,178,978	123,041	1,232,900	58.7	20.7	244,000	72,200	316,200
1999	1,209,123	135,246	1,366,369	61.0	21.0	253,900	82,500	336,400
2000	1,236,476	145,416	1,381,892	—	—	—	—	—

— Data not available.

¹Estimated from total prisoners and percent who are drug offenders and rounded to the nearest 100.

²The 1998 prison custody count was estimated and rounded to nearest 100.

Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 2000* (August 2001); *Prisoners in 1999* (August 2000), *Prisoners in 1998* (August 1999), *Prisoners in 1997* (August 1998). *Correctional Populations in the United States, 1989–1995*; Data for 1997 percentages of drug offenders are estimated from Bureau of Justice Statistics Special Report, *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (January 1999) and unpublished Bureau of Prisons data.

DRUG TREATMENT

Table 29. One-Day Census of Clients in Treatment, by Facility Ownership, 1980–2000

Year	Private for-profit	Private nonprofit	State/local government	Federal government	Tribal government	Other	Total
1980	17,977	284,483	150,356	25,977	n/c	n/c	478,793
1982	25,072	274,927	132,525	30,888	n/c	n/c	463,412
1984	60,191	395,831	164,232	45,595	n/c	4,430	670,279
1987	71,837	362,340	152,643	26,565	n/c	n/c	613,385
1989	94,251	441,247	174,649	24,808	n/c	n/c	734,955
1990	113,522	451,951	172,290	27,025	3,041	n/c	767,829
1991	124,952	463,024	194,842	25,920	3,081	n/c	811,819
1992	166,470	536,628	192,594	37,146	10,328	n/c	943,166
1993	169,470	534,725	192,038	41,511	6,712	n/c	944,208
1995	179,337	575,002	198,579	46,861	9,348	n/c	1,009,127
1996	195,159	529,276	163,861	42,548	9,297	n/c	940,141
1997	168,106	510,680	191,693	48,683	9,646	n/c	929,086
1998	252,369	556,191	178,545	41,627	9,646	n/c	1,038,378
2000	242,922	550,541	151,790	40,365	12,082	n/c	997,700

n/c: Not collected.

Notes: Changes in data collection methods include: Before 1992, no attempt was made to adjust for survey nonresponse. Beginning in 1992, survey nonrespondents were contacted to obtain a minimum data set. This is reflected in larger and more consistent numbers of clients.

Sources: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *National Drug and Alcoholism Treatment Unit Survey* (NDATUS) (1980–1993); *Uniform Facility Data Set Survey* (UFDS) (1995–1998); *National Survey of Substance Abuse Treatment Services* (N-SSATS) (2000).

Table 30. One-Day Census of Clients in Alcohol and/or Drug Abuse Treatment, by Age Group and by Type of Care, 1987–2000¹

Year	Hospital inpatient/residential			Outpatient			All clients
	Under 18	18 or older	Total ²	Under 18	18 or older	Total ²	
1987	8,479	76,873	89,686	51,311	443,516	523,699	613,385
1989	8,138	87,417	104,603	61,274	521,524	630,352	734,955
1990	7,587	81,790	93,888	37,998	585,275	673,835	767,723
1991	7,137	85,821	99,150	36,561	608,852	712,669	811,819
1992	10,374	111,723	122,097	42,812	779,970	822,782	944,880
1993	10,463	110,602	121,065	49,357	773,715	823,072	944,137
1995	12,841	132,001	144,842	57,209	807,076	864,285	1,009,127
1996	11,376	103,589	114,965	65,311	759,865	825,176	940,141
1997	10,800	109,330	120,130	70,656	738,300	808,956	929,086
1998	13,842	108,738	122,580	86,480	829,318	915,798	1,038,378
2000	10,428	98,668	109,096	74,315	814,289	888,604	997,700

¹The following changes in data collection methods are reflected in the table: Before 1992, no attempt was made to adjust for survey nonresponse. Beginning in 1992, survey nonrespondents were contacted to obtain a minimum data set. This is reflected in larger and more consistent numbers of clients. Also, in 1997 only, facilities providing programs for DUI/DWI offenders did not complete the full survey, and did not provide client counts.

²Totals include persons of unknown age.

Sources: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *National Drug and Alcoholism Treatment Unit Survey (NDATUS)* (1987–1993); *Uniform Facility Data Set Survey (UFDS)*, 1995–1998; *National Survey of Substance Abuse Treatment Services (N-SSATS)*, 2000.

Table 31. Estimated Number of Persons Age 12 or Older Who Needed and Received Treatment for an Illicit Drug Problem in the Past Year, by Demographic Characteristics, 2000 (Thousands)

Demographic characteristics	Needed treatment for an illicit drug problem in the past year			Received treatment at a specialty facility among persons who needed treatment (%)
	Total	Received treatment at a specialty facility	Did not receive treatment at a specialty facility	
Totals	4,655	774	3,881	16.6
Age				
12–17	1,074	122	951	11.4
18–25	1,645	142	1,503	8.6
26 and older	1,937	510	1,427	26.3
Sex				
Male	2,749	411	2,337	15.0
Female	1,907	363	1,544	19.0
Hispanic origin/race				
Not Hispanic:				
White Only	3,235	577	2,659	17.8
Black	632	118	514	*
American Indian/or Alaska Native only	46	4	42	*
Native Hawaiian or other Pacific Islander	10	3	7	*
Asian only	54	1	54	*
More than one race	103	21	82	*
Hispanic	574	51	523	9.0

*Low precision; no estimate reported.

Notes: Respondents were classified as needing treatment for an illicit drug problem if they met at least one of three criteria during the past year: (1) dependence on any illicit drug; (2) abuse of any illicit drug; or (3) received treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and prescription-type psychotherapeutic (nonmedical use).

Source: U.S. Department of Health and Human Services, *Closing the Drug Abuse Treatment Gap: A Report to the President of the United States* (September 2001).

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Table 32. Trends in Cocaine Supply, 1989–2000 (Metric Tons)

Year	Cocaine HCl available for export from producing countries	Cocaine destined for the United States	Cocaine shipped to the United States	Cocaine available for consumption in the United States	Retail value of cocaine in the United States (2000 \$, billions)
1989	709–842	603–716	547–660	432–545	\$88.4
1990	714–851	595–709	509–624	413–528	\$69.9
1991	777–931	635–760	539–664	412–532	\$57.1
1992	834–972	667–778	583–694	437–555	\$49.9
1993	581–692	455–542	375–462	364–463	\$45.0
1994	558–670	428–513	371–456	258–345	\$42.8
1995	616–738	462–553	421–513	287–376	\$40.0
1996	608	455	385	301	\$39.2
1997	560	444	340	275	\$34.7
1998	521	434	341	267	\$34.9
1999	518	431	335	271	\$35.6
2000	501	402	318	259	\$35.3 ¹

Notes: Data in the first four columns for 1985–1995 represent ranges estimated by the U.S. Department of State. Data for 1996–2000 are point estimates derived from ONDCP's *Sequential Transition and Reduction (STAR) Model*.

¹Retail value for 2000 is projected.

Sources: U.S. Department of State, *International Narcotics Control Strategy Report* (various years); Office of National Drug Control Policy, *Estimation of Cocaine Availability, 1996–2000* (in press); and Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000* (in press).

Table 33. Average Price and Purity of Cocaine and Heroin in the United States, 1981–2000

Year	Cocaine				Heroin			
	Purchases of 1 gram or less ¹		Purchases of 10–100 pure grams ²		Purchases of 0.1 gram or less ¹		Purchases of 1–10 pure grams ²	
	Price per pure gram (\$)	Purity (%)	Price per pure gram (\$)	Purity (%)	Price per pure gram (\$)	Purity (%)	Price per pure gram (\$)	Purity (%)
1981	423	36	201	44	3,295	4	1,207	19
1982	433	36	184	46	3,285	5	1,159	32
1983	399	39	178	50	3,652	6	1,310	29
1984	378	44	153	55	3,485	8	1,293	36
1985	328	40	145	52	3,146	8	1,183	43
1986	315	51	127	64	3,502	9	1,153	37
1987	292	64	104	71	3,306	11	1,164	36
1988	238	75	80	73	3,123	17	960	40
1989	226	78	68	71	2,597	19	790	44
1990	267	69	77	59	2,924	16	878	32
1991	227	78	69	70	3,022	17	872	32
1992	224	76	65	74	2,863	21	687	39
1993	199	74	63	71	2,635	25	536	50
1994	187	73	57	74	2,721	25	433	47
1995	196	67	56	69	2,652	24	384	51
1996	175	72	51	70	2,424	23	378	45
1997	195	65	52	66	2,373	28	336	45
1998	183	68	47	68	2,087	25	331	49
1999	184	64	49	63	1,929	27	304	45
2000 ³	212	61	51	58	2,088	25	269	47

¹Quantities purchased at the “retail” level.²Quantities purchased at the “dealer” level.³2000 data are preliminary, based on first two quarters of data.Source: Office of National Drug Control Policy, *The Price of Illicit Drugs, 1981-2000* (in press).

Table 34. Federal-wide Cocaine, Heroin, Methamphetamine, and Cannabis Seizures, 1989–2001 (Kilograms)

Year	Cocaine	Heroin	Methamphetamine	Cannabis	
				Marijuana	Hashish
1989	114,903	1,311	—	393,276	23,043
1990	96,085	687	—	233,478	7,683
1991	128,247	1,448	—	224,603	79,110
1992	120,175	1,251	—	344,899	111
1993	121,215	1,502	7	409,922	11,396
1994	129,378	1,285	178	474,856	561
1995	111,031	1,543	369	627,776	14,470
1996	128,555	1,362	136	638,863	37,851
1997	101,495	1,624	1,099	698,799	756
1998	132,063	1,151	2,779	1,092,604	797
1999	103,975	1,605	3,341	1,234,853	10,878
2000	56,004	581	1,756	645,693	—
2001 ¹	86,620	1,660	1,941	1,057,456	135

— Data not available.

¹Figures for 2001 are for January through September only.Source: *Federal-wide Drug Seizure System*, Drug Enforcement Administration, 1989–2001.**Table 35. Eradicated Domestic Cannabis by Plant Type, 1982–2001 (Plants in Thousands)**

	Cultivated Plants Outdoors ¹	Ditchweed	Indoor Plants	Total Plants Eradicated
1982	2.590	—	—	2.590
1983	3.794	—	—	3.794
1984	3.803	9.178	—	12.981
1985	3.961	35.270	—	39.231
1986	4.673	125.013	—	129.686
1987	7.433	105.842	—	113.275
1988	5.344	101.932	—	107.329
1989	5.636	124.289	—	129.925
1990	7.329	118.548	—	125.877
1991	5.257	133.786	283	139.326
1992	7.490	264.207	349	272.046
1993	4.049	387.942	290	392.281
1994	4.032	504.414	220	508.665
1995	3.054	370.275	243	373.572
1996	2.843	419.662	217	422.723
1997	3.827	237.140	224	241.193
1998	2.283	132.407	233	134.924
1999	3.205	130.192	208	133.605
2000	2.598	139.581	217	142.396
2001 ²	2.933	544.221	204	547.358

— Data not available.

Note: Federal data only.

¹May include tending ditchweed.²Through third quarter 2001 only.

Source: Drug Enforcement Administration, 1982–2001.

Table 36. Estimated Worldwide Potential Net Production of Opium, 1987–2000 (Metric Tons)

Year	Afghanistan	India	Iran ¹	Pakistan	Total Southwest Asia	Burma	China	Laos	Thailand	Vietnam	Total Southeast Asia	Colombia	Lebanon ²	Guatemala	Mexico	Subtotal	Total All Regions
1987	600	—	300	205	1,105	835	—	225	24	—	1,084	—	—	3	50	53	2,242
1988	750	—	—	205	955	1,280	—	255	25	—	1,560	—	—	8	67	75	2,590
1989	585	—	—	130	715	2,430	—	380	50	—	2,860	—	45	12	66	123	3,698
1990	415	—	—	165	580	2,255	—	275	40	—	2,570	—	32	13	62	107	3,257
1991	570	—	—	180	750	2,350	—	265	35	—	2,650	—	34	11	41	86	3,486
1992	640	—	—	175	815	2,280	—	230	24	—	2,534	—	—	—	40	40	3,389
1993	685	—	—	140	825	2,575	—	180	42	—	2,797	—	4	—	49	53	3,675
1994	950	90	—	160	1,200	2,030	25	85	17	—	2,157	—	—	—	60	60	3,417
1995	1,250	77	—	155	1,482	2,340	19	180	25	—	2,564	65	1	—	53	119	4,165
1996	2,174	47	—	75	2,296	2,560	—	200	30	25	2,815	63	1	—	54	118	4,285
1997	2,184	30	—	85	2,299	2,365	—	210	25	45	2,645	66	—	—	46	112	5,056
1998	2,340	—	—	66	2,406	1,750	—	140	16	20	1,926	61	—	—	60	121	4,453
1999	2,861	—	—	37	2,898	1,090	—	140	6	11	1,247	75	—	—	43	118	4,263
2000	3,656	—	—	11	3,667	1,085	—	210	6	15	1,316	—	—	—	21	21	5,004

— Data not available.

¹Although there is no solid information on Iranian opium production, the U.S. Government estimates that Iran potentially may produce between 35 and 75 metric tons of opium gum annually.

²There was no information for 1992 production. For 1994, a vigorous eradication campaign reduced potential production to insignificant levels.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report (1988–2001)*.

Table 37. Estimated Worldwide Potential Net Production of Cannabis, 1987–2000 (Metric Tons)

Year	Mexico ¹	Colombia	Jamaica	Belize	Other	Total
1987	5,933	5,600	460	200	1,500	13,693
1988	5,655	7,775	405	120	3,500	17,445
1989	30,200	2,800	190	65	3,500	36,775
1990	19,715	1,500	825	60	3,500	25,600
1991	7,775	1,650	641	49	3,500	13,615
1992	7,795	1,650	263	—	3,500	13,208
1993	6,280	4,125	502	—	3,500	14,407
1994	5,540	4,138	208	—	3,500	13,386
1995	12,400	4,133	206	—	3,500	20,239
1996	11,700	4,133	356	—	3,500	19,689
1997	8,600	4,133	214	—	3,500	16,447
1998	8,300	4,000	—	—	3,500	15,800
1999	3,700	4,000	—	—	3,500	11,200
2000	7,000	4,000	—	—	3,500	14,500

— Data not available.

¹Cannabis yield figures updated in November 1999, based on information provided by the Mexican Attorney General's Office.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001).

Table 38. Estimated Worldwide Potential Net Production of Coca Leaf, 1987–2000 (Metric Tons)

Year	Bolivia	Colombia ¹	Peru	Ecuador	Total
1987	79,200	20,500	191,000	400	291,100
1988	79,500	27,200	187,700	400	294,800
1989	78,200	33,900	186,300	270	298,670
1990	77,000	32,100	196,900	170	306,170
1991	78,000	30,000	222,700	40	330,740
1992	80,300	29,600	223,900	100	333,900
1993	84,400	31,700	155,500	100	271,700
1994	89,800	35,800	165,300	—	290,900
1995	85,000	229,300	183,600	—	497,900
1996	75,100	302,900	174,700	—	552,700
1997	70,100	347,000	130,200	—	547,300
1998	52,900	437,600	95,600	—	586,100
1999	22,800	521,400	69,200	—	613,400
2000	13,400	583,000	54,400	—	650,800

— Data not available.

¹Coca and cocaine yield figures for 1995–1999 were revised upward in 1999, based on United States Government studies. See Methodology section of INCSR 2001 for details.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001).

Table 39. Domestic Drug Consumption, Calendar Years 1996–2000 (Metric Tons)

Year	Cocaine	Heroin	Marijuana	Methamphetamine
1988	660	15	894	23
1989	576	17	866	19
1990	447	14	837	16
1991	355	12	793	10
1992	346	12	761	14
1993	331	11	791	19
1994	323	11	874	34
1995	321	12	848	54
1996	301	13	874	54
1997	275	12	960	35
1998	267	14	952	27
1999	271	14	1,028	18
2000 ¹	259	13	1,047	20

¹Estimated.

Source: Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000* (in press).

Table 40. Trends in Heroin Supply, 1996–2000 (Metric Tons)

Year	Heroin availability prior to border entry	Heroin availability after border entry	Heroin available for consumption in the United States	Retail value of heroin in the United States (1998 dollars, billions)
1996	13.3	12.7	12.4	\$12.75
1997	14.2	13.3	13.1	\$11.44
1998	13.5	12.8	12.5	\$11.12
1999 ¹	13.7	13.1	12.9	\$10.08
2000 ¹	13.7	13.0	12.9	\$10.04

¹Retail values for 1999 and 2000 are projected.

Sources: Office of National Drug Control Policy, *Estimating Heroin Availability* (2000). Retail value data are from Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000*, (in press).

Table 41. Amount of Coca Leaf Cultivated and Eradicated, Calendar Years 1987–2000 (Hectares)

Year	Cultivated			Eradicated		
	Bolivia	Colombia	Peru	Bolivia	Colombia	Peru
1987	41,400	22,960	109,155	1,040	460	355
1988	50,400	34,230	115,530	1,475	230	5,130
1989	55,400	43,400	121,685	2,500	640	1,285
1990	58,400	41,000	121,300	8,100	900	—
1991	53,386	38,472	120,800	5,486	972	—
1992	48,652	38,059	129,100	3,152	959	—
1993	49,597	40,493	108,800	2,397	793	—
1994	49,158	49,610	108,600	1,058	4,910	—
1995	54,093	59,650	115,300	5,493	8,750	—
1996	55,612	72,800	95,659	7,512	5,600	1,259
1997	52,826	98,500	72,262	7,026	19,000	3,462
1998	49,621	—	58,825	11,621	—	7,825
1999	38,779	—	52,500	16,999	43,246	13,800
2000	22,253	183,200	40,200	7,653	47,000	6,200

— Data not available.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001). Data for 1992–2000 are from the March 2001 report.**Table 42. Amount of Opium Poppy Cultivated and Eradicated, Calendar Years 1990–2000 (Hectares)**

Year	Afghanistan	Pakistan	Burma	Laos	Thailand	Colombia	Guatemala	Mexico ¹
Cultivated								
1990	12,370	8,405	150,100	30,580	3,435	—	1,930	10,100
1991	17,190	8,645	160,000	29,625	3,000	2,316	1,721	10,130
1992	19,470	9,147	154,915	25,610	3,630	32,858	1,200	10,170
1993	21,080	7,136	166,404	26,040	2,880	29,821	864	11,780
1994	29,180	7,733	149,945	18,520	2,110	23,906	200	12,415
1995	38,740	6,950	154,070	19,650	2,330	10,300	125	13,500
1996	37,950	4,267	163,100	25,250	3,050	12,328	12	13,000
1997	39,150	4,754	165,651	28,150	2,700	13,572	10	12,000
1998	41,720	5,224	146,494	—	2,065	—	15	15,000
1999	51,500	2,767	99,300	—	1,643	—	1	11,500
2000	64,510	2,219	108,700	—	1,647	—	1	9,500
Eradicated								
1990	—	185	—	0	720	—	1,085	4,650
1991	—	440	1,012	0	1,200	1,156	576	6,545
1992	—	977	1,215	0	1,580	12,858	470	11,583
1993	—	856	604	0	0	9,821	426	13,015
1994	—	463	3,345	0	0	3,906	150	11,036
1995	—	0	0	0	580	3,760	86	15,389
1996	—	867	0	0	880	6,028	12	14,671
1997	—	654	10,501	0	1,050	6,972	3	17,732
1998	—	2,194	16,194	—	715	—	12	17,449
1999	—	1,197	9,800	—	808	—	1	15,469
2000	—	1,704	0	—	757	9,254	1	15,300

— Data not available.

¹The eradication figures shown for 1992–2000 are derived from data supplied by Mexican authorities to INCSR. The effective eradication figure is an estimate of the actual amount of crop destroyed—factoring in replanting, repeated spraying of one area, and other factors.Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001). Data for 1992–2000 are from the March 2001 report.

Table 43. Amount of Cannabis Cultivated and Eradicated by Foreign Countries, Calendar Years 1990–2000 (Hectares)

Year	Cultivated			Eradicated		
	Mexico	Jamaica	Colombia	Mexico ¹	Jamaica	Colombia
1990	—	2,250	2,000	6,750	1,030	500
1991	—	1,783	2,000	10,795	833	0
1992	28,520	1,200	2,049	16,872	811	49
1993	21,190	1,200	5,050	16,645	456	50
1994	19,045	1,000	5,000	14,227	692	14
1995	18,650	1,000	5,000	21,573	695	20
1996	18,700	1,000	5,000	22,961	473	—
1997	15,300	1,060	5,000	23,576	743	—
1998	14,100	—	5,000	23,928	705	—
1999	23,100	—	5,000	33,583	894	—
2000	16,900	—	5,000	33,000	517	—

— Data not available.

¹The eradication figures shown for 1992–2000 are derived from data supplied by Mexican authorities to INCSR. The effective eradication figure is an estimate of the actual amount of crop destroyed—factoring in replanting, repeated spraying of one area, and other factors.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001). Data for 1992–2000 are from the March 2001 report.

Table 44. Amount of Cocaine Seized by Foreign Countries, Calendar Years 1990–2000 (Metric Tons)

Year	South America	Caribbean	Central America	Mexico
1990	71	7	21	49
1991	112	7	28	50
1992	69	8	24	39
1993	65	3	25	46
1994	102	3	15	22
1995	91	5	10	22
1996	94	3	18	24
1997	95	4	28	35
1998	142	7	24	23
1999	82	7	15	34
2000	108	6	10	18

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (March 2001).

Table 45. Amount of Heroin Seized by Foreign Countries, Calendar Years 1990–2000 (Kilograms)

Year	Pakistan		Thailand		China		Laos		Colombia	
	Heroin	Opium	Heroin	Opium	Heroin	Opium	Heroin	Opium	Heroin	Opium
1990	6,400	8,200	1,100	800	1,445	720	40	575	0	0
1991	5,700	5,900	1,500	1,500	2,621	2,327	15	165	0	0
1992	2,900	3,400	992	600	4,489	2,660	2	281	50	430
1993	3,900	4,400	2,100	2,200	4,459	3,354	1	54	261	261
1994	6,200	14,360	1,100	600	3,881	1,737	62	54	181	128
1995	18,040	215,520	690	920	2,376	1,110	43	194	419	78
1996	4,050	8,080	390	620	3,500	1,400	16	216	183	36
1997	5,070	8,540	320	700	5,470	1,600	72	200	261	120
1998	3,330	5,020	530	1,500	—	—	80	442	317	100
1999	4,980	16,320	310	440	—	—	15	226	504	183
2000	7,410	7,840	290	630	—	—	20	78	572	—

— Data not available.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001). Data for 1992–2000 are from the March 2001 report.**Table 46. Amount of Marijuana Seized by Foreign Countries, Calendar Years 1990–2000 (Metric Tons)**

Year	Mexico	Jamaica	Colombia	Pakistan	Thailand	Other
1990	408	29	664	241	130	10
1991	255	43	329	237	54	17
1992	405	35	206	188	87	71
1993	495	75	549	189	98	130
1994	528	46	2,000	178	71	32
1995	780	37	166	544	46	31
1996	1,015	53	235	202	44	64
1997	1,038	24	136	109	9	37
1998	1,062	36	69	65	6	26
1999	1,459	56	65	81	45	29
2000	1,619	56	46	108	7	93

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001). Data for 1992–2000 are from the March 2001 report.

Table 47. Number of Drug Labs Destroyed by Foreign Countries, Calendar Years 1990–2000

Year	Bolivia		Brazil	Colombia		Ecuador	Peru	Mexico	Thailand		Pakistan
	Coca base	Cocaine HCl	Cocaine HCl	Cocaine & base	Morphine & Heroin	Cocaine HCl	Coca base	Not specified	Heroin labs	Methamphetamine	Not specified
1990	1,446	33	3	269	—	1	151	13	2	—	—
1991	1,461	34	3	239	5	4	89	9	5	—	18
1992	1,393	17	0	224	7	0	88	4	0	—	11
1993	1,300	10	5	401	10	0	38	5	2	—	13
1994	1,891	32	0	560	9	0	21	9	0	—	18
1995	2,226	18	0	396	11	0	21	19	1	—	15
1996	2,033	7	0	861	9	1	14	19	2	1	10
1997	1,022	1	0	213	9	0	18	8	3	19	4
1998	1,205	1	2	311	10	2	—	7	1	13	0
1999	89	1	2	156	10	2	—	—	0	14	2
2000	62	2	—	—	—	0	—	—	0	9	0

— Data not available.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2001). Data for 1992–2000 are from the March 2001 report.

Table 48. DEA-Reported Seizures of MDMA, 1998–2001

Year	Non-Analyzed ¹		Analyzed ²
	Grams	Dosage Units	Dosage Units
1998	20,977	184,206	143,613
1999	180,887	543,996	1,054,973
2000	358,225	3,084,215	3,300,864
2001 ³	98,819	792,612	3,072,704

¹Figures based on DEA *Information-7* report.

²Figures based on lab analyses, data taken from STRIDE (dosage units calculated at 0.125 grams per tablet).

³2001 data through September 2001.

Sources: STRIDE and DEA *Information-7* reports (FDSS tabulation of MDMA commenced April 2001).

Table 49. Estimated Numbers (Thousands) and Percentages of Past-Month Users of Any Illicit Drug, by State or Jurisdiction,¹ Age 12 and Older, 1999

State or jurisdiction ¹	Any illicit drug ²				Marijuana				Cocaine			
	Estimated number of users		Percent who are current users		Estimated number of users		Percent who are current users		Estimated number of users		Percent who are current users	
	Num-ber	Prediction interval	Per-cent	Prediction interval	Num-ber	Prediction interval	Per-cent	Prediction interval	Num-ber	Prediction interval	Per-cent	Prediction interval
United States³	14,182		6.4		10,769		4.9		4,024		1.8	
Alabama	176	(138 - 221)	4.9	(3.8 - 6.1)	120	(91 - 155)	3.3	(2.5 - 4.3)	73	(47 - 107)	2.0	(1.3 - 3.0)
Alaska	52	(42 - 63)	10.7	(8.6 - 13.0)	34	(27 - 42)	7.1	(5.6 - 8.8)	14	(9 - 21)	2.9	(1.8 - 4.3)
Arizona	260	(202 - 328)	6.9	(5.4 - 8.7)	195	(145 - 257)	5.2	(3.8 - 6.8)	68	(47 - 96)	1.8	(1.2 - 2.5)
Arkansas	101	(82 - 124)	4.7	(3.8 - 5.8)	74	(57 - 94)	3.5	(2.7 - 4.4)	32	(22 - 45)	1.5	(1.0 - 2.1)
California	1,979	(1,681 - 2,311)	7.8	(6.6 - 9.1)	1,521	(1,278 - 1,795)	7.7	(5.0 - 7.0)	500	(380 - 646)	2.0	(1.5 - 2.5)
Colorado	291	(232 - 359)	8.7	(6.9 - 10.7)	259	(198 - 330)	7.7	(5.9 - 9.9)	76	(53 - 105)	2.3	(1.6 - 3.1)
Connecticut	190	(148 - 241)	7.1	(5.5 - 8.9)	135	(102 - 176)	5.0	(3.8 - 6.5)	47	(31 - 69)	1.8	(1.1 - 2.6)
Delaware	49	(38 - 60)	7.8	(6.2 - 9.6)	41	(32 - 51)	6.5	(5.1 - 8.2)	15	(10 - 21)	2.4	(1.7 - 3.4)
District of Columbia	32	(25 - 40)	7.4	(5.8 - 9.3)	30	(22 - 40)	7.1	(5.1 - 9.5)	11	(7 - 16)	2.5	(1.6 - 3.7)
Florida	777	(645 - 928)	6.2	(5.2 - 7.4)	628	(500 - 776)	5.0	(4.0 - 6.2)	253	(192 - 326)	2.0	(1.5 - 2.6)
Georgia	357	(277 - 449)	5.7	(4.4 - 7.2)	261	(194 - 342)	4.2	(3.1 - 5.5)	129	(86 - 184)	2.1	(1.4 - 3.0)
Hawaii	65	(49 - 85)	6.7	(5.0 - 8.8)	57	(41 - 75)	5.8	(4.3 - 7.8)	21	(12 - 36)	2.2	(1.2 - 3.7)
Idaho	66	(52 - 81)	6.2	(4.9 - 7.7)	45	(34 - 57)	4.2	(3.2 - 5.4)	15	(10 - 20)	1.4	(1.0 - 1.9)
Illinois	613	(527 - 707)	6.3	(5.4 - 7.3)	472	(406 - 545)	4.8	(4.2 - 5.6)	145	(109 - 188)	1.5	(1.1 - 1.9)
Indiana	330	(266 - 402)	6.7	(5.4 - 8.2)	228	(176 - 289)	4.6	(3.6 - 5.9)	88	(46 - 95)	1.4	(0.9 - 1.9)
Iowa	124	(98 - 154)	5.2	(4.1 - 6.4)	78	(59 - 101)	3.3	(2.5 - 4.2)	29	(20 - 39)	1.2	(0.9 - 1.6)
Kansas	112	(88 - 140)	5.2	(4.1 - 6.5)	79	(61 - 99)	3.7	(2.9 - 4.6)	30	(20 - 42)	1.4	(0.9 - 2.0)
Kentucky	182	(145 - 224)	5.6	(4.4 - 6.9)	117	(90 - 149)	3.6	(2.7 - 4.6)	53	(38 - 72)	1.6	(1.2 - 2.2)
Louisiana	193	(156 - 235)	5.4	(4.4 - 6.6)	125	(98 - 156)	3.5	(2.8 - 4.4)	69	(46 - 98)	1.9	(1.3 - 2.8)
Maine	67	(53 - 84)	6.4	(5.1 - 8.0)	61	(48 - 75)	5.8	(4.6 - 7.2)	12	(8 - 16)	1.1	(0.8 - 1.6)
Maryland	221	(174 - 276)	5.2	(4.1 - 6.5)	207	(156 - 269)	4.9	(3.7 - 6.3)	69	(47 - 96)	1.6	(1.1 - 2.3)
Massachusetts	486	(375 - 614)	9.5	(7.4 - 12.1)	384	(296 - 485)	7.5	(5.8 - 9.5)	114	(73 - 168)	2.2	(1.4 - 3.3)
Michigan	564	(487 - 648)	7.1	(6.2 - 8.2)	419	(360 - 486)	5.3	(4.6 - 6.2)	126	(96 - 162)	1.6	(1.2 - 2.1)
Minnesota	240	(198 - 287)	6.1	(5.0 - 7.3)	208	(168 - 253)	5.3	(4.3 - 6.5)	66	(46 - 90)	1.7	(1.2 - 2.3)
Mississippi	120	(96 - 148)	5.3	(4.3 - 6.6)	75	(58 - 95)	3.3	(2.6 - 4.2)	40	(26 - 58)	1.8	(1.2 - 2.6)
Missouri	273	(219 - 334)	6.1	(4.9 - 7.4)	212	(163 - 269)	4.7	(3.6 - 6.0)	61	(42 - 85)	1.3	(0.9 - 1.9)
Montana	56	(45 - 69)	7.4	(5.9 - 9.1)	45	(35 - 57)	5.9	(4.6 - 7.4)	11	(8 - 15)	1.4	(1.0 - 1.9)

See notes at end of table (continued).

Table 49 (cont.). Estimated Numbers (in Thousands) and Percentages of Past Month Users of Any Illicit Drug, by State or Jurisdiction,¹ Age 12 and Older, 1999

State or jurisdiction ¹	Any illicit drug ²			Marijuana			Cocaine			
	Estimated number of users		Percent who are current users	Estimated number of users		Percent who are current users	Estimated number of users		Percent who are current users	
	Num-ber	Prediction interval	Per-cent	Num-ber	Prediction interval	Per-cent	Num-ber	Prediction interval	Per-cent	
Nebraska	69	(55 - 87)	5.1	54	(41 - 69)	3.9	19	(13 - 27)	1.4	(1.0 - 2.0)
Nevada	136	(104 - 174)	9.1	83	(62 - 110)	5.6	38	(23 - 60)	2.6	(1.5 - 4.0)
New Hampshire	64	(51 - 78)	6.4	59	(46 - 73)	5.9	15	(10 - 23)	1.6	(1.0 - 2.4)
New Jersey	478	(380 - 593)	7.2	331	(256 - 421)	5.0	141	(90 - 209)	2.1	(1.4 - 3.1)
New Mexico	114	(91 - 141)	7.8	95	(74 - 120)	6.5	44	(31 - 60)	3.0	(2.2 - 4.1)
New York	968	(805 - 1,153)	6.6	716	(603 - 843)	4.9	289	(201 - 403)	2.0	(1.4 - 2.7)
North Carolina	363	(284 - 454)	5.8	295	(225 - 378)	4.7	118	(83 - 162)	1.9	(1.3 - 2.6)
North Dakota	26	(21 - 32)	4.9	21	(16 - 26)	3.9	6	(4 - 9)	1.1	(0.8 - 1.6)
Ohio	560	(476 - 653)	6.0	399	(337 - 468)	4.3	143	(110 - 184)	1.5	(1.2 - 2.0)
Oklahoma	138	(106 - 176)	5.1	95	(71 - 123)	3.5	47	(30 - 70)	1.7	(1.1 - 2.6)
Oregon	204	(159 - 257)	7.3	184	(140 - 236)	6.6	41	(28 - 57)	1.5	(1.0 - 2.1)
Pennsylvania	638	(529 - 761)	6.3	450	(374 - 535)	4.5	125	(95 - 161)	1.2	(0.9 - 1.6)
Rhode Island	66	(53 - 80)	8.0	61	(47 - 76)	7.4	13	(9 - 19)	1.6	(1.1 - 2.3)
South Carolina	157	(124 - 196)	5.1	119	(91 - 151)	3.8	59	(38 - 87)	1.9	(1.2 - 2.8)
South Dakota	33	(27 - 40)	5.3	25	(20 - 31)	4.1	9	(6 - 12)	1.4	(1.0 - 1.9)
Tennessee	241	(187 - 303)	5.2	164	(122 - 215)	3.6	94	(62 - 134)	2.0	(1.4 - 2.9)
Texas	800	(694 - 917)	5.1	554	(469 - 649)	3.5	369	(298 - 452)	2.3	(1.9 - 2.9)
Utah	101	(82 - 123)	6.0	82	(62 - 105)	4.9	26	(20 - 34)	1.6	(1.2 - 2.1)
Vermont	31	(25 - 38)	6.2	27	(22 - 34)	5.4	7	(5 - 11)	1.5	(1.0 - 2.2)
Virginia	253	(195 - 322)	4.5	224	(165 - 297)	4.0	105	(70 - 150)	1.9	(1.3 - 2.7)
Washington	388	(308 - 480)	8.2	318	(243 - 408)	6.8	78	(53 - 111)	1.7	(1.1 - 2.3)
West Virginia	75	(59 - 91)	4.8	56	(43 - 72)	3.6	21	(15 - 29)	1.4	(0.9 - 1.9)
Wisconsin	274	(224 - 330)	6.3	223	(178 - 275)	5.1	65	(47 - 87)	1.5	(1.1 - 2.0)
Wyoming	29	(23 - 36)	7.0	24	(18 - 30)	5.6	7	(5 - 10)	1.7	(1.3 - 2.4)

¹Excludes jurisdictions outside the United States and the District of Columbia.

²Any illicit drug² indicates use at least once of marijuana/hashish, cocaine (including crack), inhalants, hallucinogens (including PCP and LSD), heroin, or any prescription-type psychotherapeutic used nonmedically.

³The estimated number of users for the United States is the sum of the hierarchical Bayes estimates across all states and the District of Columbia and typically is not equal to the direct sample-weighted estimate for the Nation. The estimated percentage for the United States is the weighted average of the hierarchical Bayes estimates across all states and the District of Columbia, and typically is not equal to the direct sample-weighted estimate for the Nation.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *National Household Survey on Drug Abuse, 1999*.

Table 50. Estimated Number of Persons Age 12 or Older Needing but Not Receiving Treatment for an Illicit Drug Problem in the Past Year, by State, 2000

State or jurisdiction	Total	Age groups (years)		
		12–17	18–25	26 or older
Total ¹	3,994,321	963,682	1,511,823	1,518,816
Alabama	60,846	13,085	26,845	20,916
Alaska	10,381	2,879	3,451	4,051
Arizona	88,686	19,499	25,902	43,284
Arkansas	34,202	9,509	14,384	10,309
California	563,676	147,129	172,043	244,504
Colorado	71,131	16,164	24,240	30,727
Connecticut	52,010	13,550	20,130	18,329
Delaware	11,100	2,743	3,719	4,637
District of Columbia	8,820	1,852	2,820	4,148
Florida	196,128	47,578	71,294	77,256
Georgia	110,012	27,273	41,947	40,792
Hawaii	16,838	5,034	4,375	7,492
Idaho	19,700	5,408	9,029	7,429
Illinois	164,309	34,985	65,356	5,263
Indiana	82,093	19,227	35,911	63,967
Iowa	32,845	7,980	14,102	26,955
Kansas	35,310	7,244	13,406	10,764
Kentucky	63,647	13,165	22,798	17,684
Louisiana	65,208	16,667	28,934	19,607
Maine	18,817	5,463	7,565	5,789
Maryland	80,734	19,869	26,850	34,014
Massachusetts	108,669	28,215	36,641	43,812
Michigan	137,607	34,424	61,890	41,293
Minnesota	75,663	18,474	26,808	30,382
Mississippi	37,181	8,488	16,533	12,160
Missouri	67,487	15,037	27,465	24,985
Montana	12,396	3,955	4,616	3,825
Nebraska	22,267	5,205	9,747	7,315
Nevada	27,941	6,816	9,672	11,453
New Hampshire	19,883	6,566	7,006	6,310
New Jersey	110,186	21,851	44,599	43,737
New Mexico	25,748	7,533	8,854	9,362
New York	285,054	49,307	125,708	110,039
North Carolina	98,671	19,877	39,033	39,762
North Dakota	8,019	2,259	3,162	2,598
Ohio	150,150	34,443	61,867	53,840
Oklahoma	43,449	10,098	17,632	15,719
Oregon	54,906	13,900	19,589	21,417
Pennsylvania	160,117	30,162	72,657	57,298
Rhode Island	13,983	3,417	5,282	5,284
South Carolina	48,469	13,398	17,298	17,773
South Dakota	9,262	2,784	3,739	2,739
Tennessee	78,992	22,063	30,487	26,442
Texas	287,765	88,677	106,489	92,599
Utah	36,474	8,360	15,995	12,120
Vermont	9,810	2,511	3,980	3,320
Virginia	87,768	19,913	30,225	37,630
Washington	94,245	21,368	26,444	46,433
West Virginia	22,959	5,606	8,916	8,437
Wisconsin	75,832	21,142	31,298	23,392
Wyoming	6,872	1,531	3,089	2,252

Note: Estimates are based on a survey-weighted hierarchical Bayes estimation approach, and the prediction intervals are generated by Markov Chain Monte Carlo techniques.

¹This estimate is the weighted average of the hierarchical Bayes estimates across all States and the District of Columbia and typically is not equal to the direct sample-weighted estimate for the Nation.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *National Household Survey on Drug Abuse, 2000* (unpublished data).

Table 51. Number of Clients in Treatment Age 12 or Older by Substance Abuse Problem, According to State or Jurisdiction:¹ October 1, 1997, October 1, 1998, and October 1, 2000

State or jurisdiction	Substance abuse problem											
	Total			Both alcohol and drug abuse			Drug abuse only			Alcohol abuse only		
	1997	1998	2000	1997	1998	2000	1997	1998	2000	1997	1998	2000
Clients in treatment	916,637	1,030,028	969,863	376,482	509,784	472,826	299,593	275,320	280,015	240,562	244,924	217,022
Alabama	10,664	8,933	8,632	2,385	4,274	3,043	5,808	2,929	4,204	2,471	1,730	1,385
Alaska	5,261	2,915	2,762	2,101	1,439	1,292	894	215	297	2,266	1,261	1,173
Arizona	12,307	19,804	25,709	4,297	8,795	10,802	4,612	5,883	7,086	3,398	5,126	7,821
Arkansas	4,129	7,006	3,112	1,652	4,096	1,629	1,588	1,480	999	889	1,430	484
California	88,876	126,340	103,261	36,421	57,515	46,562	39,646	41,512	36,552	12,809	27,313	20,147
Colorado	13,530	24,079	28,298	4,388	10,890	11,301	4,297	4,280	5,110	4,845	8,909	11,887
Connecticut	15,592	16,037	17,638	5,949	7,079	7,423	7,199	6,192	7,976	2,444	2,766	2,239
Delaware	3,567	3,767	3,789	2,256	1,912	2,387	624	1,059	619	687	796	783
District of Columbia	8,201	6,499	6,145	2,722	3,949	2,719	4,033	1,654	2,571	1,446	896	855
Florida	41,663	45,591	43,158	19,358	24,867	22,717	13,908	11,961	11,804	8,397	8,763	8,637
Georgia	16,118	15,775	12,922	7,299	7,231	6,576	4,883	4,452	3,303	3,936	4,092	3,043
Hawaii	2,177	3,012	2,601	893	1,700	1,313	784	663	902	500	649	386
Idaho	2,464	2,896	2,811	1,717	1,858	1,857	360	430	349	387	608	605
Illinois	39,040	45,872	41,183	17,967	22,638	17,631	10,839	12,088	13,390	10,234	11,146	10,162
Indiana	18,458	16,855	15,360	7,597	7,384	7,826	4,334	3,695	3,157	6,527	5,776	4,377
Iowa	5,373	7,287	5,538	2,580	3,646	2,839	870	1,028	864	1,923	2,613	1,835
Kansas	8,288	8,951	12,041	3,906	5,022	7,790	1,637	1,557	1,815	2,745	2,372	2,436
Kentucky	12,119	14,656	17,950	4,093	6,597	7,978	3,365	2,712	4,023	4,661	5,347	5,949
Louisiana	12,185	16,991	11,303	6,273	9,664	5,747	3,595	4,162	4,032	2,317	3,165	1,524
Maine	8,188	8,577	4,680	3,948	4,306	2,465	1,496	1,195	669	2,744	3,076	1,546
Maryland	23,794	23,960	30,395	10,088	11,001	12,817	8,868	7,921	11,810	4,838	5,038	5,768
Massachusetts	33,219	42,508	34,373	13,984	23,781	16,967	10,235	9,871	10,961	9,000	8,856	6,445
Michigan	49,788	48,963	43,380	18,123	19,858	17,467	14,135	13,266	12,253	17,530	15,839	13,660
Minnesota	7,593	10,403	8,264	3,621	5,532	4,024	1,275	2,227	2,057	2,697	2,644	2,183
Mississippi	5,334	8,877	7,326	2,515	5,028	4,477	1,391	1,882	1,133	1,428	1,967	1,716
Missouri	11,090	17,596	17,309	5,789	11,330	9,921	2,740	2,913	4,075	2,561	3,353	3,313
Montana	2,298	2,470	1,898	1,135	1,326	846	482	317	307	681	827	745

See notes at end of table (continued).

Table 51 (cont.). Number of Clients in Treatment Age 12 and Older by Substance Abuse Problem, According to State or Jurisdiction:¹ October 1, 1997, October 1, 1998, and October 1, 2000

State or Jurisdiction	Substance abuse problem											
	Total			Both alcohol and drug abuse			Drug abuse only			Alcohol abuse only		
	1997	1998	2000	1997	1998	2000	1997	1998	2000	1997	1998	2000
Nebraska	4,197	5,515	4,559	2,140	3,065	2,300	444	746	906	1,613	1,704	1,353
Nevada	5,279	7,962	7,292	1,697	4,678	3,609	2,158	1,590	2,281	1,424	1,694	1,402
New Hampshire	2,507	3,374	3,253	1,028	1,741	1,818	465	312	482	1,014	1,321	953
New Jersey	20,594	24,666	22,936	9,147	11,999	9,891	7,928	8,882	9,922	3,519	3,785	3,123
New Mexico	6,452	10,304	9,791	2,469	4,280	4,136	1,132	2,051	2,529	2,851	3,973	3,126
New York	127,272	115,870	115,438	35,175	49,495	55,795	64,260	49,257	44,539	27,837	17,118	15,104
North Carolina	17,379	25,358	30,487	8,358	13,535	15,374	3,427	4,538	6,067	5,594	7,285	9,046
North Dakota	2,086	3,011	1,290	856	1,418	620	242	365	87	988	1,228	583
Ohio	40,401	42,490	37,956	20,864	23,839	21,018	7,950	7,413	7,252	11,587	11,238	9,686
Oklahoma	7,572	8,750	7,346	2,511	3,480	4,046	2,415	2,587	1,332	2,646	2,683	1,968
Oregon	22,627	18,116	21,319	10,731	9,644	12,166	5,154	4,631	5,011	6,742	3,841	4,142
Pennsylvania	36,382	36,536	37,281	17,957	21,460	20,439	10,231	8,282	10,305	8,194	6,794	6,537
Rhode Island	5,084	6,390	5,884	1,874	2,957	2,158	1,914	2,143	2,833	1,296	1,290	893
South Carolina	10,862	9,648	11,942	3,943	3,661	5,537	2,513	2,443	2,444	4,406	3,544	3,961
South Dakota	1,880	2,785	1,797	739	1,261	921	229	205	168	912	1,319	708
Tennessee	13,166	12,903	8,217	6,113	5,111	3,288	4,069	4,502	3,170	2,984	3,290	1,759
Texas	40,693	47,379	44,211	14,860	28,033	25,459	14,346	11,108	12,470	11,487	8,238	6,282
Utah	13,621	11,650	6,250	5,771	5,815	3,156	3,709	3,431	1,893	4,141	2,404	1,201
Vermont	1,638	2,577	2,734	721	1,414	1,404	215	317	322	702	846	1,008
Virginia	21,039	20,888	22,640	10,839	10,595	12,010	4,810	4,431	4,629	5,390	5,862	6,001
Washington	31,260	31,953	32,962	17,295	18,864	19,115	4,392	4,438	5,642	9,573	8,651	8,205
West Virginia	4,704	4,658	4,859	1,159	1,630	1,890	748	792	783	2,797	2,236	2,186
Wisconsin	16,535	18,916	15,308	6,333	8,279	6,875	2,659	3,089	2,405	7,543	7,548	6,028
Wyoming	2,091	1,709	2,273	845	812	1,385	285	223	225	961	674	663

¹Excludes jurisdictions outside the United States and the District of Columbia. Facilities operated by Federal agencies are included in the States in which the facilities are located. Source: Substance Abuse and Mental Health Services Administration, *Uniform Facility Data Set (UFDS): 1997 and 1998*. (1999 and 2000).

Table 52. Percentage¹ of Adult Male Booked Arrestees Who Used Any Drug,² by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	65
Albuquerque	—	—	—	—	—	—	—	65	64	65
Anchorage	—	—	—	—	—	—	—	43	54	52
Atlanta	63	69	72	69	74	80	72	66	77	70
Birmingham	63	64	68	69	73	70	67	67	64	65
Charlotte-Metro	—	—	—	—	—	—	—	—	—	68
Chicago	74	69	81	79	79	82	80	74	74	—
Cleveland	56	64	64	66	65	67	64	65	71	72
Dallas	56	59	62	57	60	63	63	63	61	55
Denver	50	60	64	67	66	71	71	69	67	64
Des Moines	—	—	—	—	—	—	—	57	56	55
Detroit	55	58	63	66	67	66	62	68	65	70
Ft. Lauderdale	61	64	61	58	58	67	73	74	64	62
Honolulu	—	—	—	—	—	—	—	—	—	63
Houston	65	59	59	48	58	64	63	60	60	57
Indianapolis	45	52	60	69	64	74	63	67	64	64
Laredo	—	—	—	—	—	—	—	57	58	59
Las Vegas	—	—	—	—	—	—	—	57	60	59
Los Angeles	62	67	66	66	62	64	59	64	62	—
Miami	68	68	70	66	57	67	61	62	66	63
Minneapolis	—	—	—	—	—	—	—	63	60	67
New Orleans	59	60	62	63	66	67	67	67	69	69
New York City ³	73	77	78	82	83	78	79	77	75	80
Oklahoma City	—	—	—	—	—	—	—	69	64	71
Omaha	36	48	54	59	54	63	62	60	62	63
Philadelphia	74	78	76	76	76	69	67	79	70	72
Phoenix	42	47	62	65	63	59	64	63	64	66
Portland	61	60	63	65	65	66	71	72	64	64
Sacramento	—	—	—	—	—	—	—	71	68	74
St. Louis	59	64	68	74	77	75	74	72	—	—
Salt Lake City	—	—	—	—	—	—	—	60	60	54
San Antonio	49	54	55	52	51	57	52	56	50	53
San Diego	75	77	78	79	72	71	73	69	64	64
San Jose	58	50	54	55	52	48	51	48	55	53
Seattle	—	—	—	—	—	—	—	65	66	64
Spokane	—	—	—	—	—	—	—	62	62	58
Tucson	—	—	—	—	—	—	—	63	68	69
Washington, D.C.	59	60	60	64	64	66	69	65	69	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

²"Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

³Data before the third quarter of 1998 pertain to Manhattan only.

Sources: 1991–1996 data from *Drug Use Forecasting (1991–1996)*; 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees (1997 and 1998)*; 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees, Arrestee Drug Abuse Monitoring Program (ADAM)*, National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports, ADAM, NIJ (2001)*.

Table 53. Percentage¹ of Adult Male Booked Arrestees Who Used Marijuana, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	45
Albuquerque	—	—	—	—	—	—	—	36	37	47
Anchorage	—	—	—	—	—	—	—	33	38	38
Atlanta	12	22	26	25	32	37	36	26	44	38
Birmingham	16	22	28	28	36	44	43	39	39	45
Charlotte	—	—	—	—	—	—	—	—	—	44
Chicago	23	26	40	38	41	47	48	42	45	—
Cleveland	12	17	23	28	29	37	46	37	43	49
Dallas	19	28	28	33	37	44	44	43	39	36
Denver	25	34	36	39	33	42	42	41	44	41
Des Moines	—	—	—	—	—	—	—	42	43	42
Detroit	18	27	37	38	42	46	44	47	48	50
Ft. Lauderdale	28	32	30	29	33	38	38	44	39	43
Honolulu	—	—	—	—	—	—	—	—	—	30
Houston	17	24	24	23	29	33	24	36	38	36
Indianapolis	23	35	42	39	38	51	44	45	48	49
Laredo	—	—	—	—	—	—	—	39	33	29
Las Vegas	—	—	—	—	—	—	—	26	28	33
Los Angeles	19	23	23	20	23	30	27	27	32	—
Miami	23	30	26	28	29	34	32	29	36	39
Minneapolis	—	—	—	—	—	—	—	45	44	54
New Orleans	16	19	25	28	32	40	38	38	40	47
New York City ²	18	22	21	24	28	38	32	39	41	41
Oklahoma City	—	—	—	—	—	—	—	53	48	57
Omaha	26	38	42	44	42	52	33	44	51	48
Philadelphia	18	26	32	32	34	39	41	45	41	49
Phoenix	22	22	31	29	29	28	30	32	36	34
Portland	33	28	30	27	29	35	38	37	35	36
Sacramento	—	—	—	—	—	—	—	44	44	50
St. Louis	16	21	28	36	39	52	48	50	—	—
Salt Lake City	—	—	—	—	—	—	—	37	35	34
San Antonio	20	28	32	30	34	39	34	41	36	41
San Diego	33	35	40	36	35	40	38	36	36	39
San Jose	25	24	27	30	27	27	29	25	34	36
Seattle	—	—	—	—	—	—	—	35	39	38
Spokane	—	—	—	—	—	—	—	43	44	40
Tucson	—	—	—	—	—	—	—	39	45	45
Washington, D.C.	11	20	26	30	32	40	39	38	35	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.²Data before the third quarter of 1998 pertain to Manhattan only.

Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 54. Percentage¹ of Adult Male Booked Arrestees Who Used Cocaine, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	25
Albuquerque	—	—	—	—	—	—	—	39	43	35
Anchorage	—	—	—	—	—	—	—	20	26	22
Atlanta	57	58	59	57	57	59	51	51	51	49
Birmingham	52	49	51	50	49	43	39	41	37	33
Charlotte	—	—	—	—	—	—	—	—	—	44
Chicago	61	56	53	57	51	52	49	45	42	—
Cleveland	48	53	48	48	42	41	27	37	40	38
Dallas	43	41	44	35	31	32	32	29	34	28
Denver	30	38	41	40	44	44	40	40	41	35
Des Moines	—	—	—	—	—	—	—	18	16	11
Detroit	41	37	34	34	30	27	23	28	27	24
Ft. Lauderdale	44	46	43	41	39	44	51	50	41	31
Honolulu	—	—	—	—	—	—	—	—	—	16
Houston	56	41	41	29	40	39	40	36	36	32
Indianapolis	22	23	32	47	39	42	31	34	34	31
Laredo	—	—	—	—	—	—	—	37	42	45
Las Vegas	—	—	—	—	—	—	—	24	30	23
Los Angeles	44	52	48	48	44	44	38	43	36	—
Miami	61	56	61	56	42	52	46	47	49	44
Minneapolis	—	—	—	—	—	—	—	27	29	26
New Orleans	50	49	48	47	47	46	46	46	44	35
New York City ²	62	62	66	68	68	56	58	47	44	49
Oklahoma City	—	—	—	—	—	—	—	27	26	22
Omaha	14	16	19	26	19	24	21	25	22	18
Philadelphia	62	63	56	54	51	40	34	45	39	31
Phoenix	20	26	30	28	27	32	32	31	32	32
Portland	30	35	33	32	30	34	37	29	23	22
Sacramento	—	—	—	—	—	—	—	18	16	18
St. Louis	48	50	50	50	51	43	41	35	—	—
Salt Lake City	—	—	—	—	—	—	—	20	22	18
San Antonio	31	32	31	31	24	28	26	27	23	20
San Diego	45	45	37	30	28	27	21	19	17	15
San Jose	33	28	23	19	18	16	14	8	14	12
Seattle	—	—	—	—	—	—	—	36	33	31
Spokane	—	—	—	—	—	—	—	18	18	15
Tucson	—	—	—	—	—	—	—	39	40	41
Washington, D.C.	49	44	37	38	35	33	33	33	38	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

²Data before the third quarter of 1998 pertain to Manhattan only.

Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 55. Percentage¹ of Adult Male Booked Arrestees Who Used Opiates, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	7
Albuquerque	—	—	—	—	—	—	—	8	14	12
Anchorage	—	—	—	—	—	—	—	2	3	4
Atlanta	3	4	3	2	3	3	2	1	4	3
Birmingham	5	3	4	4	2	4	5	4	4	10
Charlotte	—	—	—	—	—	—	—	—	—	2
Chicago	21	19	28	27	22	20	22	18	20	—
Cleveland	3	3	4	3	5	3	4	6	4	4
Dallas	4	4	4	3	5	5	4	2	5	3
Denver	2	2	4	4	5	5	4	4	3	3
Des Moines	—	—	—	—	—	—	—	3	1	3
Detroit	8	8	8	7	7	7	5	7	9	8
Ft. Lauderdale	1	1	1	1	2	2	3	2	1	2
Honolulu	—	—	—	—	—	—	—	—	—	7
Houston	3	3	2	3	5	8	10	8	6	7
Indianapolis	3	4	4	3	2	3	3	2	3	3
Laredo	—	—	—	—	—	—	—	11	11	10
Las Vegas	—	—	—	—	—	—	—	3	5	5
Los Angeles	10	10	9	10	7	6	6	6	6	—
Miami	2	2	2	2	3	1	2	2	3	4
Minneapolis	—	—	—	—	—	—	—	5	4	3
New Orleans	4	4	5	5	7	7	11	13	14	16
New York City ²	14	18	20	19	20	17	19	16	15	21
Oklahoma City	—	—	—	—	—	—	—	2	2	3
Omaha	2	2	2	2	1	1	2	2	0	2
Philadelphia	11	12	11	14	12	11	11	18	15	12
Phoenix	5	5	6	6	8	9	9	6	8	7
Portland	9	11	11	12	15	13	14	16	13	14
Sacramento	—	—	—	—	—	—	—	3	4	3
St. Louis	6	7	9	11	11	10	10	11	—	—
Salt Lake City	—	—	—	—	—	—	—	8	9	7
San Antonio	16	15	14	13	10	10	10	10	10	10
San Diego	17	16	16	12	8	9	7	9	9	6
San Jose	8	4	6	6	5	5	6	4	4	6
Seattle	—	—	—	—	—	—	—	17	14	10
Spokane	—	—	—	—	—	—	—	9	7	8
Tucson	—	—	—	—	—	—	—	7	9	9
Washington, D.C.	10	11	10	9	8	9	10	10	16	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.²Data before the third quarter of 1998 pertain to Manhattan only.Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees, Arrestee Drug Abuse Monitoring Program (ADAM)*, National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 56. Percentage¹ of Adult Male Booked Arrestees Who Used Methamphetamine, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	0.0
Albuquerque	—	—	—	—	—	—	—	3.4	5.1	4.7
Anchorage	—	—	—	—	—	—	—	0.0	0.5	0.2
Atlanta	0.2	0.1	0.4	0.1	0.4	—	0.6	0.0	0.4	0.5
Birmingham	0.1	0.0	0.0	0.2	0.1	—	0.6	0.0	0.1	0.2
Charlotte	—	—	—	—	—	—	—	—	—	1.4
Chicago	0.0	0.0	0.0	0.1	0.0	—	0.3	0.2	0.0	—
Cleveland	0.0	0.0	0.0	0.0	0.0	—	0.0	0.0	0.0	0.1
Dallas	0.6	0.9	2.0	2.0	2.2	—	2.6	3.3	2.5	2.1
Denver	0.8	1.0	1.2	2.1	4.1	—	5.0	5.2	3.0	2.6
Des Moines	—	—	—	—	—	—	—	10.2	14.0	18.6
Detroit	0.1	0.0	0.0	0.0	0.0	—	0.0	0.2	0.0	0.0
Ft. Lauderdale	0.0	0.0	0.0	0.0	0.1	—	0.1	0.0	0.4	0.0
Honolulu	—	—	—	—	—	—	—	—	—	35.9
Houston	0.1	0.1	0.1	0.0	0.1	—	0.0	0.2	0.1	0.5
Indianapolis	0.0	0.1	0.2	0.4	0.8	—	0.2	0.8	0.6	0.7
Laredo	—	—	—	—	—	—	—	0.0	0.2	0.0
Las Vegas	—	—	—	—	—	—	—	13.8	16.2	17.8
Los Angeles	5.4	4.8	8.2	7.7	5.8	—	4.7	8.0	8.9	—
Miami	0.0	0.0	0.0	0.0	0.0	—	0.0	0.2	0.0	0.0
Minneapolis	—	—	—	—	—	—	—	0.8	1.1	1.6
New Orleans	0.2	0.2	0.0	0.1	0.0	—	0.0	0.2	0.1	0.2
New York City ²	0.2	0.0	0.1	0.3	0.0	—	0.0	0.0	0.0	0.0
Oklahoma City	—	—	—	—	—	—	—	8.0	8.7	11.3
Omaha	0.1	0.5	1.4	3.3	7.8	—	9.7	10.2	7.8	11.0
Philadelphia	0.5	0.5	0.4	0.1	0.4	—	0.6	0.6	0.2	0.0
Phoenix	4.5	5.1	15.6	25.4	22.0	—	16.4	16.4	16.6	19.1
Portland	7.5	5.9	11.3	16.3	18.1	—	15.9	18.1	19.8	21.4
Sacramento	—	—	—	—	—	—	—	24.6	27.6	29.3
St. Louis	0.2	0.1	0.0	0.5	0.6	—	0.4	0.3	—	—
Salt Lake City	—	—	—	—	—	—	—	20.3	24.8	17.1
San Antonio	1.3	0.8	0.6	1.0	1.1	—	1.7	2.0	1.8	0.2
San Diego	18.0	23.7	35.5	41.0	36.0	—	39.6	33.2	26.0	26.3
San Jose	6.6	5.9	15.3	19.9	16.3	—	18.4	19.7	24.4	21.5
Seattle	—	—	—	—	—	—	—	6.4	9.0	9.2
Spokane	—	—	—	—	—	—	—	15.8	20.1	20.4
Tucson	—	—	—	—	—	—	—	4.0	5.8	6.9
Washington, D.C.	0.1	0.0	0.1	0.1	0.1	—	0.3	0.0	0.9	—

— Data not available.

¹ Percent positive by urinalysis, January through December of each year.² Data before the third quarter of 1998 pertain to Manhattan only.

Sources: 1991–1996 data from *Drug Use Forecasting (1991–1996)*; 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees (1997 and 1998)*; 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ)*; 2000 data from *2000 Annualized Site Visit Reports, ADAM, NIJ (2001)*.

Table 57. Percentage¹ of Adult Female Booked Arrestees Who Used Any Drug,² by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 ³
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	50
Albuquerque	—	—	—	—	—	—	—	73	74	58
Anchorage	—	—	—	—	—	—	—	58	56	46
Atlanta	70	65	74	72	68	77	74	—	77	72
Birmingham	62	59	55	63	57	59	67	74	53	53
Chicago	—	—	—	—	—	—	—	72	77	80
Cleveland	79	74	77	82	71	70	57	58	68	68
Dallas	56	66	61	63	58	58	53	49	56	39
Denver	54	61	66	68	66	69	69	69	69	71
Des Moines	—	—	—	—	—	—	—	67	53	59
Detroit	68	72	76	62	78	69	69	60	69	70
Ft. Lauderdale	64	62	60	62	60	66	68	67	68	61
Honolulu	—	—	—	—	—	—	—	—	—	63
Houston	59	54	53	48	50	54	45	52	43	52
Indianapolis	54	50	58	69	72	72	67	67	69	72
Laredo	—	—	—	—	—	—	—	33	22	31
Las Vegas	—	—	—	—	—	—	—	70	72	61
Los Angeles	75	72	77	72	68	78	70	71	62	65
Minneapolis	—	—	—	—	—	—	—	44	57	61
New Orleans	50	52	47	32	50	35	40	51	59	57
New York City ⁴	77	85	83	90	84	83	81	82	81	75
Oklahoma City	—	—	—	—	—	—	—	—	65	67
Omaha	—	—	—	58	56	51	54	60	62	53
Philadelphia	75	78	79	76	77	81	75	77	76	59
Phoenix	61	63	62	67	63	65	66	71	67	66
Portland	68	73	74	74	68	74	78	74	68	69
Sacramento	—	—	—	—	—	—	—	73	75	85
St. Louis	54	70	69	76	69	73	70	69	—	—
Salt Lake City	—	—	—	—	—	—	—	69	66	59
San Antonio	45	44	42	39	41	44	37	38	31	—
San Diego	73	72	78	76	73	62	73	64	67	66
San Jose	52	56	51	61	50	53	53	42	61	69
Seattle	—	—	—	—	—	—	—	81	70	74
Spokane	—	—	—	—	—	—	—	68	71	42
Tucson	—	—	—	—	—	—	—	57	58	71
Washington, D.C.	75	72	71	67	65	58	57	65	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.²“Any drug” includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.³Data for 2000 are unweighted and not based on probability sampling.⁴Data before the third quarter of 1998 pertain to Manhattan only.Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 58. Percentage¹ of Adult Female Booked Arrestees Who Used Marijuana, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 ²
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	30
Albuquerque	—	—	—	—	—	—	—	24	24	18
Anchorage	—	—	—	—	—	—	—	23	31	28
Atlanta	8	13	16	15	13	26	28	—	34	26
Birmingham	10	13	12	17	12	22	25	18	26	18
Chicago	—	—	—	—	—	—	—	20	27	26
Cleveland	7	11	13	16	11	22	22	27	28	24
Dallas	11	24	19	22	21	44	28	24	27	21
Denver	16	19	24	22	21	27	32	30	34	34
Des Moines	—	—	—	—	—	—	—	15	34	36
Detroit	4	11	10	16	18	19	28	22	26	24
Ft. Lauderdale	14	21	20	18	18	24	24	25	29	28
Honolulu	—	—	—	—	—	—	—	—	—	19
Houston	8	12	15	13	18	26	17	20	23	27
Indianapolis	22	26	25	22	24	31	30	31	38	38
Laredo	—	—	—	—	—	—	—	13	9	17
Las Vegas	—	—	—	—	—	—	—	22	23	25
Los Angeles	9	13	15	12	14	38	18	22	21	32
Minneapolis	—	—	—	—	—	—	—	23	29	44
New Orleans	7	8	14	7	16	13	12	22	25	28
New York City ³	11	12	19	15	16	19	25	23	26	28
Oklahoma City	—	—	—	—	—	—	—	—	39	45
Omaha	—	—	—	28	24	33	33	28	36	33
Philadelphia	14	15	20	18	20	21	21	24	26	22
Phoenix	14	15	20	22	19	22	21	25	26	23
Portland	28	17	17	19	16	26	19	23	23	26
Sacramento	—	—	—	—	—	—	—	28	33	26
St. Louis	8	11	15	15	18	29	31	32	—	—
Salt Lake City	—	—	—	—	—	—	—	29	23	25
San Antonio	9	16	16	15	16	19	17	18	16	—
San Diego	20	25	25	20	20	23	24	27	29	27
San Jose	13	18	17	18	12	19	17	14	26	31
Seattle	—	—	—	—	—	—	—	38	28	48
Spokane	—	—	—	—	—	—	—	27	32	25
Tucson	—	—	—	—	—	—	—	22	24	29
Washington, D.C.	6	8	9	10	18	23	19	29	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

²Data for 2000 are unweighted and not based on probability sampling.

³Data before the third quarter of 1998 pertain to Manhattan only.

Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 59. Percentage¹ of Adult Female Booked Arrestees Who Used Cocaine, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 ²
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	23
Albuquerque	—	—	—	—	—	—	—	59	56	41
Anchorage	—	—	—	—	—	—	—	50	36	24
Atlanta	66	58	68	62	62	63	61	—	62	58
Birmingham	44	46	41	50	48	39	49	57	34	42
Chicago	—	—	—	—	—	—	—	56	64	59
Cleveland	76	66	69	74	63	52	39	41	50	52
Dallas	45	48	43	46	44	36	34	30	40	24
Denver	41	50	47	51	52	53	50	50	51	47
Des Moines	—	—	—	—	—	—	—	24	22	18
Detroit	62	62	64	46	61	53	48	46	46	42
Ft. Lauderdale	55	47	45	52	50	52	57	53	52	45
Honolulu	—	—	—	—	—	—	—	—	—	19
Houston	52	44	43	36	32	34	29	37	23	32
Indianapolis	26	25	36	56	54	52	45	43	45	45
Laredo	—	—	—	—	—	—	—	33	21	22
Las Vegas	—	—	—	—	—	—	—	35	50	28
Los Angeles	62	58	59	53	49	56	49	45	37	33
Minneapolis	—	—	—	—	—	—	—	29	36	33
New Orleans	42	44	37	25	37	26	32	39	41	41
New York City ³	66	72	70	80	71	69	62	67	65	53
Oklahoma City	—	—	—	—	—	—	—	—	35	27
Omaha	—	—	—	34	30	28	17	36	32	22
Philadelphia	64	67	61	61	59	69	58	61	60	41
Phoenix	45	49	38	36	33	42	33	40	43	35
Portland	40	54	47	43	40	46	45	37	33	30
Sacramento	—	—	—	—	—	—	—	31	30	37
St. Louis	47	62	62	69	57	55	53	44	—	—
Salt Lake City	—	—	—	—	—	—	—	20	26	15
San Antonio	25	25	24	22	24	23	18	20	19	—
San Diego	40	37	36	18	28	22	23	20	23	26
San Jose	30	32	19	23	16	21	16	10	20	8
Seattle	—	—	—	—	—	—	—	57	48	39
Spokane	—	—	—	—	—	—	—	32	31	8
Tucson	—	—	—	—	—	—	—	41	41	49
Washington, D.C.	68	64	62	55	46	40	39	40	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.²Data for 2000 are unweighted and not based on probability sampling.³Data prior to the third quarter of 1998 pertain to Manhattan only.Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 60. Percentage¹ of Adult Female Booked Arrestees Who Used Opiates, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 ²
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	8
Albuquerque	—	—	—	—	—	—	—	15	31	14
Anchorage	—	—	—	—	—	—	—	4	2	8
Atlanta	4	5	4	4	3	3	3	—	5	3
Birmingham	11	4	4	3	3	6	5	18	4	4
Chicago	—	—	—	—	—	—	—	27	32	40
Cleveland	6	5	4	4	6	6	4	1	8	7
Dallas	9	8	10	7	5	5	5	5	7	5
Denver	2	5	6	5	6	5	6	3	3	6
Des Moines	—	—	—	—	—	—	—	6	3	7
Detroit	11	15	14	13	15	18	9	22	16	24
Ft. Lauderdale	4	3	3	3	3	3	4	5	4	7
Honolulu	—	—	—	—	—	—	—	—	—	8
Houston	4	4	4	6	3	4	5	7	7	3
Indianapolis	11	7	4	5	7	3	3	5	5	6
Laredo	—	—	—	—	—	—	—	0	2	7
Las Vegas	—	—	—	—	—	—	—	14	9	5
Los Angeles	18	13	14	12	10	17	11	9	8	8
Minneapolis	—	—	—	—	—	—	—	6	9	6
New Orleans	7	6	5	2	4	3	3	3	7	9
New York City ³	21	24	23	30	19	27	20	22	21	19
Oklahoma City	—	—	—	—	—	—	—	—	3	5
Omaha	—	—	—	2	2	3	4	5	0	1
Philadelphia	9	11	14	18	14	16	16	15	14	11
Phoenix	17	15	14	12	12	13	8	7	12	7
Portland	17	22	19	21	18	26	27	25	19	22
Sacramento	—	—	—	—	—	—	—	8	5	11
St. Louis	7	7	16	8	8	7	9	5	—	—
Salt Lake City	—	—	—	—	—	—	—	14	15	9
San Antonio	21	14	14	14	13	13	9	9	10	—
San Diego	21	17	20	13	12	10	12	7	11	8
San Jose	7	9	8	10	10	9	12	5	13	4
Seattle	—	—	—	—	—	—	—	17	20	17
Spokane	—	—	—	—	—	—	—	17	13	8
Tucson	—	—	—	—	—	—	—	7	9	17
Washington, D.C.	16	19	21	13	16	11	11	10	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.²Data for 2000 are unweighted and not based on probability sampling.³Data prior to the third quarter of 1998 pertain to Manhattan only.Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 61. Percentage¹ of Adult Female Booked Arrestees Who Used Methamphetamine, by Location, 1991–2000

Location	Year									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 ²
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	0.0
Albuquerque	—	—	—	—	—	—	—	2.4	8.9	5.7
Anchorage	—	—	—	—	—	—	—	0.0	0.0	0.8
Atlanta	0.3	0.0	0.3	0.3	0.6	—	0.7	—	0.8	0.0
Birmingham	0.3	0.0	1.2	1.2	0.0	—	0.5	0.0	0.9	2.2
Chicago	—	—	—	—	—	—	—	0.0	0.0	0.3
Cleveland	0.3	0.0	0.0	0.0	0.0	—	0.0	0.0	0.0	0.0
Dallas	1.5	2.7	3.3	3.3	3.7	—	2.8	4.0	3.2	3.0
Denver	1.7	1.4	2.1	2.1	3.2	—	4.6	4.6	2.4	5.3
Des Moines	—	—	—	—	—	—	—	24.2	22.4	20.5
Detroit	0.0	0.0	0.0	0.0	0.6	—	0.0	0.0	0.0	0.0
Ft. Lauderdale	0.0	0.0	0.2	0.2	0.0	—	0.0	0.0	0.0	0.0
Honolulu	—	—	—	—	—	—	—	—	—	47.2
Houston	0.9	0.0	0.2	0.2	0.9	—	0.5	0.0	0.1	1.7
Indianapolis	0.3	0.0	0.6	0.6	0.0	—	0.2	0.0	0.5	0.7
Laredo	—	—	—	—	—	—	—	0.0	0.0	0.0
Las Vegas	—	—	—	—	—	—	—	24.3	17.9	20.5
Los Angeles	6.8	8.0	9.8	9.8	11.3	—	8.9	11.8	12.0	12.3
Minneapolis	—	—	—	—	—	—	—	0.0	2.5	0.0
New Orleans	0.3	0.5	0.5	0.5	0.0	—	0.0	0.3	0.0	0.4
New York City ³	0.0	0.0	0.0	0.0	0.2	—	0.0	0.0	0.0	0.0
Oklahoma City	—	—	—	—	—	—	—	—	11.3	16.2
Omaha	—	—	2.7	2.7	10.3	—	13.3	13.6	11.1	13.2
Philadelphia	0.2	0.4	0.7	0.7	1.1	—	0.0	0.3	0.0	0.0
Phoenix	5.6	6.9	26.0	26.0	21.7	—	25.6	22.4	14.3	24.1
Portland	11.5	7.3	21.4	21.4	19.7	—	20.7	22.3	24.8	23.5
Sacramento	—	—	—	—	—	—	—	29.2	32.4	29.6
St. Louis	0.0	0.0	0.0	0.0	0.3	—	2.1	2.5	—	—
Salt Lake City	—	—	—	—	—	—	—	31.4	34.1	28.9
San Antonio	1.6	1.6	0.7	0.7	2.5	—	2.4	1.7	1.4	—
San Diego	24.9	25.5	53.0	53.0	40.2	—	42.2	33.3	36.3	28.7
San Jose	7.1	11.3	23.3	23.3	23.6	—	24.9	21.1	31.6	40.8
Seattle	—	—	—	—	—	—	—	5.2	9.5	21.7
Spokane	—	—	—	—	—	—	—	22.0	26.6	8.3
Tucson	—	—	—	—	—	—	—	2.5	9.6	9.0
Washington, D.C.	0.0	0.0	0.0	0.0	0.0	—	0.0	0.5	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year.²Data for 2000 are unweighted and not based on probability sampling.³Data prior to the third quarter of 1998 pertain to Manhattan only.

Sources: 1991–1996 data from *Drug Use Forecasting* (1991–1996); 1997–1998 data from *Annual Report on Adult and Juvenile Arrestees* (1997 and 1998); 1999 data from *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 62. Percentage¹ of Juvenile Male Booked Arrestees Who Used Any Drug,² by Location, 1994–2000

Location	1994	1995	1996	1997	1998	1999	2000
Birmingham	38	44	55	63	51	45	42
Cleveland	47	53	63	61	62	62	57
Denver	54	51	61	65	62	62	67
Indianapolis	30	34	44	42	50	—	—
Los Angeles	37	42	57	62	61	54	62
Phoenix	51	48	56	56	69	69	60
Portland	23	19	38	43	53	43	51
St. Louis	38	38	56	54	40	—	—
San Antonio	39	44	50	58	55	56	54
San Diego	42	53	53	63	56	57	47
San Jose	35	35	46	52	42	—	—
Tucson	—	—	—	—	51	56	54
Washington, D.C.	64	58	67	66	59	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

²“Any drug” includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

Source: 1994–1996 data from *Drug Use Forecasting* (1994–1996); 1997–1999 data from *Annual Report on Adult and Juvenile Arrestees* (1997–1999), Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 63. Percentage¹ of Juvenile Male Booked Arrestees Who Used Marijuana, by Location, 1994–2000

Location	1994	1995	1996	1997	1998	1999	2000
Birmingham	34	42	53	61	47	43	42
Cleveland	42	47	62	58	60	60	55
Denver	52	49	60	62	59	59	65
Indianapolis	26	33	43	39	47	—	—
Los Angeles	31	34	51	55	56	52	57
Phoenix	41	41	52	49	64	62	55
Portland	18	16	36	41	50	41	46
St. Louis	34	34	56	54	40	—	—
San Antonio	35	41	48	53	49	53	54
San Diego	33	48	48	53	49	53	44
San Jose	28	31	41	45	35	—	—
Tucson	—	—	—	—	48	53	52
Washington, D.C.	61	54	65	65	57	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1994–1996 data from *Drug Use Forecasting* (1994–1996); 1997–1999 data from *Annual Report on Adult and Juvenile Arrestees* (1997–1999), Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 64. Percentage¹ of Juvenile Male Booked Arrestees Who Used Cocaine, by Location, 1994–2000

Location	1994	1995	1996	1997	1998	1999	2000
Birmingham	6	6	9	8	9	4	0
Cleveland	17	17	12	12	12	9	8
Denver	10	8	7	8	13	9	11
Indianapolis	8	5	6	3	11	—	—
Los Angeles	8	12	13	12	15	8	9
Phoenix	11	8	13	14	14	16	13
Portland	3	2	3	4	4	3	3
St. Louis	10	5	4	4	2	—	—
San Antonio	9	6	10	15	8	7	5
San Diego	2	4	5	4	4	3	3
San Jose	5	4	4	4	6	—	—
Tucson	—	—	—	—	5	12	11
Washington, D.C.	9	4	4	4	3	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1994–1996 data from *Drug Use Forecasting* (1994–1996); 1997–1999 data from *Annual Report on Adult and Juvenile Arrestees* (1997–1999), Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 65. Percentage¹ of Juvenile Male Booked Arrestees Who Used Opiates, by Location, 1994–2000

Location	1994	1995	1996	1997	1998	1999	2000
Birmingham	2	1	2	2	0	0	2
Cleveland	*	0	*	2	0	*	0
Denver	*	*	*	0	0	*	2
Indianapolis	1	*	*	1	0	—	—
Los Angeles	*	1	1	1	1	1	1
Phoenix	0	1	1	1	1	2	1
Portland	*	*	*	1	1	3	3
St. Louis	2	2	0	1	0	—	—
San Antonio	1	*	4	3	1	3	3
San Diego	1	1	1	2	1	*	1
San Jose	*	*	*	0	2	—	—
Tucson	—	—	—	—	0	1	0
Washington, D.C.	*	1	*	0	2	—	—

— Data not available.

*Less than 1 percent.

¹Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1994–1996 data from *Drug Use Forecasting* (1994–1996); 1997–1999 data from *Annual Report on Adult and Juvenile Arrestees* (1997–1999), Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); 2000 data from *2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 66. Percentage¹ of Juvenile Male Booked Arrestees Who Used Methamphetamine, by Location, 1997–2000

Location	1997	1998	1999	2000
Birmingham	2.1	0.0	0.0	0.0
Cleveland	0.0	0.0	0.0	0.0
Denver	1.2	0.7	0.3	1.0
Indianapolis	0.2	0.0	—	—
Los Angeles	6.5	3.6	2.2	3.8
Phoenix	6.5	6.0	5.6	5.7
Portland	2.5	3.0	0.0	5.8
St. Louis	0.0	0.0	—	—
San Antonio	0.3	0.4	0.0	0.0
San Diego	17.2	12.2	15.8	7.8
San Jose	13.7	9.0	—	—
Tucson	—	0.0	0.7	0.0
Washington, D.C.	0.0	0.0	—	—

— Data not available.

¹Percent positive by urinalysis, January through December of each year.

Source: *Annual Report on Adult and Juvenile Arrestees (1997–1999)* Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice (NIJ); *2000 data from 2000 Annualized Site Visit Reports*, ADAM, NIJ (2001).

Table 67. Methamphetamine Lab Seizures, by State: 1995–2001

State	1995	1996	1997	1998	1999	2000	2001 ¹
Alabama	2	5	4	1	26	81	104
Alaska	0	1	0	0	10	19	7
Arizona	16	83	129	222	364	375	235
Arkansas	19	74	164	148	130	209	205
California	108	155	178	118	164	1,625	846
Colorado	13	17	26	51	85	126	101
Connecticut	0	0	0	0	0	0	0
Delaware	1	0	1	0	0	1	0
District of Columbia	0	0	1	0	0	0	0
Florida	3	0	1	6	13	15	20
Georgia	3	4	10	3	21	52	21
Hawaii	0	0	3	0	2	4	3
Idaho	1	3	3	4	1	88	65
Illinois	0	5	14	45	67	112	130
Indiana	0	1	4	3	3	217	204
Iowa	4	10	22	19	16	208	218
Kansas	16	43	43	29	44	379	310
Kentucky	1	3	1	8	6	87	95
Louisiana	1	1	1	3	6	14	8
Maine	0	0	0	1	0	2	2
Maryland	0	0	0	0	1	0	0
Massachusetts	0	0	0	3	0	0	0
Michigan	3	2	4	3	7	18	49
Minnesota	10	14	14	21	20	102	63
Mississippi	0	1	0	5	9	95	89
Missouri	37	235	396	315	195	628	494
Montana	1	1	2	1	16	20	33
Nebraska	1	1	1	7	7	35	38
Nevada	23	37	19	15	20	244	144
New Hampshire	0	0	0	1	0	1	1
New Jersey	0	1	3	0	0	0	0
New Mexico	4	7	20	26	44	48	45
New York	0	0	0	0	1	1	0
North Carolina	0	0	2	1	4	13	20
North Dakota	1	1	1	0	6	22	27
Ohio	0	1	7	6	14	27	54
Oklahoma	8	71	106	102	200	300	394
Oregon	2	8	10	25	10	237	281
Pennsylvania	2	12	6	5	1	8	5
Rhode Island	0	0	0	0	0	0	1
South Carolina	0	0	0	0	0	5	2
South Dakota	1	1	2	0	1	7	14
Tennessee	2	2	22	50	60	221	265
Texas	10	12	24	31	101	341	336
Utah	29	63	112	91	204	203	113
Vermont	0	0	0	0	0	0	0
Virginia	0	0	2	1	8	1	3
Washington	2	1	4	8	23	708	447
West Virginia	0	0	0	1	4	11	9
Wisconsin	2	2	0	0	0	2	15
Wyoming	1	1	0	8	4	10	6
Total	327	879	1,362	1,387	1,918	6,922	5,522

¹2001 data through September.

Source: El Paso Intelligence Center.

Table 68. Estimated Number of Emergency Department Drug Episodes, by Metropolitan Area, 1993–2000

Metro area	1993	1994	1995	1996	1997	1998	1999	2000
Total U.S.	460,910	518,521	513,633	514,347	527,058	542,544	554,932	601,776
Atlanta	7,728	10,828	11,063	9,400	8,004	10,722	10,195	11,114
Baltimore	13,474	15,862	15,966	15,994	12,755	13,736	14,172	11,505
Boston	12,644	15,225	16,073	13,539	12,229	13,657	11,669	14,902
Buffalo	2,522	2,926	2,714	3,587	2,812	2,683	2,711	2,899
Chicago	17,978	21,511	21,885	23,524	26,891	26,209	26,158	30,330
Dallas	4,739	5,160	5,230	4,978	6,195	7,198	6,245	6,798
Denver	3,791	5,034	4,609	3,419	4,338	4,091	4,816	4,946
Detroit	19,169	17,162	18,630	20,822	17,604	17,483	16,126	17,042
L.A.-Long Beach	20,611	19,256	19,260	20,278	17,187	17,103	20,678	25,288
Miami-Hialeah	5,588	5,849	6,421	6,292	6,285	6,426	7,128	8,560
Minn.-St. Paul	4,558	4,611	4,327	4,836	4,974	4,348	4,643	5,198
New Orleans	4,092	4,739	5,868	5,844	5,209	5,091	4,459	4,664
New York	45,116	43,127	40,792	40,471	37,116	36,142	30,662	31,885
Newark	9,216	9,395	10,870	9,909	8,893	8,944	8,301	7,749
Philadelphia	19,801	17,711	20,502	21,634	23,229	24,928	24,413	23,433
Phoenix	5,930	6,879	7,913	7,434	7,327	7,060	8,293	9,072
St. Louis	4,020	6,039	5,662	6,188	5,664	5,719	6,336	6,908
San Diego	5,310	5,051	4,661	5,811	6,754	6,982	7,036	7,094
San Francisco	11,763	11,766	10,165	9,536	9,424	9,070	8,930	7,857
Seattle	7,266	10,049	8,517	8,476	10,593	8,332	8,426	11,116
Washington, DC	12,339	14,152	11,830	11,720	11,194	11,596	10,282	10,303
National panel	223,256	266,189	260,674	260,654	282,380	295,023	313,254	343,112

Note: These estimates are based on a representative sample of non-Federal short-stay hospitals with 24-hour emergency departments in the coterminous United States.

Source: Office of Applied Studies, *Drug Abuse Warning Network, 2000* (March 2001 update).

Table 69. Estimated Number of Emergency Department Cocaine Mentions, by Metropolitan Area, 1993–2000

Metro Area	1993	1994	1995	1996	1997	1998	1999	2000
Total U.S.	123,423	142,878	135,801	152,433	161,087	172,014	168,763	174,896
Atlanta	4,384	6,165	6,515	5,434	4,244	5,980	5,236	6,229
Baltimore	7,643	8,882	8,603	8,515	6,253	6,871	6,921	4,943
Boston	3,912	4,715	5,267	4,109	3,333	4,526	3,560	4,101
Buffalo	974	1,207	1,334	2,203	1,526	1,225	1,119	1,018
Chicago	8,640	10,797	10,702	12,688	14,373	13,640	13,399	14,871
Dallas	1,345	1,426	1,457	1,393	1,778	2,586	2,107	2,180
Denver	968	1,299	1,149	811	1,072	1,254	1,382	1,342
Detroit	8,991	7,964	8,767	10,435	8,093	8,617	7,699	7,870
L.A.-Long Beach	5,362	5,070	4,985	5,710	4,707	5,783	6,772	9,111
Miami-Hialeah	2,662	2,742	3,078	3,104	3,254	3,553	4,018	4,381
Minn.-St. Paul	457	578	465	675	736	773	814	841
New Orleans	1,686	1,884	2,018	2,380	2,363	2,396	2,140	1,998
New York	21,085	20,214	19,724	21,592	20,202	19,549	14,799	14,250
Newark	3,825	4,228	4,658	4,436	3,571	3,743	3,124	2,726
Philadelphia	9,943	8,446	9,502	10,384	11,202	13,049	12,434	10,497
Phoenix	838	1,067	1,165	1,382	1,334	1,486	1,882	1,778
St. Louis	1,220	2,329	1,841	1,852	1,494	2,073	2,329	2,403
San Diego	869	668	644	906	846	971	1,063	1,002
San Francisco	3,035	3,123	2,560	2,315	1,979	1,843	1,936	2,056
Seattle	1,760	2,896	2,157	2,143	2,850	2,399	2,520	3,338
Washington, DC	4,275	4,849	3,542	3,881	3,223	3,718	3,150	2,830
National panel	29,550	42,330	35,668	46,085	62,654	66,078	70,361	75,129

Note: These estimates are based on a representative sample of non-Federal short-stay hospitals with 24-hour emergency departments in the coterminous United States.

Source: Office of Applied Studies, *Drug Abuse Warning Network, 2000* (March 2001 update).

Table 70. Estimated Number of Emergency Department Heroin/Morphine Mentions, by Metropolitan Area, 1993–2000

Metro Area	1993	1994	1995	1996	1997	1998	1999	2000
Total U.S.	63,232	64,013	70,838	73,846	72,010	77,645	84,409	97,287
Atlanta	250	456	424	414	400	483	432	507
Baltimore	5,719	7,510	8,222	8,111	5,873	6,725	7,013	5,414
Boston	2,319	2,527	2,971	2,751	2,517	2,756	2,874	3,888
Buffalo	279	355	385	448	471	545	525	687
Chicago	3,581	4,787	4,725	6,282	8,633	9,383	9,725	12,564
Dallas	297	237	276	347	516	512	444	492
Denver	276	495	470	344	476	509	651	682
Detroit	2,380	2,106	2,401	3,214	3,046	2,901	2,678	3,369
L.A.-Long Beach	3,724	2,949	3,088	3,305	2,532	2,631	2,955	3,225
Miami-Hialeah	251	264	336	391	599	772	921	1,459
Minn.-St. Paul	138	78	106	127	170	177	207	237
New Orleans	140	179	274	308	431	534	664	996
New York	11,351	11,185	10,728	11,167	9,491	9,244	9,331	11,028
Newark	4,526	4,498	5,686	5,392	4,367	5,080	4,736	4,401
Philadelphia	2,478	2,440	3,879	3,941	3,817	3,586	4,152	4,719
Phoenix	487	483	490	635	832	893	877	899
St. Louis	215	408	394	502	472	644	876	1,111
San Diego	842	695	691	982	927	1,011	1,112	1,070
San Francisco	3,694	3,555	3,139	3,157	2,751	2,386	3,074	2,773
Seattle	1,727	2,092	2,034	2,442	2,922	2,439	2,488	2,522
Washington, DC	1,414	1,261	1,307	1,535	1,691	2,112	1,794	1,967
National panel	17,146	15,437	18,813	18,052	19,074	22,323	26,880	33,277

Note: These estimates are based on a representative sample of non-Federal short-stay hospitals with 24-hour emergency departments in the coterminous United States.

Source: Office of Applied Studies, *Drug Abuse Warning Network, 2000* (March 2001 update).

Table 71. Estimated Number of Emergency Department Marijuana/Hashish Mentions, by Metropolitan Area, 1993–2000

Metro area	1993	1994	1995	1996	1997	1998	1999	2000
Total U.S.	28,873	40,183	45,271	53,789	64,744	76,870	87,150	96,446
Atlanta	849	1,527	1,671	1,547	1,578	2,633	2,515	2,431
Baltimore	625	770	945	1,194	1,402	1,495	1,679	1,620
Boston	1,185	1,870	2,400	2,127	1,768	2,907	1,961	2,945
Buffalo	138	230	295	512	472	453	493	553
Chicago	1,366	2,219	2,919	3,533	4,424	5,002	4,561	5,401
Dallas	367	477	555	556	916	1,513	1,176	1,226
Denver	202	406	497	288	505	579	681	818
Detroit	2,716	2,849	3,875	4,215	3,746	4,335	4,100	4,344
LA-Long Beach	1,745	1,658	1,706	2,132	2,084	3,423	5,473	5,846
Miami-Hialeah	472	711	969	1,015	1,030	1,118	1,285	1,770
Minn.-St. Paul	391	482	469	544	604	491	627	803
New Orleans	610	885	1,025	1,247	1,345	1,196	1,044	1,068
New York	2,092	2,589	2,976	3,571	3,842	3,684	3,491	3,544
Newark	436	628	743	627	500	532	533	541
Philadelphia	1,955	2,085	3,061	3,436	4,556	5,310	5,465	4,936
Phoenix	226	453	474	610	741	726	1,028	1,073
St. Louis	155	901	861	925	1,109	1,338	1,640	1,763
San Diego	479	513	480	626	970	1,127	923	955
San Francisco	451	479	507	425	390	394	470	627
Seattle	406	870	993	897	1,663	936	808	1,414
Washington, DC	2,102	2,712	2,035	2,167	2,394	2,362	2,518	2,511
National panel	9,905	14,868	15,814	21,596	28,075	35,316	44,679	50,255

Note: These estimates are based on a representative sample of non-Federal short-stay hospitals with 24-hour emergency departments in the coterminous United States.

Source: Office of Applied Studies, *Drug Abuse Warning Network, 2000* (March 2001 update).

Table 72. Estimated Number of Emergency Department Methamphetamine/Speed Mentions, by Metropolitan Area, 1993–2000

Metro area	1993	1994	1995	1996	1997	1998	1999	2000
Total U.S.	9,926	17,665	15,936	11,002	17,154	11,491	10,447	13,513
Atlanta	55	101	147	135	214	162	83	109
Baltimore	5	4	4	6	7	6	10	6
Boston	15	3	7	—	13	6	12	14
Buffalo	7	8	6	9	8	9	7	5
Chicago	20	20	34	28	29	33	22	25
Dallas	79	154	203	115	159	186	100	135
Denver	55	145	176	105	292	120	101	110
Detroit	24	17	15	—	—	0	—	—
LA-Long Beach	1,226	1,400	1,276	1,268	1,229	786	910	1,375
Miami-Hialeah	4	8	5	9	10	16	9	15
Minn.-St. Paul	42	64	93	108	217	112	112	153
New Orleans	10	12	18	22	26	25	23	27
New York	16	21	23	21	32	36	17	31
Newark	1	—	—	—	—	—	3	6
Philadelphia	110	92	91	66	101	48	47	67
Phoenix	481	813	777	725	800	446	341	600
St. Louis	29	52	76	39	67	66	104	162
San Diego	929	913	686	666	976	721	584	747
San Francisco	992	1,258	1,106	934	1,012	616	554	591
Seattle	177	299	260	195	479	266	353	540
Washington, DC	20	33	24	11	—	16	33	62
National panel	5,628	12,245	10,906	6,499	11,454	7,810	7,010	8,731

— Estimate does not meet standard of precision.

Note: These estimates are based on a representative sample of non-Federal short-stay hospitals with 24-hour emergency departments in the coterminous United States.

Source: Office of Applied Studies, *Drug Abuse Warning Network, 2000* (March 2001 update).

Table 73. Alcohol and Other Drug Use Among Students¹ in Select European Countries and the United States, 1995 and 1999

Country	Cigarette use in past 30 days		Alcohol use in past 30 days		Lifetime any illicit drug use		Lifetime marijuana use		Marijuana use in past 30 days		Lifetime inhalant use	
	1995	1999	1995	1999	1995	1999	1995	1999	1995	1999	1995	1999
Bulgaria	—	50	—	5	—	14	—	12	—	—	—	3
Croatia	32	38	6	6	8	17	9	16	3	6	13	13
Cyprus	23	16	12	8	6	3	5	2	2	1	—	—
Czech Republic	36	44	9	14	23	35	22	35	7	16	8	7
Denmark	28	38	15	18	18	25	17	24	6	8	6	7
Estonia	28	32	2	4	8	16	7	13	—	—	8	7
Faroe Islands	42	41	4	4	12	8	11	7	2	1	8	5
Finland	37	43	1	1	5	10	5	10	1	2	4	5
France	—	44	—	8	—	35	—	35	—	22	—	11
FYROM ²	—	37	—	3	—	10	—	8	—	3	—	4
Greece	—	35	—	13	—	10	—	9	—	4	—	14
Greenland	—	67	—	3	—	21	—	23	—	10	—	19
Hungary	34	36	4	5	5	12	4	11	1	4	6	4
Iceland	32	28	1	1	10	16	10	15	4	4	8	11
Ireland	41	37	12	16	37	32	37	32	19	15	—	22
Italy	36	40	13	7	21	26	19	25	13	14	8	6
Latvia	—	40	—	2	—	22	—	17	—	—	—	6
Lithuania	25	40	2	8	3	15	1	12	0	4	16	10
Malta	31	32	16	20	2	8	8	7	2	3	17	16
Norway	36	40	1	3	6	13	6	11	3	4	7	16
Poland	28	33	4	8	9	18	8	14	3	7	9	9
Portugal	24	31	5	6	8	11	7	8	4	5	—	3
Romania	—	24	—	4	—	11	—	1	—	1	—	1
Russia (Moscow)	—	45	—	8	—	24	—	22	—	5	—	9
Slovak Republic	27	37	—	7	10	20	9	19	3	6	6	7
Slovenia	19	29	5	8	13	26	13	25	5	13	12	4
Sweden	30	30	1	2	6	9	6	8	1	2	12	8
Ukraine	38	40	3	5	14	21	14	20	5	5	5	8
United Kingdom	36	34	13	16	42	36	41	35	24	16	20	15
United States	—	26	—	5	—	—	—	41	—	19	—	17

— Data not available.

¹Students surveyed were in the 15–16 year age range, approximately equivalent to 10th graders in the United States.²Former Yugoslav Republic of Macedonia.Source: *The 1999 European School Survey Project on Alcohol and Other Drugs: Alcohol and Other Drug Use Among Students in 30 European Countries*, The Swedish Council for Information on Alcohol and Other Drugs, CAN Council of Europe, Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, Pompidou Group (2000).

Table 74. Percentage of High School Students Who Used Selected Drugs by State, Youth Risk Behavior Survey, 1999 State Surveys

State	Current use ¹				Episodic heavy drinking ²	Lifetime ³	
	Marijuana	Cocaine	Inhalant	Cigarette		Illegal steroid use	Injecting illegal drug use
Weighted data⁴							
Alabama	22.2	3.2	4.4	36.6	29.0	5.3	3.0
Alaska	30.7	4.1	4.3	33.9	34.4	5.0	3.5
Arkansas	24.4	4.6	4.8	39.6	33.4	5.0	3.8
Delaware	29.0	2.7	4.0	32.2	27.1	3.2	2.3
Hawaii	24.7	3.3	3.9	27.9	26.8	2.5	1.6
Massachusetts	30.6	4.3	4.1	30.3	32.6	4.6	2.7
Michigan	25.9	3.4	4.2	34.1	29.9	4.0	2.3
Mississippi	18.9	2.1	4.5	31.5	25.4	4.4	1.8
Missouri	25.6	2.7	3.0	32.8	32.0	3.5	2.0
Montana	25.5	4.0	4.4	35.0	43.6	4.1	2.4
Nevada	25.9	4.9	5.1	32.6	35.6	4.0	3.0
New York	23.4	3.0	3.7	31.8	28.8	3.7	2.0
North Dakota	18.8	—	3.7	40.6	46.2	2.5	2.4
Ohio	26.1	3.4	4.3	40.3	37.4	4.2	2.3
South Carolina	24.5	3.5	4.1	36.0	25.4	4.6	2.8
South Dakota	20.7	3.3	—	43.6	46.1	3.2	2.5
Tennessee	26.6	3.8	5.0	37.5	28.5	5.6	2.2
Utah	10.6	1.5	3.6	11.9	15.8	4.3	2.3
Vermont	33.7	5.4	5.3	33.4	32.4	5.3	—
West Virginia	29.3	4.4	6.7	42.2	35.5	5.3	3.2
Wisconsin	21.5	4.4	3.8	38.1	34.4	3.4	2.3
Wyoming	21.4	3.7	4.2	35.2	39.5	4.9	2.8
Unweighted data							
Connecticut	27.8	3.6	3.7	31.2	27.5	4.1	2.4
Florida	23.1	5.4	4.4	27.4	27.9	4.9	3.7
Illinois	21.5	2.6	4.7	34.0	33.1	2.7	1.5
Iowa	18.5	3.0	3.2	35.8	39.6	3.3	1.7
Kentucky	23.6	4.1	5.7	41.5	36.8	5.1	3.0
Louisiana	20.2	3.2	3.7	33.3	29.4	5.6	3.0
Maine	30.9	3.8	5.6	31.2	35.1	6.1	3.3
Nebraska	15.6	2.3	3.5	37.3	40.8	2.6	1.8
New Hampshire	30.3	3.4	5.2	34.1	33.2	4.3	2.5
New Jersey	22.7	2.4	4.3	33.8	30.2	2.1	1.5
New Mexico	31.2	8.5	6.5	36.2	38.1	5.9	4.5

— Data not available.

¹Use at least once on at least one of the 30 days preceding the survey.²Drank five or more drinks of alcohol on one or more occasions on at least one of the 30 days preceding the survey.³Ever used.⁴Weighted data are representative of the state or jurisdiction.Source: *Morbidity and Mortality Weekly Report*, Youth Risk Behavior Surveillance—United States (1999), Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.

Table 75. Percentage of High School Students Who Used Selected Drugs in Selected Cities, Youth Risk Behavior Survey, 1999 Local Surveys

Local Area	Current Use ¹				Episodic heavy drinking ²	Lifetime ³	
	Marijuana	Cocaine	Inhalant	Cigarette		Illegal steroid use	Injecting illegal drug use
Weighted data⁴							
Boston	20.5	2.1	2.0	17.8	17.4	2.5	0.6
Chicago	27.3	2.7	3.4	29.0	19.3	3.4	2.5
Dallas	23.2	4.1	3.6	25.0	21.1	3.2	1.1
Detroit	20.7	2.0	3.3	17.7	12.6	4.1	2.5
District of Columbia	25.7	1.3	2.1	19.9	14.9	1.4	1.1
Ft. Lauderdale	20.9	2.6	3.2	21.9	20.1	2.9	1.8
Houston	19.0	3.7	2.1	25.4	20.5	3.2	1.4
Miami	19.3	5.2	4.0	20.9	19.5	4.2	2.7
New Orleans	21.0	2.4	3.6	17.0	15.2	4.4	3.1
New York City	17.3	1.7	3.1	24.1	16.6	2.7	0.8
Palm Beach	26.3	5.5	5.4	26.1	31.7	5.8	4.1
Philadelphia	21.4	2.1	2.2	23.0	17.0	3.8	1.6
San Diego	22.2	3.2	4.1	23.1	22.3	3.4	1.5
Seattle	26.2	—	2.6	25.9	21.5	—	1.4
Unweighted data							
San Bernadino	19.4	2.7	3.4	19.9	29.1	4.7	1.8
San Francisco	15.2	1.6	3.1	18.7	11.4	2.2	0.9

— Data not available.

¹Use at least once on at least 1 of the 30 days preceding the survey.

²Drank 5 or more drinks of alcohol on 1 or more occasions on at least 1 of the 30 days preceding the survey.

³Ever used.

⁴Weighted data are representative of the state or jurisdiction.

Source: *Morbidity and Mortality Weekly Report*, Youth Risk Behavior Surveillance—United States (1999), Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.

List of Acronyms

ADAM	Arrestee Drug Abuse Monitoring system (formerly DUF)
AIDS	acquired immunodeficiency syndrome
BJS	Bureau of Justice Statistics
CAI	computer-assisted interview
CDC	Centers for Disease Control and Prevention
CPS	Current Population Survey
CSAP	Center for Substance Abuse Prevention (under SAMHSA)
CSAT	Center for Substance Abuse Treatment (under SAMHSA)
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DUF	Drug Use Forecasting program
ED	emergency department
EPIC	El Paso Intelligence Center
ESPAD	European School Survey Project on Alcohol and Other Drugs
FBI	Federal Bureau of Investigation
FDSS	Federal-Wide Drug Seizure System
HIV	human immunodeficiency virus
ICD-9	International Classification of Diseases, Version 9
ICD-10	International Classification of Diseases, Version 10
INCSR	International Narcotics Control Strategy Report
MDMA	3, 4-methylenedioxymethamphetamine (Ecstasy)
ME	medical examiner

MTF	Monitoring the Future study
NCHS	National Center for Health Statistics (under CDC)
NDATUS	National Drug and Alcoholism Treatment Unit Survey
NDCS	National Drug Control Strategy
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIJ	National Institute of Justice
NTOMS	National Treatment Outcome Monitoring System
OAS	Office of Applied Studies
ONDCP	Office of National Drug Control Policy
PAPI	paper-and-pencil interview
PME	Performance Measures of Effectiveness
SAMHSA	Substance Abuse and Mental Health Services Administration
SIFCF	Survey of Inmates in Federal Correctional Facilities
SISCF	Survey of Inmates in State Correctional Facilities
STAR	Sequential Transition and Reduction Model
STRIDE	System To Retrieve Information on Drug Evidence
STD	sexually transmitted disease
TB	tuberculosis
THC	delta-9-tetrahydrocannabinol (the principal psychoactive ingredient of marijuana)
UCR	Uniform Crime Reports
UFDS	Uniform Facility Data Set
YRBS	Youth Risk Behavior Survey

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