National Drug Control Strategy

The White House
February 2003

National Drug Control Strategy

U P D A T E

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TO THE CONGRESS OF THE UNITED STATES:

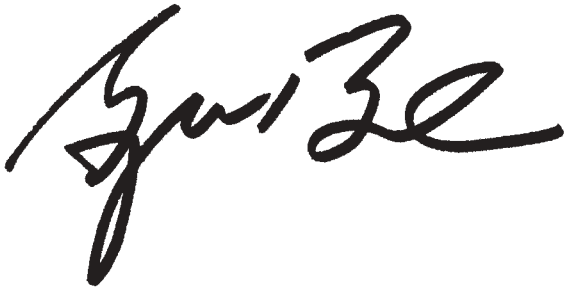
I am pleased to transmit the 2003 National Drug Control Strategy, consistent with the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1705).

A critical component of our Strategy is to teach young people how to avoid illegal drugs because of the damage drugs can do to their health and future. Our children must learn early that they have a lifelong responsibility to reject illegal drug use and to stay sober. Our young people who avoid drugs will grow up best able to participate in the promise of America.

Yet far too many Americans already use illegal drugs, and most of those whose drug use has progressed -- more than five million Americans -- do not even realize they need help. While those who suffer from addiction must help themselves, family, friends, and people with drug experiences must do their part to help to heal and to make whole men and women who have been broken by addiction.

We know the drug trade is a business. Drug traffickers are in that business to make money, and this Strategy outlines how we intend to deny them revenue. In short, we intend to make the drug trade unprofitable wherever we can.

Our Strategy is performance-based, and its success will be measured by its results. Those results are our moral obligation to our children. I ask for your continued support in this critical endeavor.



THE WHITE HOUSE

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INTRODUCTION

Last year's National Drug Control Strategy opened on an unsettling note. Just-released data from the 2000–2001 school year had confirmed the continuation of a trend, begun in the early 1990s, of near-record levels of drug use among young people. More than half of American high school seniors had tried illegal drugs at least once by graduation, while a quarter of seniors were regular users. An unacceptably high percentage were regular users of drugs such as marijuana, Ecstasy, and hallucinogens such as LSD. As was the case in the 1960s and 1970s, drug use had once again become all too accepted by our young people.

In this year's Strategy, by contrast, we are pleased to report that after a long upward trajectory, teen drug use is once again headed in the right direction—down. In fact, data from the University of Michigan's most recent *Monitoring the Future* survey show the first significant downturn in youth drug use in nearly a decade, with reductions in drug use noted among 8th, 10th, and 12th graders, and levels of use for some drugs that are lower than they have been in almost three decades. Such comprehensive declines are remarkably rare; they carry the hopeful suggestion that America has, again, begun to work effectively to reduce the drug problem.

Among the survey's findings:

- The percentages of 8th and 10th graders using "any illicit drug" were at their lowest levels since 1993 and 1995, respectively.

- Among 10th graders, marijuana use in the past year and past month decreased, as did daily use in the past month. Past-year marijuana use among 8th graders has dropped to 14.6 percent—its lowest level since 1994.

- With a single exception (past-month, or "current," use by 12th graders), the use of illegal drugs other than marijuana fell for all three grades surveyed and for all three prevalence periods (lifetime, annual, and past month), although not all changes reached statistical significance.

- Ecstasy use was down in all three grades. Ecstasy use in the past year and past month decreased significantly among 10th graders from 2001 to 2002. Past-year and lifetime rates were below those for 2000 in all three grades.

- Lifetime and past-year LSD use decreased significantly among 8th, 10th, and 12th graders, and past-month use declined among 10th and 12th graders. Past-year and past-month LSD use by 12th graders reached its lowest point in the 28-year history of the survey.

Nor are these hopeful trends confined to a single survey. The *Monitoring the Future* data is reinforced by other studies, including the annual survey of the Parents' Resource Institute for Drug Education (PRIDE), which measures drug use among junior high and high school students. The simultaneous decline of teen drinking and smoking (another finding of the *Monitoring the Future* survey) shows that students are not substituting one substance for another, as some had predicted, but rather avoiding (and in some cases having difficulty obtaining) intoxicants of all types.

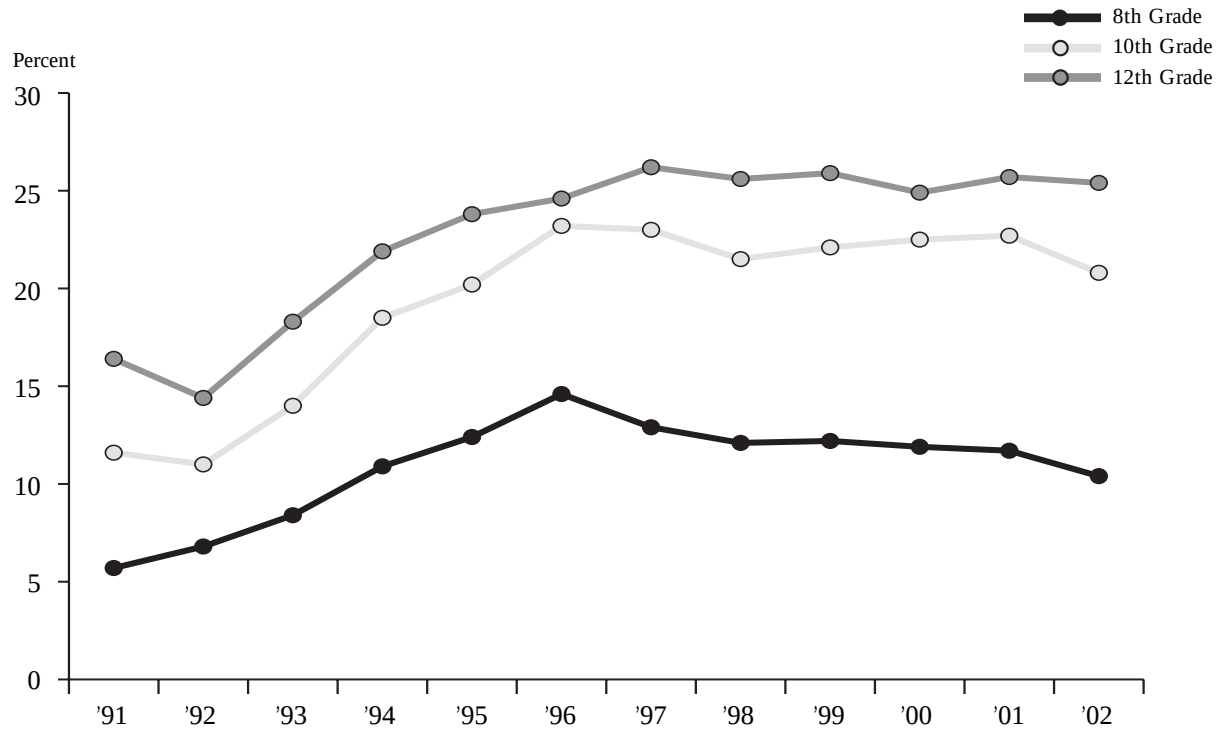
A Balanced Strategy

We have achieved the important goal of getting drug use by our young people moving downward. We now must secure the equally important objective of sustaining, accelerating, and broadening that downward movement. This time we intend to make the problem much smaller and build the structures that will keep it from growing larger in the future. Maintaining our momentum will require a sustained focus on all aspects of drug control, as well as a balanced strategy for approaching the problem. With its three priorities and clarity of purpose, this document offers both.

With regard to Priority I of the Strategy, Stopping Drug Use Before It Starts, this document recognizes that it is critical to teach young people how to avoid drug use because of the damage drugs can inflict on their health and on their future. Our children must learn from an early age that avoiding drug use is a lifelong responsibility. Where parents and educators deem appropriate, we should use programs such as student drug testing. Testing programs work because they reflect an understanding of teen motivations, giving students an easy way to say "no" at an age when peer pressure is at its peak.

Despite our substantial drug prevention efforts, some 16 million Americans still use drugs on a current basis, and roughly six million meet the

Figure 1: Past-Month Use of Any Illicit Drug by Eighth, Tenth, and Twelfth Graders

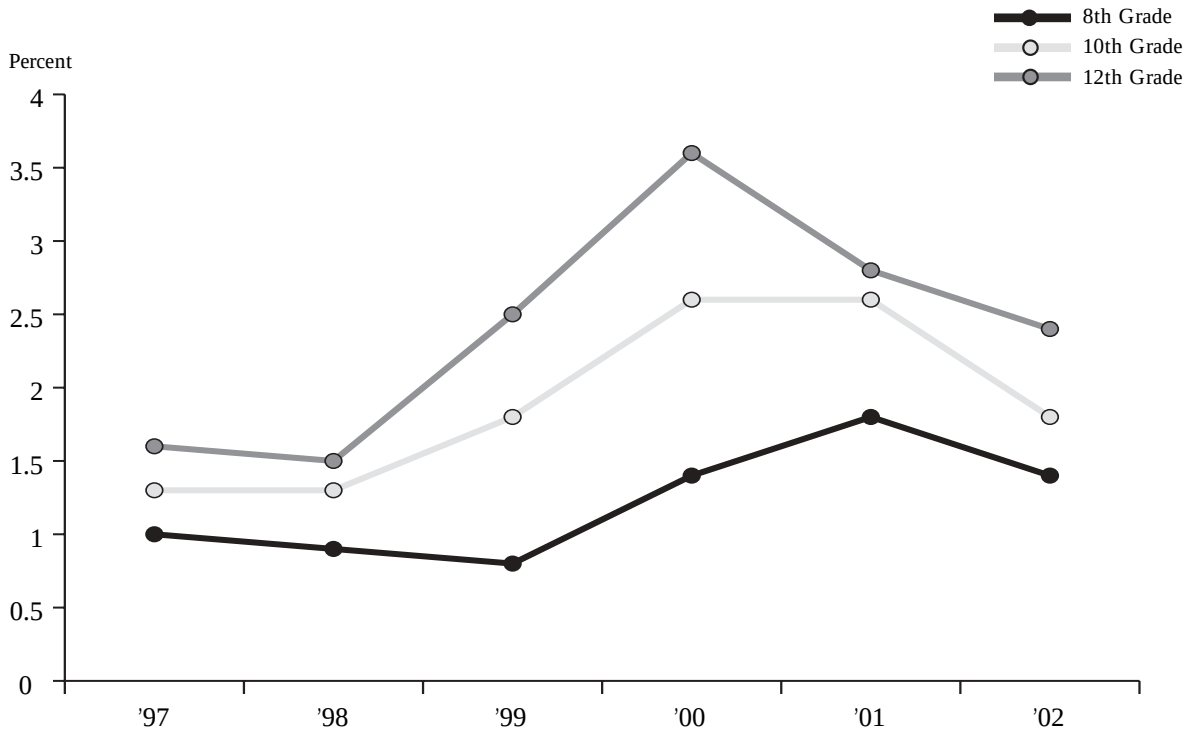


Source: Monitoring the Future (2002)

clinical criteria for needing drug treatment. Yet the overwhelming majority of users in need of drug treatment fail to recognize it—a fact that would not come as a surprise to those with a loved one who has battled drug dependency. Priority II of the Strategy, Healing America's Drug Users, emphasizes the crucial need for family, friends, and people with shared experiences to intercede with and support those fighting to overcome substance abuse. Drug users also need the support of institutions and the people who run them—employers, law enforcement agencies, faith communities, and health care providers, among others—to help identify them as drug users and direct those who need it into drug treatment. To expand access to substance abuse treatment, this Strategy proposes a new voucher program, funded with $600 million over three years, that will encourage accountability in the treatment system while making funds available on a non-discriminatory basis to all providers—including programs run by faith-based organizations.

Priority III of the Strategy, Disrupting the Market, addresses the drug trade as a business—one that faces numerous and often overlooked obstacles that may be used as pressure points. The drug trade is not an unstoppable force of nature but rather a profit-making enterprise where costs and rewards exist in an equilibrium that can be disrupted. Every action that makes the drug trade more costly and less profitable is a step toward "breaking" the market. As the Strategy explains, drug traffickers are in business to make money. We intend to deny them that revenue.

Figure 2: Past-Month Use of MDMA (Ecstasy) by Eighth, Tenth, and Twelfth Graders



Source: Monitoring the Future (2002)

Progress Toward Two- and Five-Year Goals

The President's National Drug Control Strategy, transmitted to Congress in February 2002, had as its goal reducing past-month, or current, use of illegal drugs in the 12- to 17-year-old age group by 10 percent over 2 years and 25 percent over 5 years. Similarly, the Strategy set the goal of reducing current drug use among adults (age 18 and up) by 10 percent over 2 years and 25 percent over 5 years.

Progress toward youth goals was to have been measured entirely from the baseline of the *National Household Survey on Drug Abuse*, but recent improvements to that survey have created a discontinuity between the 2002 survey and previous years' data. Although changes to the survey will permit more reliable estimates of drug use in future years, they prevent comparisons with use rates from the baseline year (2000). Fortunately, there is another survey that measures drug use among young people while preserving continuity over time. As a result, the Strategy will measure progress toward the two- and five-year goals as follows: drug use by young people will be measured at the 8th, 10th, and 12th grade levels using the *Monitoring the Future* survey, with the 2000–2001 school year as a baseline.

Although only the first year of the two-year goal period has elapsed, the goal of reducing current use by 10 percent among 8th, 10th, and 12th graders, as measured by *Monitoring the Future*, is well on the way to being met (with reductions of 11.1, 8.4, and 1.2 percent, respectively). These findings are comparable to those of the PRIDE survey, which, using a different methodology and measuring slightly different age groups, found

NATIONAL DRUG CONTROL STRATEGY GOALS

Two-Year Goals:	A 10-percent reduction in current use of illegal drugs by 8th, 10th, and 12th graders.
	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 8th, 10th, and 12th graders.
	A 25-percent reduction in current use of illegal drugs by adults age 18 and older.

Progress toward youth goals will be measured from the baseline established by the *Monitoring the Future* survey for the 2000–2001 school year. Progress toward adult goals will be measured from the baseline of the 2002 *National Household Survey on Drug Abuse*. All Strategy goals seek to reduce "current" use of "any illicit drug." Use of alcohol and tobacco products, although illegal for youths, is not measured in these estimates.

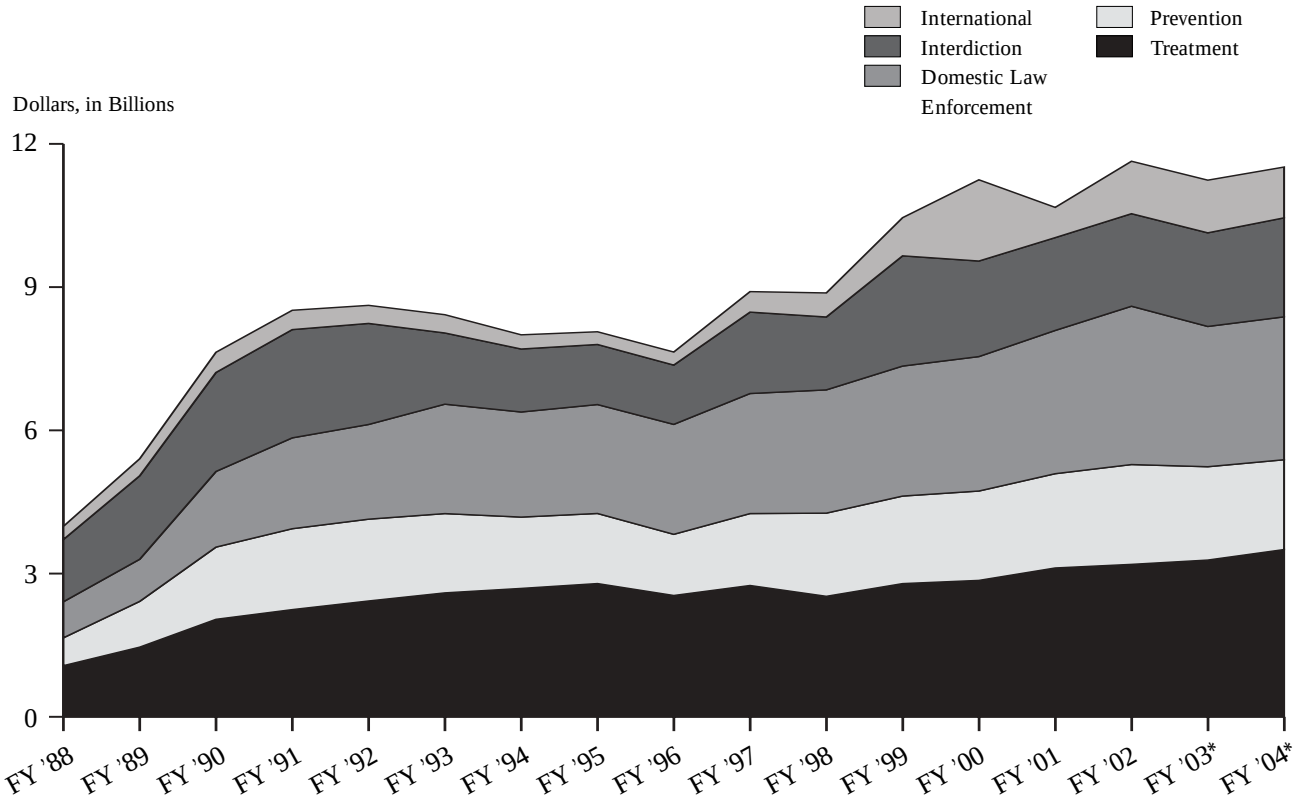
reductions of 14.3 percent for past-month drug use by junior high school students and an 11.1 percent drop among high school students—over the same one-year period. Either way, the observed reductions are on track for meeting the Strategy's goal of a 10 percent reduction over two years.

Given the discontinuity problem, and with no available substitute for measuring adult use (*Monitoring the Future* focuses on teen use), measuring the two- and five-year goals for adults poses a different challenge. This Strategy meets the challenge by measuring adult use from the baseline of the improved and redesigned 2002 *Household Survey*.

The President's Management Agenda: Integrating Budget and Performance

Over the past year, the Administration has continued to apply the principles of the President's management agenda to the National Drug Control Program. Working with the Office of Management and Budget (OMB), the Office of National Drug Control Policy (ONDCP)

Figure 3: The Federal Drug Control Budget 1988–2004—Constant Dollars



* President's Request

has implemented the budget restructuring proposal outlined last year in the National Drug Control Strategy. Additionally, all national drug control agencies have worked to enhance information on program performance and integrate this information into budget decisions. The Administration is committed to continuing this effort and integrating performance data more closely with the new drug budget.

As a result, the drug budget presented for fiscal year 2004 reflects for the first time actual resources committed to anti-drug efforts. (See Figure 3 for a brief history of the drug budget.) Rather than being based on estimates derived after decisions were made, as was the case in previous years, with few exceptions this budget reflects actual dollars identified in the congressional presentations of drug control agencies that accompany the annual submission of the President's budget. Additionally, the budget reflects only those expenditures aimed at reducing drug use rather than, as in the past, those associated with the consequences of drug use. (The latter are reported periodically in *The Economic Costs of Drug Abuse in the United States.*)

Now that the drug control budget has been narrowed in scope and presented in terms of actual expenditures, it will serve as a more useful tool for policymakers. Resource allocation will become part of the decision-making process rather than information reported after decisions are made.

Making wise allocation decisions requires that policymakers have better performance data about the programs supported by the budget. To that end, in preparation for the development of the President's budget, ONDCP worked closely with OMB to assess the results of selected drug control programs that collectively comprise 32 percent of the drug budget. The results of those assessments are presented in the President's budget.

As we work together to expand the coverage of these assessments across the drug control budget, we will develop a new framework for integrating program results with the Strategy's principal goal—reducing drug use.

Progress toward reducing overall U.S. drug use will be measured by monitoring key indicators and targets that are tied to the Strategy's three priorities—Stopping Use Before it Starts, Healing America's Drug Users, and Disrupting the Market. Each of these priority indicators in turn will be supported by the goals of the individual drug control programs.

Under the Government Performance and Results Act, each drug control agency already presents a strategic plan and annual performance plans and reports. Over the coming year, ONDCP will work with the agencies responsible for drug control programs to ensure that measures of effectiveness are in place and appropriate targets are set.

From the central goal of reducing drug use, all planning will proceed to the priorities, and from there to individual program plans. Program results will be tracked in reverse order: as each program accomplishes its objective, progress will be reflected in the priorities and, ultimately, in the central goal of reducing drug use. Where progress is lacking, we will adjust the array of programs to get back on track. Allocation decisions will be made to support programs that work and those that effectively support the Strategy.

The new drug budget and the results framework that supports it will enhance accountability in government by integrating budget and performance across the Federal Government.

National Drug Control Strategy:
NATIONAL PRIORITIES

BUDGET HIGHLIGHTS

- **ONDCP—National Youth Anti-Drug Media Campaign: $170 million.** The fiscal year 2004 President's Budget continues funding for ONDCP's Media Campaign, which uses paid advertising and grassroots public outreach to educate the Nation's families, parents, and youth about drug use and its consequences. Targeted, high-impact media messages—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. In a continuing effort to reach the Nation's youth, the Media Campaign has recently undergone a significant revision and instituted a new strategy. This new strategy requires testing of all television advertising for effectiveness before airing; a shift of the youth target audience to focus on ages 14–16, the years during which youth appear to be at greater risk for initiating drug use; reduction in the number of youth-strategic message platforms from three to two, for a more focused approach; modification of the Media Campaign to focus primarily on the prevention of marijuana use by youth; more oversight by ONDCP in the creative/ad development process; and a harder-hitting ad style.

- **ONDCP—Drug-Free Communities Program: $70 million.** This program assists community groups in forming and sustaining effective community and anti-drug coalitions that fight the use of illegal drugs. These coalitions work toward reducing substance abuse among youth and strengthening collaboration among organizations and agencies in both the private and public sectors, and serve as catalysts for increased citizen participation in strategic planning to reduce drug use over time. In addition, Drug-Free Community coalitions are expected to synthesize data from all available sources to better document the nature and extent of local drug problems, including the underage use of alcohol and tobacco and any use of illicit drugs and inhalants. To further the efforts of these important coalitions, the Administration proposes an increase of $10 million over the fiscal year 2003 requested level.

- **Education—Safe and Drug-Free Schools and Communities (SDFSC) Program: $694 million** ($584 million drug related). The fiscal year 2004 President's Budget determined that this program is ineffective, and recommends the investigation of new strategies for measuring program performance and distributing funds. The Budget makes a modest reduction in funding for this school-based drug prevention program, which reaches young people in most of the Nation's school districts, until the program can demonstrate results. SDFSC funds are appropriated directly for State Grants and National Programs. State Grants provide funding to all 50 governors and state education agencies. As part of the National Programs budget in fiscal year 2004, $8 million is requested for a competitive grant program that will provide for drug testing, assessment, referral, and intervention. Drug testing has been shown to be effective at reducing drug use in schools and businesses across the country. This funding will expand drug testing efforts initiated by the Department of Education in fiscal year 2003.

- **Corporation for National and Community Service—Parents Drug Corps Initiative: $5 million.** This initiative will establish a program to support and encourage parents to help children stay drug free. This program will provide matching funds to national parents' organizations to train thousands of parents nationwide in how to reduce drug abuse and form parent drug prevention groups.

Stopping Use Before It Starts: Education and Community Action

Prevention efforts are our first line of defense against illegal drug use. Such efforts hold out the promise of preventing drug use before it starts and sparing families the anguish of watching a loved one slip into the grasp of addiction. Although we face a major challenge in driving down drug use—with 16 million past-month (current) users and six million in need of drug treatment—our Nation's strategy for preventing the use of illegal drugs has much to recommend it. The fact is that although 7 percent of Americans use an illegal drug on a current basis, 93 percent do not. Legal substances such as alcohol are inherently more difficult to control, and the numbers show it, with 109 million current users, 13 million of whom need help. Similarly, alcohol use among young people is more prevalent than use of illegal drugs.

Drug prevention programs—particularly those programs that are research-based and involve the community—are invaluable in educating young people about the dangers of drug use and reinforcing a climate of social disapproval of drug use. The Federal Government supports such programs both with funding and by supplying the best available evidence, technology, and tools.

But drug prevention makes for a difficult public policy discussion because prevention activities are not, for the most part, discrete, government-funded programs. In fact, they can best be understood as the sum of the efforts parents and communities make in bringing up young people.

Unfortunately, for too many years, the popular culture has not supported parents seeking to educate their children about the dangers of drug use and to empower them to make good decisions. In music, film, and television, drug use has too often been portrayed as glamorous and exciting, drug users and even drug dealers as free-spirited nonconformists.

Worse, well-funded legalization groups have spread misinformation about the effects of drugs. They have even insinuated to young people that drug use is an adolescent rite of passage and that adults who tell them otherwise are seeking to limit opportunities for personal growth that are rightfully theirs.

Such misinformation has taken on the force of law in states where legalization groups have pushed through a series of state referenda to legalize “medical” marijuana. Legalization lobbyists have portrayed their agenda as a representation of popular will, as though parents and communities were seeking to bring more drugs into their schools and homes. Operating with the benefit of slick ad campaigns, with virtually no opposition, and making outlandish claims that deceive well-meaning citizens, campaign proponents have tallied up an impressive string of victories.

That is, until now: in 2002, the movement lost key referenda and similar efforts in four states (Nevada, Arizona, Ohio, and South Dakota), and otherwise failed to proceed with efforts in Florida and Michigan.

The sheer comprehensiveness of the failure is impressive: losses ranged from a Nevada effort to legalize possession and use of marijuana, to an Ohio proposal that would have gutted that state's ability to incarcerate drug dealers and provide drug treatment to prisoners, to a greatly expanded medical marijuana initiative in Arizona.

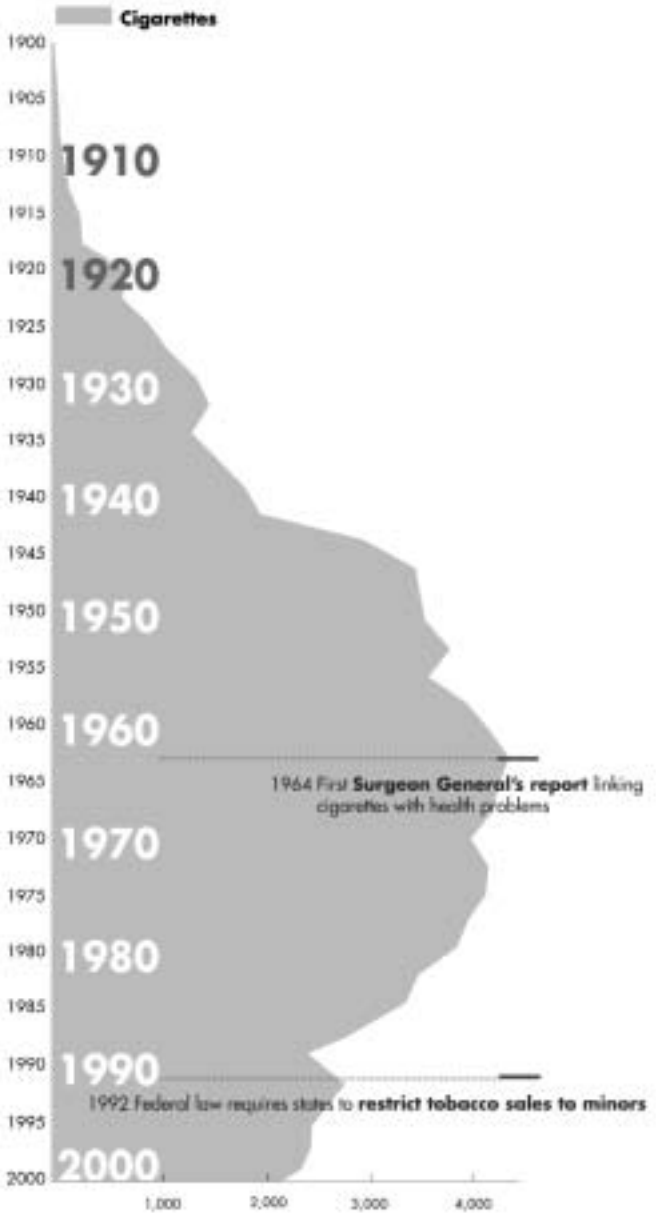
A small band of wealthy backers spent millions of dollars on various campaigns last year; their across-the-board defeat suggests something of what citizens in targeted states actually think of the deceptions they were offered. The record of 2002 also suggests that the mood of national seriousness following the September 11 attacks is less open to self-indulgent social engineering than some had hoped.

The ultimate direction of that mood is significant, and probably critical, to the success of our Nation's drug control efforts, which, like efforts to regulate smoking and alcohol use, owe much to public awareness and an engaged citizenry. As examples, the charts on these pages illustrate the major reductions in smoking that followed the 1964 Surgeon General's report linking cigarettes with health problems, and the imposition of federal restrictions on tobacco sales to minors in 1992.

Similarly, the data on the prevalence of drug use shows the steep reductions in use that followed the national mobilization started in 1985 by Nancy Reagan's "Just Say No" campaign. Like smoking and other social pathologies, drug use is a problem that responds to societal pressure; when we push against this problem, it gets smaller.

Trends in Cigarette Use, 1900–2000

Annual per Capita Consumption of Cigarettes for Those 18 Years and Over

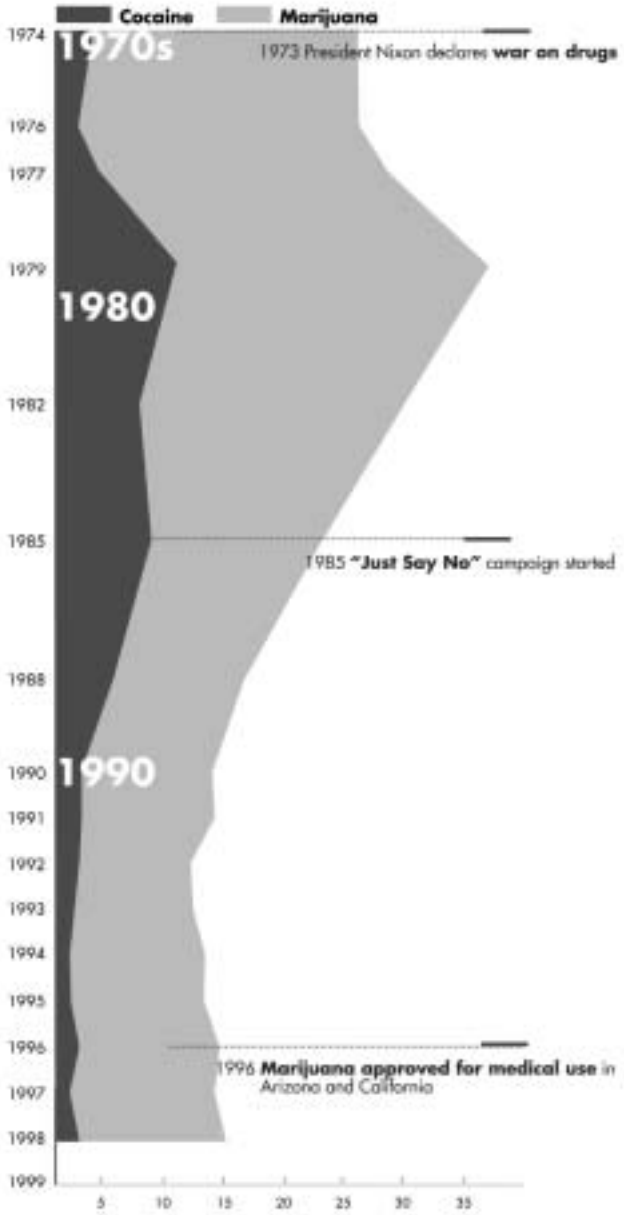


Note: Data for 2000 are preliminary.

Sources: For 1900–1974: Tobacco Yearbook, 1981. Col. Clem Cockrel. Bowling Green, KY, p. 53. For 1975–1981: U.S. Department of Agriculture. Tobacco Situation and Outlook Report. Rockville, MD: Commodity Economics Division, Economic Research Service, 1985. Table 2, p. 6. For 1982–1989: U.S. Department of Agriculture. Tobacco Situation and Outlook Report. Rockville, MD: Commodity Economics Division, Economic Research Service, 1992. Table 2, p. 4. For 1990–2000: U.S. Department of Agriculture. Tobacco Situation and Outlook Report.Washington, DC: Market and Trade Economics Division, Economic Research Service, 2000. Table 2.

Trends in Illicit Drug Use, 1974–1998

Percent Past Month Marijuana and Cocaine Users among Those Ages 18–25

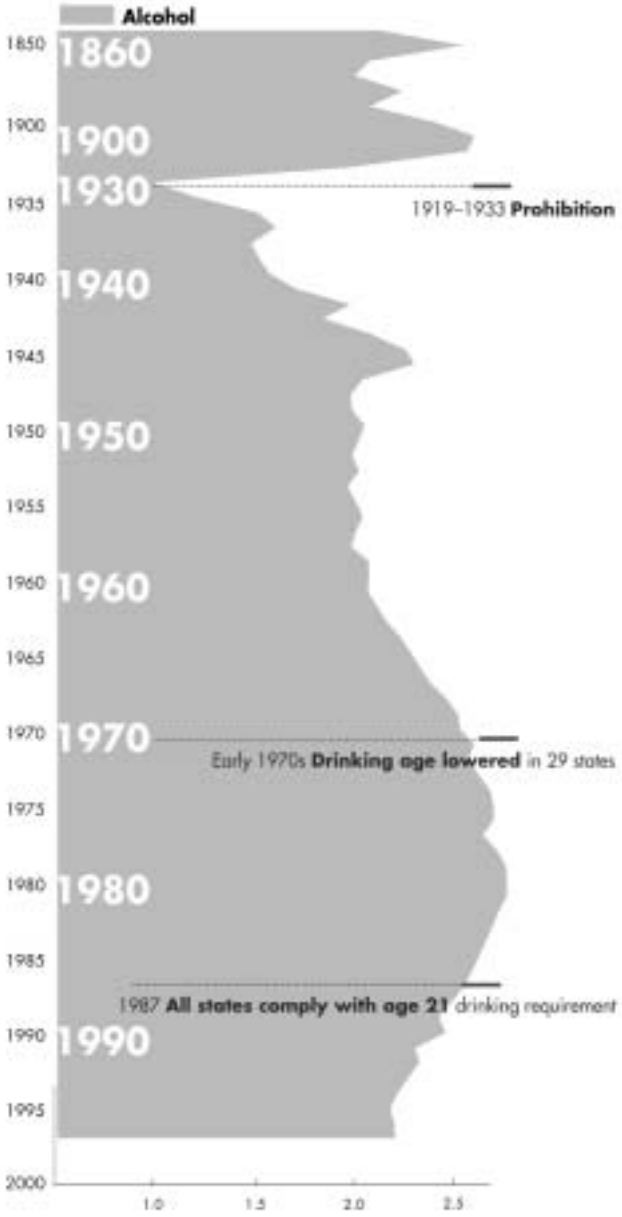


Sources: For 1974–1978: U.S. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Household Survey on Drug Abuse: Highlights 1991. Rockville, MD, 1993. Table A.10, p. 78. For 1979–1998 data: U.S. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Summary of Findings from the 1998 National Household Survey on Drug Abuse. Rockville, MD, 1999. Table 12, p. 74; Table 13, p. 75.

Adapted from charts originally published in "Substance Abuse: The Nation's Number One Health Problem." Reprinted with permission from Robert Woods Johnson Foundation.

Trends in Alcohol Use, 1850–1997

Annual per Capita Consumption in Gallons of Ethanol



Notes: Alcohol consumption is measured by converting the gallons of sold or shipped wine, beer and spirits into gallons of ethanol (pure alcohol), using estimates of average ethanol content for each beverage type. Per capita estimates are then calculated per person age 15 and older prior to 1970 and per person age 14 and older thereafter.

Source: National Institute on Alcohol Abuse and Alcoholism, Division of Biometry and Epidemiology. Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977–1997. Surveillance Report No. 51. December 1999. Table 1, p. 16.

A Boost for Student Drug Testing Programs

For young people in middle and high school, drug testing programs are an effective means of identifying those in need of drug treatment or counseling—and discouraging others from ever starting. But until recently, the legal future of school drug testing programs was unclear.

In a landmark decision last summer, the U.S. Supreme Court gave a boost to schools struggling to combat illegal drugs. By upholding an Oklahoma school district's drug testing policy, the Court cleared the way for schools everywhere to perform random drug tests on a broad segment of the student population. The decision marks the beginning of a hopeful new phase in the effort to keep our children drug free.

Previous Court rulings were restricted to the testing of student athletes. The new ruling expands the scope of drug testing to include not only boys and girls who play sports, but those who participate in any competitive extracurricular activity, from cheerleading to the debate team. Now, public middle and high schools everywhere can more effectively gauge their drug problem and direct students in trouble to the treatment they need.

The purpose of school-based drug testing is not to punish students who use drugs. If drug-using students are suspended or expelled without any attempt to intervene in their drug use, the community will be faced with a surge in the number of drug-using dropouts—a more serious problem in the long run. Of course, any effective testing program should include clear-cut consequences for students who use illegal drugs—suspension from an athletic activity, for example. But above all else, the goal is to keep students from using drugs and to guide users into counseling or drug treatment.

Student drug testing programs also function as a prevention tool, ideally as part of a comprehensive prevention strategy. Testing programs work because they reflect an understanding of teen motivations, giving students an easy way to say "no" at an age when peer pressure is at its peak. For many young people, simply knowing they may suddenly be called in to take a drug test provides a convenient

REDUCING DRUG USE THROUGH STUDENT DRUG TESTING

- According to the *Journal of Adolescent Health*, a school in Oregon that drug tested student athletes had a rate of drug use that was one-quarter that of a comparable school with no drug testing policy.
- After two years of a drug testing program, Hunterdon Central Regional High School in New Jersey saw significant reductions in 20 of 28 key drug use categories. For instance, use of cocaine by seniors dropped from 13 to 4 percent.

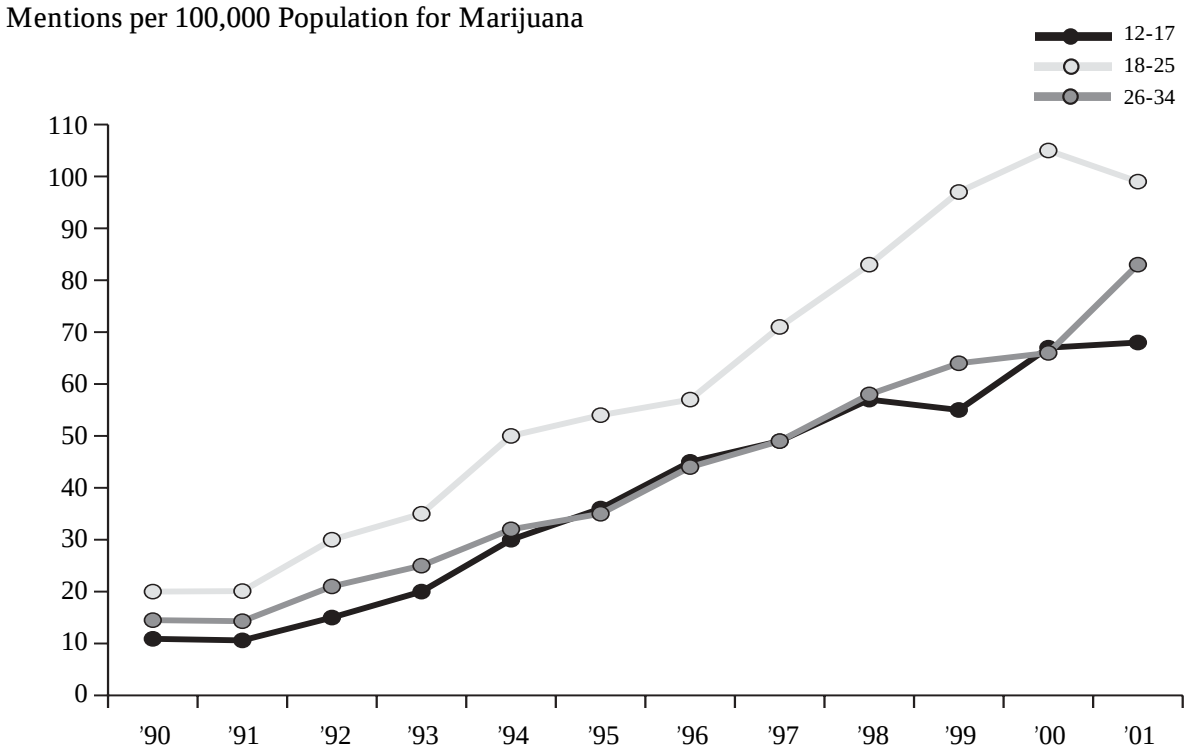
"out," which is often enough to make a student stop taking drugs or never start in the first place.

This Administration is committed to providing families and schools with the tools they need to keep children focused on learning, undistracted by drug use. To that end, it will devote a portion of the Safe and Drug-Free Schools and Communities program's national activities funds to provide grants to schools that choose to implement effective drug testing programs that include provision of treatment services for students who test positive. In fiscal year 2004, $8 million is requested for student drug testing, which will expand efforts initiated by the Department of Education in 2003.

Seeing through the Haze: Marijuana Use and the Debate over Dependency

No analysis of drug prevention would be complete without a discussion of marijuana, the drug so widespread in today's schools that nearly half of all high school seniors report having tried it by graduation. After years of giggling at quaintly outdated marijuana scare stories like the 1936 movie "Reefer Madness," many Americans have been conditioned to think that any warnings about the true dangers

Figure 7: Among Youth and Young Adults, a Steep Increase in Emergency Department Mentions for Marijuana



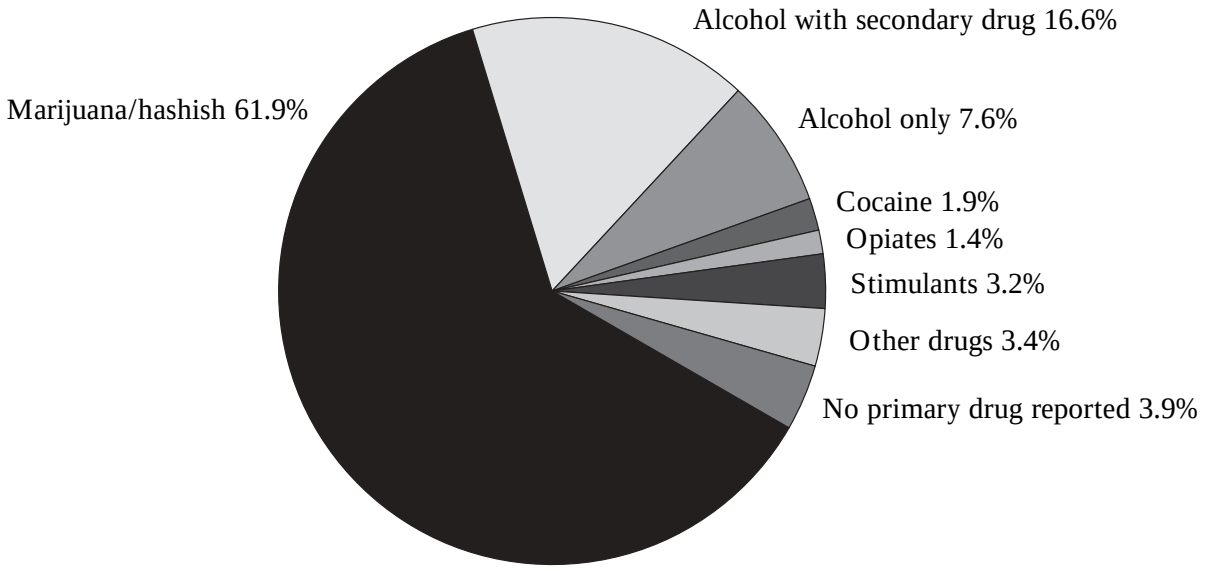
Source: Drug Abuse Warning Network (2001)

of marijuana are overblown. But marijuana produces withdrawal symptoms and is associated with learning and memory disturbances. Among youth, frequent users of marijuana are four times more likely than non-users to have physically attacked someone during the past six months. Daily marijuana smoking was recently implicated in a five-fold increase of risk for depression and anxiety among females, according to an article in the *British Medical Journal*.

And the harm is not just to the user. Marijuana is the illicit drug most used by pregnant women and women of reproductive age; yet recent research has shown motor, behavioral, and cognitive disturbances in offspring who were exposed to cannabis in the womb. Such disturbances include findings indicative of reduced activity in portions of the brain that regulate emotion and attentiveness. In some communities, as many as 20 percent of infants are prenatally exposed to a mother's marijuana intake.

Moreover, research has now conclusively established that marijuana is addictive. Of the 5.6 million Americans who meet the diagnostic criteria for needing drug treatment (criteria developed by the American Psychiatric Association, not police departments or prosecutors), 62 percent were found to abuse or be dependent on marijuana, according to data compiled by the Department of Health and Human Services. These are not occasional pot smokers. These are people with real problems directly traceable to their use of marijuana, including significant health problems, emotional problems, and difficulty in cutting down on use.

Figure 8: Treatment Admissions by Primary Substance of Abuse (Ages 12–17)



Source: Treatment Episode Data Set (2000)

Parents are often unaware that today's marijuana, with its blend of sophisticated cultivation and plant breeding techniques, is different from that of a generation ago. In 1974, according to data compiled by the Drug Enforcement Administration (DEA), the average THC content of marijuana was less than 1 percent. Twenty-five years later, potency was averaging around 7 percent, with some samples in the 30 percent range. Recent research published in the *British Journal of Psychiatry* suggests a 15-fold increase in THC content and concludes that "the modern cannabis smoker may be exposed to doses of THC many times greater than his or her counterpart in the 1960s and 1970s." The *Journal* concludes that this "single fact has made obsolete much of what we once knew about the risks and consequences of marijuana use."

The topic of drug treatment is handled in greater detail in the following chapter, but the implications are obvious. More than 60 percent of young people in drug treatment are there for problems associated with marijuana, and there has been a nearly four-fold increase in the number of adolescent marijuana admissions between 1992 and 2000.

BUDGET HIGHLIGHTS

- **Substance Abuse and Mental Health Services Administration (SAMHSA)—President's Treatment Initiative: +$600 million over three years.** The President has committed to add $1.6 billion to the drug treatment system over five years. As part of this effort, the fiscal year 2004 Budget includes new funding of $200 million in indirect aid for substance abuse treatment and other supportive services. People in need of treatment, no matter where they are—emergency rooms, health clinics, the criminal justice system, schools, or the faith community—will receive an evidence-based assessment of their treatment need and will be issued vouchers for the cost of providing that treatment.

- **Office of Justice Programs—Drug Courts Program: $68 million.** The Administration proposes an increase in the Drug Courts program of $16 million above the fiscal year 2003 requested level. This enhancement will expand the number of drug courts; increase retention in, and successful completion of, drug court programs by expanding the scope and improving the quality of drug court services; and generate drug court program outcome data. Successful drug courts provide alternatives to incarceration by using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

- **National Institute on Drug Abuse (NIDA): +$35.6 million.** This proposed increase would enable NIDA to fund ongoing commitments, undertake research collaborations with other National Institutes of Health organizations, and embark on new initiatives to advance treatment and prevention. NIDA projects that are instrumental in helping to meet the drug use reduction goals outlined by the President include the National Prevention Research Initiative, National Drug Abuse Treatment Clinical Trials Network, and Research-Based Treatment Approaches for Drug Abusing Criminal Offenders.

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

In 1854, Dr. John Snow revolutionized the field of public health when he discovered how a plague of cholera was spreading through London. In one neighborhood, the number of deaths reached more than 500 in ten days. Snow mapped the cases and found they radiated out from the Broad Street pump, where infected people had drawn their water. Snow had the pump handle removed. The epidemic ceased.

Medicine was transformed by Dr. Snow's strategy, which was to block the vectors that spread contagion. The same logic can help us fight a modern epidemic—the spread of drug use and addiction.

Medical research has established a clear fact about drug use: once started, it can develop into a devastating disease of the brain, with consequences that are anything but enticing. No young person watching an addict stumbling on the street looks at the loss of human potential and decides to seek the same end.

And yet the disease spreads. It spreads because the vectors of contagion are not addicts in the streets but users who do not yet show the consequences of their drug habit. Last year, some 16 million Americans used an illegal drug on at least a monthly basis, while 6.1 million Americans were in need of treatment. The rest, still in the "honeymoon" phase of their drug-using careers, are "carriers" who transmit the disease to others who see only the surface of the fraud. Treatment practitioners report that new users in particular are prone to encouraging their peers to join them in their new behavior.

Applying Principles of Public Health

The public health model offers three key lessons for drug policy.

First, as discussed in the previous chapter, young people must be educated about the lie that drug use represents. Drug use promises one thing but delivers something else—something sad and debilitating for users, their families, and their communities. The deception can be masked for some time, and it is during this time that the habit is "carried" by users to other vulnerable young people.

A second, key lesson of the public health model applies to those still in the honeymoon phase. It is a lesson with important implications for the field of drug treatment, where a large and growing collection of providers have been hampered by an imperfect intake mechanism for directing individuals in need of help to the most appropriate form, or modality, of drug treatment. Simply put, for many users—including the large majority in the 18–25 age group—the optimal response to their drug use is not an extended stay at a treatment center but screening to determine if help is needed. This screening can be followed, if necessary, by a brief period of drug treatment.

The third lesson involves those whose use has progressed to the point where they need drug treatment but who are not actively seeking help, because even the best treatment program cannot

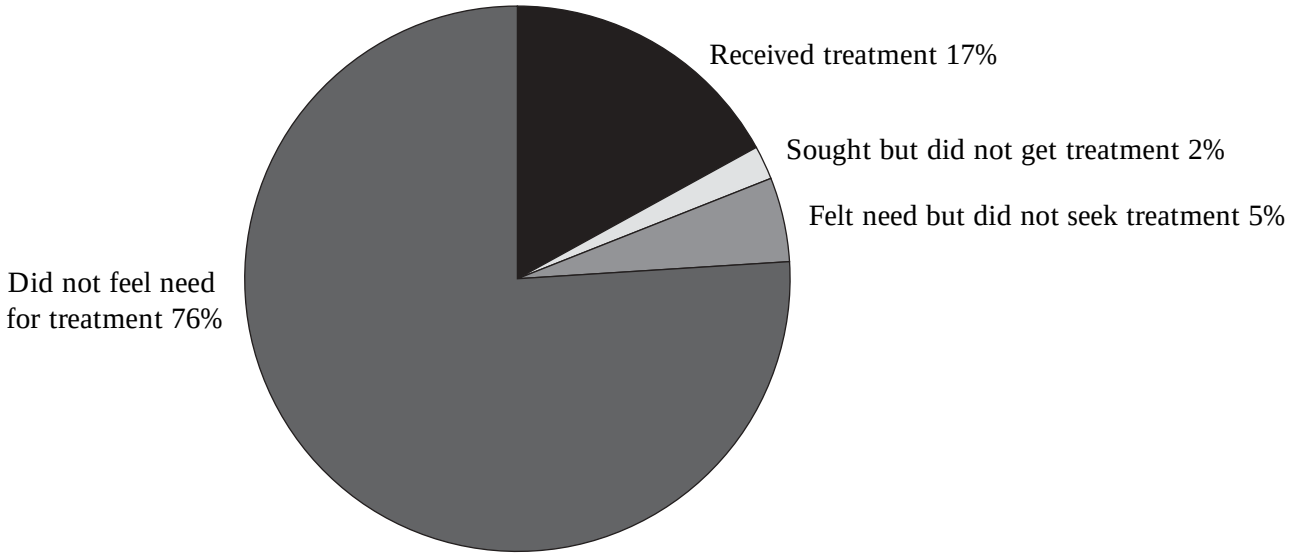
help a drug user who does not seek its assistance. According to a survey by the Department of Health and Human Services, the overwhelming majority of drug users who need treatment fail to recognize it (see Figure 9), a fact that would not come as a surprise to those with a loved one who has battled drug dependency. Of the estimated five million individuals who needed but did not receive treatment in 2001, fewer than 8 percent felt they actually needed help.

The conventional wisdom about drug treatment—that the hardest to help are the down-and-out cases—turns out to be less than accurate, because the hardest cases are actually those who are never seen. The third lesson of the public health model thus involves the crucial need to get people into treatment—no small matter when dealing with an illness whose core characteristic is denial.

Closing this "denial gap" requires us as a Nation to create a climate in which Americans confront drug use honestly and directly, encouraging those in need to enter and remain in drug treatment. Compassionate coercion of this type begins with family, friends, and the community, including colleagues in the workplace. It also requires the support of institutions and the people who run them—law enforcement, faith communities, and health care providers, among others—to identify and direct individuals in need into drug treatment. And it requires the use of innovative techniques for fighting addiction, such as specialized pharmaceuticals. (The approval in October 2002 of buprenorphine, a drug used for fighting opiate dependence, marks the first narcotic drug available for the treatment of opiate dependence that can be prescribed in a doctor's office.)

Figure 9: Most of Those in Need of Drug Treatment Did Not Seek It

Total in need of treatment = 6.1 million



Source: National Household Survey on Drug Abuse (2001)

While most of those who are dependent on illegal drugs are in denial, the good news is that more than one million Americans receive treatment each year and have started down the road to recovery. They deserve our respect for having the courage to come forward and seek help. Unfortunately, it is estimated that as many as 101,000 of those who seek treatment each year are not able to receive it. They have an immediate need, and when that need goes unfilled, many revert to their old ways and may not seek help.

To address this critical need, this year we will launch a new program, funded with $600 million over three years, that will expand access to substance abuse treatment while encouraging accountability in the treatment system. For those without private treatment coverage, we will make sure that medical professionals in emergency rooms, health clinics, the criminal justice system, schools, and private practice will be able to evaluate their treatment need and at the same time issue a voucher good for

LIFECHANGE: HARNESSING THE POWER OF FAITH

At the Union Gospel Mission in Portland, Oregon, homeless men and women can get food, clothing, and blankets. The people who walk through the doors of this faith-based center may also find an opportunity to change their lives for better through LifeChange—a drug treatment program with a difference.

LifeChange was founded in 1995 by Bill Russell, a former prosecutor, and has since graduated 62 people. Although drug treatment programs typically last 90 days, LifeChange's much longer duration limits it to 32 people at any given time, although expansion to a total of 80 recovery beds is in the works. Close to one-third of those in the program were ordered to LifeChange by judges and parole officers.

Although members of LifeChange do not have direct access to money while in the program, they do earn a living of sorts, working full-time at the Union Gospel Mission thrift store, where two-thirds of the program's budget is raised. Residents also help area homeless. A staff member puts it this way: "When you're in the program, you're supposed to give something back. You have to make up for all the bad things you did to your family and community when you were an addict." In addition to the work they do, residents attend academic classes, go to Bible study, and tackle the issues that led to their life of addiction.

Residents gradually attain increasing levels of responsibility, in preparation for the world after LifeChange. Coupled with education, the program arms graduates with job skills, a GED, and, frequently, vocational training. Assistance and mentoring are provided as residents make the transition to full employment and independent living. LifeChange is a faith-based program that works.

the cost of providing that treatment. Treatment vouchers will be redeemable on a sliding scale that rewards the provider for treatment effectiveness. Services can range from interventions designed for young substance abusers before they progress deeper into dependency, to outpatient services, to intensive residential treatment. For the first time, we will provide a consumer-driven path to treatment.

The path to help will be direct, appropriate, and open on a non-discriminatory basis to all treatment programs that save lives, including programs run by faith-based organizations. For many Americans, the transforming powers of faith are resources in overcoming dependency. Through this new program, we will ensure that treatment vouchers are available to those individuals who choose to turn to faith-based treatment organizations for help. Our goal is to make recovery the future for all those struggling with substance abuse.

Ending the Honeymoon: A New Focus on Brief Treatments

The nearly 12 million current drug users whose use has not progressed to dependence face an uncertain future. Their likelihood of eventually crossing over into addiction ranges from one in three to roughly one in ten, depending on the drug—high enough to be unacceptable but low enough to encourage many to persist in their drug use. More urgent, from the public health perspective, is the need to head off the destructive message non-dependent users send to others. A developing trend toward "brief treatments" offers promise in this area.

A drug addicted individual typically comes into contact with the health care and criminal justice systems repeatedly and in a variety of ways. Not so for the relatively asymptomatic casual drug user, whose use is not obvious and may go for months or years before a triggering event such as an automobile accident, an overdose, or an arrest.

One promising way to reach out to people in this latter category is to use the existing medical infrastructure, which already has extensive experience in identifying problem drinkers, to screen for drug use during some of the millions of emergency room and primary care visits that occur each year.

The majority of those identified as drug users will have an incipient problem (see box), one that has not progressed to the point of requiring admission to a treatment facility. These individuals are likely to respond to a brief intervention, ranging from a highly structured, five-minute talk to half a dozen counseling sessions. The degree of professional training needed to conduct these interventions increases with their length and intensity, but most can be accomplished in a doctor's office or within a hospital's social services department.

While a referral for thorough assessment and treatment is in order for some, even brief interventions can be quite effective when delivered to a nonaddicted drug user by an authority figure. Recent research supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Cannabis Youth Treatment Study found that brief treatments are very successful, especially with low-severity clients. As can be imagined, cost savings are substantial when compared with the alternative of detoxification followed by an extended treatment stay.

Of course, many drug users have more serious problems, which not uncommonly include mental and other medical disorders. Such disorders interact in unfortunate ways: drug users are more likely to develop mental problems, while individuals with mental disorders are more likely to use illegal drugs than the population at large. These "co-occurring disorders" take a terrible toll on individuals and complicate the task of helping them through drug treatment. As a result, some state treatment systems are moving toward routinely screening individuals for both types of disorders.

PROGRAMS THAT WORK: SCREENING, BRIEF INTERVENTION, AND REFERRAL

John Doe, age 45, is admitted to the emergency room after a car accident. What the doctors do not know at the time of his arrival is that he uses cocaine and marijuana. At many hospitals, the doctors would not pursue John's health care needs beyond his injuries, thereby missing an opportunity to intervene early and derail behavior that could lead to greater harm.

Not so at Scripps Mercy Hospital in San Diego, where a Screening and Brief Intervention and Referral (SBIR) program has been implemented in various settings, including the emergency room, primary care unit, and trauma service. At Scripps Mercy, John Doe is interviewed by a specially trained peer health educator while still in the emergency room. This interview, which principally seeks to determine John's drug and alcohol use, does not interfere with traditional medical care. It does, however, determine whether Mr. Doe has a problem with drinking or drug use.

On determining that Mr. Doe has a problem, a five-minute "brief intervention" will be delivered by a physician attached to the emergency room. If Mr. Doe is found to need a more extensive intervention, he will be referred to appropriate treatment services.

John Doe, like most drug users in America, was determined in this instance not to be dependent or an abuser. (As defined by the American Psychiatric Association, 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.) The brief intervention Mr. Doe received was reinforced by the doctors who treated his injuries and may be enough to get him to stop using drugs.

Unfortunately, despite growing evidence of the effectiveness of this modest form of intervention, most primary care settings, emergency rooms, and trauma centers around the country do not integrate the SBIR program with medical care. In other words, John Doe would have been treated for his injuries and sent home, with his developing substance abuse problem overlooked.

Targeting Drugged Driving

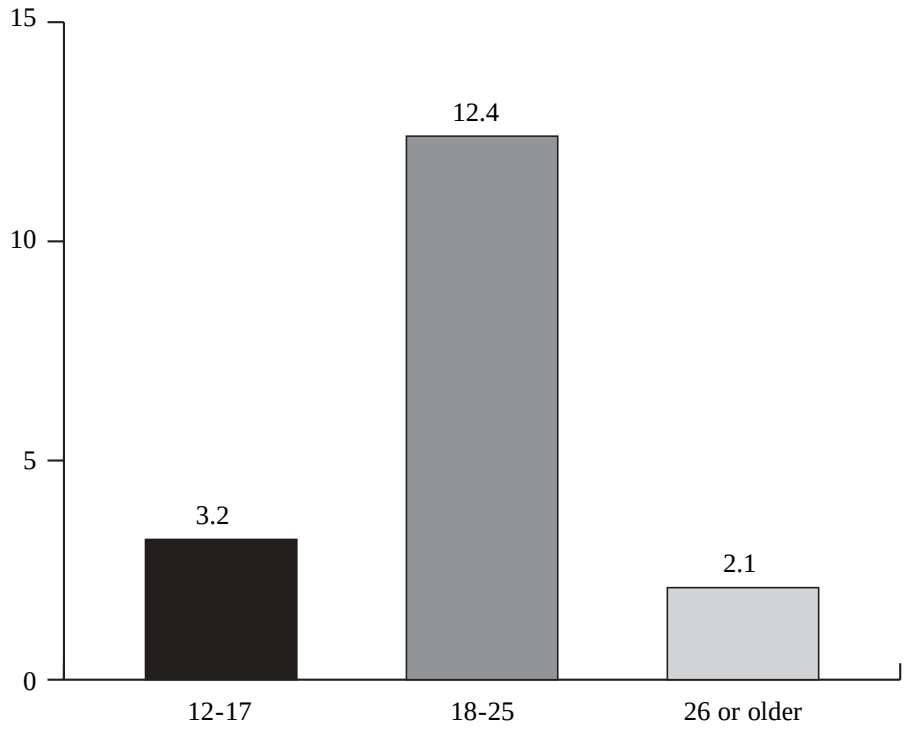
Over time, brief treatments should allow treatment professionals to reach non-dependent drug users through other institutions with which they have regular contact, notably workplace and school settings, and provide appropriate assistance. Drug users who trigger such interventions are among the most fortunate; many injure themselves or others on our Nation's roads before coming to the attention of the drug treatment system.

Drug legalization advocates who suggest that drug use is "victimless" are brought up short when confronted with the grief of a family that has lost a parent or child to a driver who was high on marijuana. The problem is real: research indicates that in 2001, some eight million drivers got behind the wheel of a car after using drugs, and the problem is particularly acute among younger drivers (see Figure 10).

More than two decades ago, a group of brokenhearted mothers formed what came to be known as Mothers Against Drunk Driving (MADD), whose tireless efforts—along with those of the National Highway Traffic Safety

Figure 10: Drugged Driving Is Highest Among Young Adults

Percent Reporting Driving Under the Influence of an Illicit Drug



Source: National Household Survey on Drug Abuse (2001)

Administration—have contributed to a 43 percent decline in alcohol-related highway fatalities. Groups like MADD have expanded to focus on drug-impaired driving, but there exists at present no reliable system that identifies drugged drivers and directs them into drug treatment before innocent lives are lost. Because slightly more than half of all contacts between law enforcement and the public occur during traffic stops, giving police officers tools to better recognize drug use is a tremendous opportunity to make our roadways safer and get users into treatment.

One means of accomplishing these two goals is support of the Drug Recognition Expert (DRE) program, which trains police officers to recognize and readily identify the signs of drug use. Such training is crucial in avoiding the common scenario where a driver who has used drugs is stopped for suspicion of driving under the influence but released after failing to register evidence of drinking. DRE training, in contrast, relies on behavioral cues to better recognize the signs of drug use and gets dangerous drivers off the road and into treatment or an appropriate correctional setting.

The chief limitation with current DRE-trained officers is simple: there are too few of them, and a drugged driver's chances of encountering a DRE-trained officer at a traffic stop are slim. (If there is an encounter, however, the odds shift; DRE training is rigorous, and toxicology tests confirm the assessments of DRE-trained officers more than 90 percent of the time.)

Research into new detection technologies promises to lead to a version of the familiar alcohol breath-testing devices to supplement officers' expertise in confirming drug use and presence. ONDCP's Counterdrug Technology Assessment Center (CTAC) is sponsoring research into saliva tests that can quickly, cleanly, and accurately help an officer tell if a driver has used illegal drugs. CTAC will fund this research at a level of $1.5 million over the next three years.

Reducing Recidivism through Drug Courts

In addition, the Administration proposes a $16 million increase in federal support for the Drug Courts program in fiscal year 2004. Drug courts use the coercive authority of a judge to require abstinence and alter behavior through a combination of graduated sanctions, mandatory drug testing, case management, supervised treatment, and aftercare programs. Intrusive and carefully modulated programs like drug courts are often the only way to free a drug user from the grip of addiction. Such programs represent one of the most promising innovations in recent memory.

New research findings suggest that drug courts are effective in reducing criminal recidivism. A preliminary report from the National Institute of Justice, "Estimate of Drug Court Recidivism Rates," followed more than 2,000 graduates from 100 drug courts and determined that the recidivism rate (defined as being arrested and charged for an offense that, on conviction, would result in a sentence of at least one year) was just 16.4 percent one year after graduation and 27.5 percent at the two-year mark. Figures for individuals who were imprisoned for drug offenses, instead of entering drug court, are 43.5 and 58.6 percent, respectively. (Because violent drug offenders are typically ineligible to be admitted to drug court, the drug court and prison populations are not strictly comparable.)

Results like these explain why the drug court movement has progressed from the novel status it enjoyed when the concept was first highlighted in the President's National Drug Control Strategy in 1991, when there were fewer than half a dozen drug courts. Now, more than 940 drug courts

GETTING PEOPLE BACK ON TRACK AT CINCINNATI'S DRUG COURT

Dan Smith, a 32-year-old drifter, is arrested on charges of possession of cocaine and methamphetamine. Numerous prior arrests of a similar nature have been documented throughout his life, but this is the first time Dan has been detained in Cincinnati. In the Hamilton County Drug Court, he will be given the tools he needs to get on track to a law-abiding, drug-free life.

After his arrest, a public defender identifies Dan as a potential candidate for the drug court. For two weeks he undergoes an inpatient assessment period conducted by substance abuse professionals at Talbert House Treatment Center. Four probation officers are assigned to the site to foster coordination between the criminal justice system and the treatment providers.

After the center's clinical experts determine that Dan is dependent on illicit drugs, he goes before the Honorable Kim W. Burke. Dan is placed on probation and ordered to complete a treatment regimen that typically includes 90 days of residential treatment, followed by six weeks of intensive outpatient care, and a minimum of 12 months of continuing care.

Judge Burke keeps a close eye on the drug court's clients, meeting with all 400 of them at least once a month and some as often as weekly. Key to the drug court's success is creating an environment that is supportive but firm. Says Judge Burke, "At our evening status reports, I have the probation officer there, I have the treatment counselor there, and I have the attorney there. That avoids a lot of people saying 'My probation officer told me I could do this,' or 'My counselor told me I could do that'."

As long as Dan remains drug- and alcohol-free for the duration of this sentence, he will serve no jail time for the original charge. The program relies on Dan's knowledge that he will receive weekly drug tests; if he is found to have used illegal drugs, he can expect immediate consequences.

Judge Burke puts it this way: "If a person tests positive, I find out about it pretty quickly—usually the next day. Relapse is part of what we deal with, but when they come in with a dirty drug screen, they know that they're going to spend a couple of days in jail. The point of it is for them to have immediate consequences for their actions."

operate in 49 states, with an additional 441 courts in the planning stages. Key goals for the program in coming years include expanding the number of drug courts, improving retention rates, and generating credible post-program outcome data.

BUDGET HIGHLIGHTS

- **DEA—Priority Targeting Initiative: +$39 million.** This proposal includes 329 positions to implement DEA's plan for addressing the Nation's illegal drug threats. This initiative will target Priority Drug Trafficking Organizations involved in the manufacture and distribution of illegal drugs, as well as those involved in the diversion of precursor chemicals used to manufacture these products.

- **Organized Crime Drug Enforcement Task Forces (OCDETF) Program.** The fiscal year 2004 Budget restructures the OCDETF program by consolidating funding within the Department of Justice. In addition, the budget includes resources for the following initiatives to strengthen these critical interagency investigations:

  - **Consolidated Priority Organization Target List (CPOT) Initiative: +$26 million.** This proposal includes 192 positions to generate and advance investigations of command and control targets linked to the Attorney General's CPOT list. The requested funds will provide agents, analysts, and Assistant U.S. Attorneys dedicated to CPOT-linked investigations.

  - **Automated Tracking Initiative: +$22 million.** This proposal will establish the automated capacity, using existing Foreign Terrorist Tracking Task Force technology, to rapidly scan, analyze, and disseminate the voluminous drug investigative information of participating OCDETF agencies. This capacity is especially important in identifying components of those organizations on the Attorney General's CPOT list.

  - **Financial and Money Laundering Initiative: +$10 million.** This enhancement includes 83 positions to expand OCDETF financial and money laundering investigations. This improvement will fund financial investigative efforts, including intelligence gathering, document exploitation, and undercover operations.

- **Department of State—Andean Counterdrug Initiative: $731 million.** The fiscal year 2004 request maintains funding to support various programs in Colombia, Bolivia, Peru, and the Andean region. This initiative includes resources for critical drug law enforcement programs, as well as other efforts associated with security in drug-producing areas, illicit crop reduction, alternative development, institution building, the administration of justice, and human rights programs. For Colombia, funding includes several broad categories to include operations and maintenance of air assets, Colombian National Police and Army Counterdrug Mobile Brigade operational support, and crop eradication programs. This request also supports humanitarian, social, economic, and alternative development programs implemented by the U.S. Agency for International Development (USAID).

- **Department of Defense—Expanded Support to Colombia: +$25 million.** This initiative adds $25 million to current funding of close to $116 million in support of counterdrug activities in Colombia. The expanded support will be used to fund various programs to conduct a unified campaign against both terrorism and drugs. These programs include counternarcotics training for Colombian ground and aviation units, riverine and coastal interdiction support activities and training, and improvements to intelligence, surveillance, and reconnaissance capabilities.

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

The National Drug Control Strategy recognizes the inherent link between drug supply and drug demand, a link that is particularly visible in the behavior of the addicted drug user. Even dependent drug users are quite conscious of the price (and purity) of the drugs they consume and can adjust their use of drugs to market conditions. This should not come as a surprise: addicts must spend almost all their disposable income on illegal drugs, and a disrupted market with unreliable quality and rising prices for drugs such as cocaine and heroin does not magically enable them to earn, beg, borrow, or steal more.

Drug users respond to market forces because the drug trade itself is just that, a market—a profitable one, to be sure (though less profitable than often assumed), but nonetheless a market that faces numerous and often overlooked obstacles that may be used as pressure points. To view the drug trade as a market is to recognize both the challenges involved and the hopeful lessons of our recent experience: that the drug trade is not an unstoppable force of nature but a profit-making enterprise where costs and rewards exist in an equilibrium that can be disrupted. Every action that makes the drug trade more costly and less profitable is a step toward "breaking" the market.

Once the drug trade is seen as a type—admittedly, a special type—of business enterprise, the next step is to examine the way the business operates and locate vulnerabilities in specific market sectors and activities that can then be attacked, both abroad and here at home. Such sectors and activities include the drug trade's agricultural sources, management structure, processing and transportation systems, financing, and organizational decisionmaking. Each represents an activity that must be performed for the market to function.

Reduced to the simplest possible terms, locating market vulnerabilities means identifying the business activities in which traffickers have invested the most in time and money and received the least back in profits. Once identified, these vulnerabilities can be exploited, the efficiency of the business suffers, and the traffickers' investment is diminished or lost.

Business costs of the drug trade include those borne by any large agroindustrial enterprise (such as labor force, cultivation and processing, transportation, communication, warehousing, and wholesale and retail distribution), as well as costs that occur because the enterprise is illegal (such as the need to consolidate and launder proceeds, pay bribes, and accommodate the risks of intertrade betrayal and violence, as well as incorporating "risk premiums" that are charged by those who face possible arrest, incarceration, or death).

Disrupting the Market at Home

As a government, faced with the obvious and urgent challenges of punishing the guilty and taking drugs off the street, our focus on targeting the drug trade as a business—with a view to

increasing its costs—has been episodic. We need to do a more consistent job of ratcheting up trafficker costs at a tempo that does not allow the drug trade to reestablish itself or adapt.

Domestically, the market approach is leading to a new focus on extracting the drug trade's ill-gotten gains; traffickers are, after all, in business to make money. The Department of Justice's Organized Crime Drug Enforcement Task Force (OCDETF) program has been a major force in driving these financial investigations. The OCDETF program was created in 1982 to concentrate federal resources on dismantling and disrupting major drug-trafficking organizations and their money laundering operations. The program also provides a framework for federal, state, and local law enforcement agencies to work together to target well-established and complex organizations that direct, finance, or engage in illegal narcotics trafficking and related crimes.

In the past year, in keeping with the strategy of attacking trafficker vulnerabilities such as money laundering, the Department of Justice has moved to refocus the OCDETF program and its nine member agencies on financial investigations and on multijurisdictional investigations directed at the most significant drug-trafficking organizations responsible for distributing most of the drugs in the United States.

For fiscal year 2004, the Administration proposes an increase of $72 million over the previous fiscal year's requested level for the OCDETF program. This request proposes to consolidate within the Department of Justice what had been three separate OCDETF appropriations, one each for the departments of Justice, Treasury, and Transportation, with the goal of improving the program's accountability, coordination, and focus. More important, it proposes to earmark $73 million of the OCDETF appropriation specifically for the Internal Revenue Service's Criminal Investigation Division—an increase of $7 million over the fiscal year 2003 level—to support that agency's special focus on complex money laundering investigations.

Achieving Unity of Effort

Tales of rival agencies' narcotics agents investigating and ultimately trying to arrest one another are a staple of crime novels, but such lapses in coordination are in fact remarkably rare. A much fairer and less often articulated criticism has been law enforcement agencies' lack of collaboration or across-the-board agreement on a set of trafficker targets.

In order to adopt a market disruption perspective and attack specific market segments, we need such a focus, along with a clear understanding of the scope and character of the drug market. We now have both, thanks largely to a unique collaboration between the DEA, the Federal Bureau of Investigation, the multiagency Special Operations Division, and the Department of Justice, which has, for the first time, resulted in a consolidated list of top trafficker targets. The Consolidated Priority Organization Target (CPOT) list makes unity of effort possible among those federal agencies.

The CPOT list will drive more than the activities of the agencies that produced it. The High Intensity Drug Trafficking Areas (HIDTA) program, administered by ONDCP in 28 HIDTA regions around the country, has already begun using the CPOT list as part of a priority targeting initiative piloted with fiscal year 2002 funds with a budget of $5.7 million.

The HIDTA program was created in 1990 to focus law enforcement efforts on the Nation's most serious drug trafficking threats, but reviews conducted as part of the President's fiscal year 2004 Budget found that the program had not demonstrated adequate results and that over time the initial focus of the program has been diluted. Over the past year, as evidenced by the pilot CPOT initiative, the HIDTA program has begun a shift back to that initial focus on the highest priority trafficking organizations—the wholesale distributors and command-and-control targets.

The HIDTA program has also increased its emphasis on money laundering and financial crimes investigations related to trafficking organizations, providing training for key law enforcement personnel in financial investigative techniques. In 2003, the HIDTA program will continue to increase its focus on investigations, such as those against organizations on the CPOT list, that target the top of the trafficking pyramid. This will entail continuing expansion and refinement of the program's intelligence network—an area that can pay dividends for federal as well as state and local law enforcement.

The goal of unity of effort is being pursued in other areas, including border security. The establishment of the Department of Homeland Security (DHS), by combining into one agency the separate activities and assets of agencies such as the Customs Service, Coast Guard, and Border Patrol, will improve our ability to identify and interdict suspect personnel and illegal contraband entering the United States. Effective DHS counterterrorism systems at and between our ports of entry are also critical in improving our ability to stem the flow of illegal drugs.

A New Focus on Revenue Denial

Americans spend more than $63 billion on illegal drugs—money that must be laundered to be usable by traffickers. It does little good to attack trafficking organizations and leave the proceeds of their crimes untouched. Indeed, money laundering investigations are often key to identifying such organizations in the first place. Anti-money laundering efforts are thus critical to destabilizing trafficking organizations and limiting their power. Enforcement experts divide the process of money laundering into three stages:

- Placement of the illicit funds into the financial system. In the case of paper currency paid for illegal narcotics, the need is obvious. Currency is anonymous, but it is hard to hide, takes time to move, and attracts attention.

- Layering of funds involves moving funds to hide their origin and suggest a legitimate source. Launderers can move funds between nations or financial institutions in a matter of seconds.

- Integration of funds means simply that the funds are put to use by the criminals who "earned" them, either to enjoy as fruits of the crime or to reinvest in their illegal enterprise.

The money launderer is most vulnerable during the placement stage. The strategy of the U.S. Government, both on the regulatory and enforcement sides, is therefore to attack the placement of funds into the financial system. (Valuable new authorities created under the USA PATRIOT Act will increase the government's ability to attack transactions, jurisdictions, and money laundering systems during the layering and integration phases as well.)

Money transmitters, broker-dealers, check cashers, and money order providers are particularly vulnerable to exploitation by organized drug money launderers seeking funds placement. New regulations and strengthened criminal laws provide law enforcement and regulatory agencies with new tools to stop money laundering, for example, subjecting money service businesses to requirements for registration and reporting of suspicious activities, and providing clearer criminal penalties for violations.
The departments of Justice, Treasury, and Homeland Security, in consultation with other responsible law enforcement agencies, will develop a long-term comprehensive plan to attack money laundering groups who exploit the money remission system.

Disrupting Markets Overseas

An effective, balanced drug policy requires an aggressive interdiction program to make drugs scarce, expensive, and of unreliable quality. Yet it is an article of faith among many self-styled drug policy "experts" that drug interdiction is futile, for at least two reasons: with millions of square miles of ocean (or "thousands of miles of border," or "millions of cargo containers"), interdictors must be everywhere to be effective. Not being everywhere, it follows that transit zone interdictors from the departments of Defense and Homeland Security are consigned to seizing

FIVE ILLEGAL DRUG MARKETS

There are five principal illegal drug markets in the United States:

- More than 10,000 metric tons (mt) of domestic marijuana and more than 5,000 mt of marijuana cultivated and harvested in Mexico and Canada—marketed to more than 20 million users.
- More than 250 mt of cocaine, most of it manufactured in Colombia and shipped through Mexico and the Caribbean—marketed to more than five million users.
- More than 13 mt of heroin manufactured in Mexico, Colombia, and Asia and shipped via commercial air and maritime carriers—marketed to more than one million users.
- Between 106 and 144 mt of methamphetamine manufactured in Mexico and in the United States—marketed to 1.3 million users.
- Roughly eight mt of Ecstasy manufactured in the Netherlands and Belgium and shipped via commercial carriers—marketed to more than three million users.

a small and irrelevant portion of the flow of cocaine, to pick the drug that currently generating the most emergency room admissions.

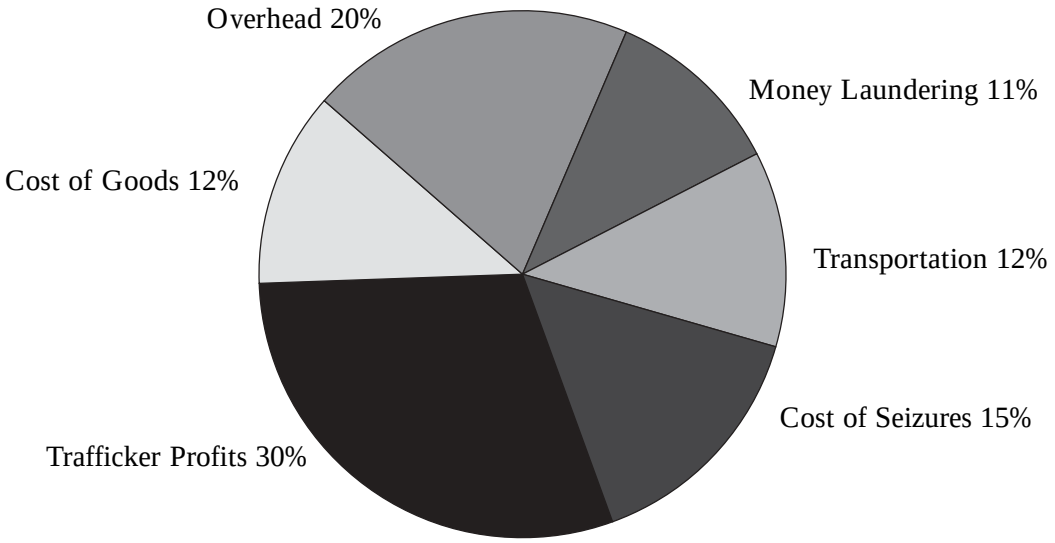
Second, the experts opine that the drug trade is so fabulously lucrative that there will "always be a ready supply" of smugglers (or "kids to deal crack on street corners" or "people willing to grow coca"), and thus seizing even 10 percent (the figure usually cited as folk wisdom) has no effect on the market.

The "experts" are in fact wrong on both counts.

First, although the drug trade is profitable, it is a misunderstanding of the market to assert that every sector and business process in that market has an unlimited capacity to shrug off losses and setbacks.

In 2001, U.S. Government and partner nations seized or otherwise interdicted more than 21 percent of the cocaine shipped to the United States, according to an interagency assessment. When added to the additional 7 percent that is seized at our borders or elsewhere in the United States, current interdiction rates are within reach of the 35 to 50 percent seizure rate that is estimated would prompt a collapse of profitability for smugglers unless they substantially raise their prices or expand their sales to non-U.S. markets. Indeed, according to an interagency assessment of the profitability of the drug trade, traffickers earn just $4,500 for each kilogram of cocaine that is safely

Figure 11: Trafficker Costs and Profits for Cocaine Sold at the U.S. Border



Note: All values are best-point estimates of industry averages. Actual individual organizations' costs can vary. At an average sale price of $15,000/kg at the U.S. border, traffickers earn $4,500/kg. These point estimates average trafficker profits and cost of seizures for two scenarios: 1) Colombian traffickers maintain ownership of the cocaine to the U.S. border, and 2) Colombian traffickers turn over ownership to Mexican counterparts on the high seas.

delivered into the United States—a kilogram that will wholesale for $15,000 (see Figure 11).

Traffickers actually face significant fixed costs for raw materials, money laundering, aircraft and boats, and business overhead such as bribes. Even assuming everything goes according to plan, Colombian groups are typically placed in the unenviable position of handing over an astonishing 40 percent of a given load of cocaine to Mexican traffickers in exchange for the Mexican groups' agreement to smuggle the remaining 60 percent across the border. (Urban ethnographers who looked into the economics of street-level crack dealers in the early 1990s found much the same thing about profitability: many of the kids who supposedly could not be bothered with earning $5 an hour at McDonald's were actually making less than minimum wage dealing crack.)

But, to press the argument, why are the critics necessarily wrong about the impossibility of successful interdiction, especially given the enormous challenge of finding small shipments hidden along extended borders or on vast oceans?

Answering this question requires a closer look at how interdiction is increasingly being focused in ways that cause damage to drug markets. Briefly, interdiction can damage the drug trade precisely because those agencies with responsibility for the interdiction mission—including the Department of Defense and elements of the Department of Homeland Security such as the Coast Guard—do not look for traffickers in millions of square miles of ocean or along thousands of miles of border. Rather, such agencies rely on intelligence to narrow the search and seek out natural chokepoints where they exist.

Interdicting the Flow in Colombia

One such chokepoint is the maritime movement of almost all Colombian cocaine through that nation's coastal waters.

More than 700 metric tons of cocaine is exported annually from South America to the United States and Europe. Roughly 500 mt departs South America in noncommercial maritime conveyances such as elongated "go-fast" boats, each carrying between 0.5 and 2.0 mt of cocaine, and fishing vessels, which typically carry multiton loads of cocaine.

The cocaine threat can thus be described, admittedly in somewhat simplified terms, as 500 maritime shipments heading north annually from the Colombian coast to Mexico and the islands of the Caribbean, in the first stage of multi-leg movements to the U.S. border. According to estimates contained in an interagency assessment of cocaine movement, the 500 shipments are divided roughly evenly between those departing Colombia's north coast (heading both to the Greater Antilles and to Central America) and the west coast (destined for Mexico). In the Pacific, larger cocaine-ferrying fishing vessels are used to consolidate loads far off the Colombian coast, to continue the movement to Mexico.

Go-fast boats are effective because they are small, easily launched from numerous estuaries and small pier locations, and difficult for interdiction forces to locate on the high seas. Colombian traffickers have a significant investment in each shipment as it departs South America—as much as $3 million per go-fast boat. That investment, moreover, is uninsured. Once the cocaine is handed off to

Mexican smugglers for the second leg of its journey, a rudimentary form of insurance takes effect in some cases, with Mexican organizations typically taking as much as 40 percent of the load while agreeing to reimburse Colombian traffickers if the drugs are lost in transport. (This arrangement has had the perverse effect of encouraging local consumption in Mexico, because organizations sell some of their product locally.) While in transit to Mexico, however, cocaine is uninsurable and is owned solely by the Colombian organization.

Attacking go-fast movements in coastal waters thus holds out the promise of rendering unprofitable or minimally profitable a key business sector. The United States will work with the Government of Colombia to direct our air and maritime interdiction resources and assets accordingly, as appropriate, while seeking to create a dedicated sensor infrastructure and establish a robust Colombian capability to interdict drug flows in their coastal waters. The seizures that result will not occur in isolation but will engender investigations into major trafficking organizations and result in better intelligence on future smuggling activities.

About 90 percent of the cocaine entering the United States originates in or passes through Colombia. In addition, the cultivation of opium poppies in Colombia has expanded from almost nothing in 1990 to roughly 6,500 hectares now, producing roughly 4.3 mt of high-purity heroin—enough to supply a sizable portion of the U.S. market. In light of this serious threat, DEA has transferred agent positions from offices in nearby countries to create a heroin task force in Colombia. The Bogota Heroin Group will work with the Colombian National Police on cases involving high-level traffickers servicing U.S. markets.

Colombia's narcotics industry fuels that country's terrorist organizations, which monopolize coca cultivation and are increasingly involved in drug production and trafficking. The Colombian Government estimates that cocaine profits fund more than half of Colombian terror-group purchases of weapons and provide key logistics funding to that nation's illegal armies. Accordingly, U.S. Government policy seeks to support the Government of Colombia in its fight against drug trafficking and terrorism. Those entwined problems are especially evident in parts of Colombia east of the Andes that are underpopulated, and lack a government presence. Most of Colombia's drug crops are grown in such areas, where the rule of law is weak and government access is limited.

In the face of this huge challenge, the past eight months have witnessed a revolution in the way Colombia perceives the link between criminal and political terrorism, drug trafficking, corruption, and weak government institutions. Rather than meekly accepting these as facts of life, Colombia's President Alvaro Uribe is pushing back, both against the drug trade and the terror groups it sustains.

Colombia's rural population, in particular, has been terrorized by Colombia's illegal armies: the FARC, ELN, and AUC. In a single raid last May, FARC rebels incinerated 117 residents of Bojaya, including 45 children, who had taken refuge in the local church. Analysts surmise that the rebels intended to regain control over a smuggling corridor.

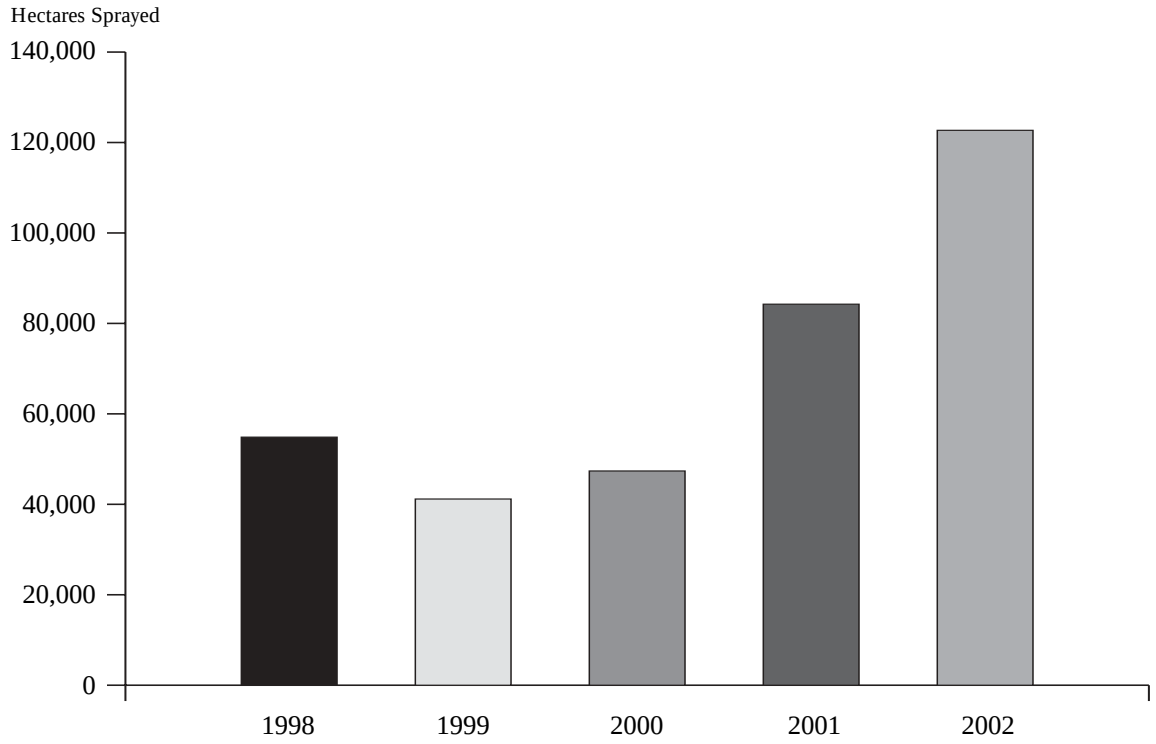
Regrettably, the Bojaya tragedy is not an isolated incident. Terrorist attacks killed more than 3,000 Colombians in 2001. Another 3,041 were kidnapped. The ELN, FARC, and AUC rebels were responsible for more than 2,000 of these victims, including 205 children as young as

three years old. The AUC has killed two Colombia legislators in the past year, and the FARC has kidnapped five legislators, a presidential candidate, and a Catholic archbishop. The three terrorist groups have also assassinated 12 mayors, and the FARC has threatened many others, leaving them with a choice of resigning or being killed.

With the election of President Uribe, Colombia has accelerated implementation of its drug control program, eradicating record levels of coca and moving aggressively in several areas to weaken criminal and terrorist organizations, reestablish the rule of law in war-torn regions, and protect the rights and security of Colombian citizens. Significant drug control gains in Colombia will require—and President Uribe has committed to pursuing—restoration of the rule of law to areas that are currently terrorist-controlled and used to cultivate and produce illegal drugs.

With U.S. assistance, Colombia has established carefully screened, or "vetted," law enforcement task forces comprised of investigators, prosecutors, and support personnel with specialties including asset forfeiture, money laundering, and human rights. Colombian authorities and their U.S. counterparts from the DEA are also working to attack the Black Market Peso Exchange money laundering system, one of the mechanisms that enable Colombian traffickers to repatriate their drug profits.

Figure 12: An Expanding Coca Eradication Program in Colombia



Note: Estimates reflect total ground area covered. Source: U.S. Department of State

Aerial spraying is a major component of Colombia's strategy for fighting the drug trade and is the program with the single greatest potential for disrupting the production of cocaine before it enters the supply train to the United States. Spray operations have the potential to cause collapse of the cocaine industry if the spraying is intensive, effective, and persistent. Replanting coca is expensive for farmers, in terms of both labor inputs and opportunity costs (coca seedlings typically take a year to begin bearing harvestable leaf). According to estimates by the Institute for Defense Analyses, eradicating 200,000 hectares of coca would cost farmers $300 million—costs significant enough to cause growers to conclude cultivation is uneconomical.

The Government of Colombia may have achieved this rate of eradication in the coca-rich parts of Putumayo and Caqueta during parts of 2002, although repeated spraying over the next twelve months will be necessary in most areas to deter replanting. Continued U.S. support will be critical for Colombia to maintain this level of eradication.

Where eradication prompts hoped-for movements of growers out of remote planting areas, alternative development programs managed by the U.S. Agency for International Development will be there to absorb some of the disruptive effect on local economies.

U.S. assistance will focus alternative development aid in areas where projects will be economically viable and self-sustaining and where there is, or soon will be, enough government presence to ensure that the projects will be implemented for the benefit of legitimate production and democratic rule. Implementation should be fully integrated with Colombian government efforts to establish security and implement other anti-drug, economic, and social programs.

The Andean Ridge

Rising demand for cocaine in Europe and Latin America and expanded drug control in Colombia are placing increased stress on Peru and Bolivia, with farmgate prices for coca products at high levels in both countries. New administrations in both these countries face difficult challenges in reducing drug production while confronting economic weakness and political instability.

The economies of Peru and Bolivia have suffered through the sluggish global economy and the economic deterioration of traditional export markets in Brazil and Argentina. This in turn has put a strain on employment and alternative development. In some cases, traffickers are pushing legitimate governments through a combination of lawlessness and radical demands. These actions are undermining democratic institutions, making them vulnerable to increased corruption and violence—the path that Colombia faced many years ago.

In Peru, the Toledo government faces the significant challenge of rebuilding democratic institutions in an atmosphere of reduced public confidence. Coca cultivation is rebounding in regions frequented by Sendero Luminoso terrorists, while Peru has weakened its security presence in some drug cultivation regions and slowed implementation of its overall drug control effort. Peru must act with renewed decisiveness to prevent a resurgence of the volatile combination of Sendero terrorism and expanded cocaine production.

Bolivia is also in the middle of a turbulent period. In the past year, radical groups launched violent protests that have damaged the economy and challenged the government. These groups, including coca growers, indigenous activists,

teachers, and urban consumers, have divergent goals and have not followed a single leader in the past, but more recently they have demonstrated an ability to work together. Opposition and minority political groups have had their legitimate issues hijacked by a vociferous pro-coca movement, and serious reformers may find themselves uncomfortably aligned with a cast of marginal political figures who believe Bolivia's destiny is to supply coca to the world.

The Sanchez de Lozada government has strenuously avoided violent confrontations but is now being pressed to grant concessions that could undo the gains made by the previous administration to substitute legal employment for coca cultivation. In 2002, Bolivian coca cultivation increased by 23 percent over 2001 levels, sufficient to produce roughly 60 mt of cocaine. The United States has been clear in its message that Bolivia must stay the course on eradication or risk losing much U.S. Government assistance and economic support.

Mexico: Building on Success

Mexico lies squarely between Andean Ridge cocaine producers and American consumers. It produces thousands of tons of marijuana, more than seven mt of heroin, and an unknown quantity of methamphetamine yearly. Here the situation is both a great challenge and a great opportunity, offering more hope than at any time in many years. On entering office, President Vicente Fox recognized that his vision for a prosperous Mexico had no place for institutionalized drug cartels and the corruption and lawlessness they foster. He is taking serious action against them, targeting the murderous Arellano Felix Organization, among others. He strengthened law enforcement cooperation with the United States and began the process of reforming dysfunctional and sometimes corrupt institutions.

Such bold action comes at a price. In February 2001, in an incident credited to the drug trade, masked men armed with machine guns herded 15 men and boys into the back of a truck and killed 12. In November of the same year, two Mexican federal judges and the wife of another judge were cut down by AK-47 fire from a passing vehicle; one of the judges had reportedly angered traffickers with a ruling. (President Fox described the latter attack as "a crime against the state as a whole.") More recently, a counterdrug police commander was boxed in on a highway and shot to death, a hit popularly attributed to drug traffickers. Despite all this, Mexican resolve to end international drug trafficking in their territory remains strong.

Since President Fox assumed office in December 2000, 14 major traffickers have been apprehended, and almost 300 of their immediate subordinates have been taken off the streets. Cooperative law enforcement targeting the Tijuana-based Arellano-Felix Organization—responsible for smuggling over one-third of the cocaine consumed in the United States—culminated last March with the arrest of Benjamin Arellano Felix (shortly after the killing of his brother, Ramon Arellano Felix). A month later, the Gulf Cartel's second in command was arrested. The leader of a Juarez-based gang that often coordinated shipments with the Gulf Cartel was arrested last May. In September, Mexican authorities placed in

custody the head of a gang that controlled Mexico City's drug trade.

Key Fox Administration steps toward institutional reform have included compartmentalizing Mexico's anti-organized crime unit to reduce leaks and ensuring that all new members are vetted with polygraph tests and psychological evaluations. A new Agencia Federal de Investigaciones was established by Attorney General Rafael Macedo de la Concha, and Mexico's *National Drug Control Program* was published in November 2002. Finally, the Fox Administration has been unafraid to go after corrupt officials in government and in the military, as evidenced by the sentencing in November 2002 of two general officers accused of aiding the drug trade, and the arrest in October 2002 of two dozen individuals charged with leaking information on the drug control activities of the army, federal police, and the Attorney General.

Other positive signs include a steady stream of internecine trafficker killings, as smugglers vie for market control and command of trafficking routes. Major challenges remain, however, including reducing the backlog of extradition requests from the United States. Meaningfully disrupting the flow of drugs to the United States will also require sustained progress toward strengthening law enforcement and ending impunity to the rule of law.

The United States will continue to support Mexico's drug control efforts through a combination of technical and material assistance that focuses on training and operational support for organizational attack and arrests, disruption of money laundering activities, cocaine and marijuana interdiction initiatives, and enhanced and expanded aid for marijuana and opium poppy eradication.

Afghanistan: Rebuilding Drug Control Capabilities

The state of internal disruption immediately following the fall of the Taliban has brought with it renewed poppy cultivation and a partial rebounding of opium production. Although production levels remain below those of the boom years of 1996–2000, recent increases have returned to Afghanistan the dubious distinction of world's largest opiate producer, with 2002 production estimated to be more than twice that of Burma, the world's other major opium producer (see Figure 13).

For post-Taliban Afghanistan, the stakes could scarcely be higher. By funding local warlords, the Afghan drug trade contributes to local political instability. It also threatens governments worldwide through the financial assistance that drug profits can provide to terrorist organizations such as al Qaeda. For these reasons, the United States strongly supports multilateral efforts to reduce the illegal opium and heroin trade that is returning to Afghanistan.

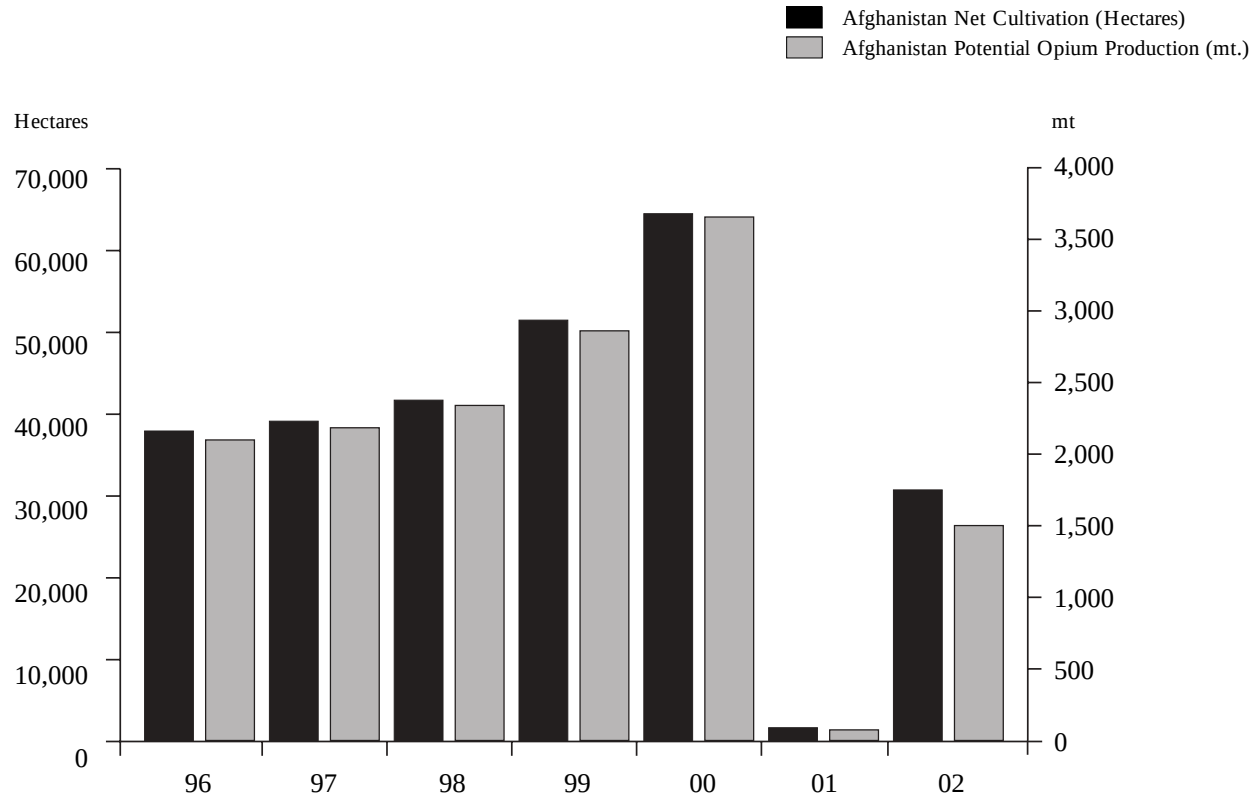
These multinational efforts include as partner nations members of the G-8, particularly the United Kingdom, which is the G-8 lead nation for counternarcotics programs in Afghanistan. The aim of our multilateral efforts is to diminish the destabilizing influence of illegal drugs in Afghanistan and break the links between Afghanistan's drug trade and its terrorist organizations. We intend to achieve these objectives through long-term initiatives that will disrupt Afghanistan's opium trade and provide alternative livelihoods and economic opportunities, a real and effective rule of law, and an environment favorable for an effective representative central government.

The strategy has two key elements. First, it seeks to disrupt the activities of the most significant drug traffickers through interdiction and law enforcement. Through activities such as DEA's Operation Containment, the United States will bolster the counternarcotics capabilities of the countries bordering Afghanistan to choke off the flow of drugs, precursor chemicals, and related supplies into and out of that nation. Second, the strategy seeks to cut opium production through alternative livelihood initiatives for farmers, coupled with comprehensive eradication efforts.

Consistent with this international effort, the United States will support the establishment of a drug policy agency and an anti-drug law enforcement agency and will work to strengthen Afghanistan's judicial institutions to enable the expansion of the rule of law. Afghan military and law enforcement personnel will be trained and equipped to perform the border and regional security functions that are vital to extending government control to areas without the rule of law and permeated by the illegal drug trade. Concurrently, near-term efforts will be started to eliminate drug-related corruption from the central and regional governments and the military.

We will collaborate with the international community and international aid organizations

Figure 13: Afghanistan Net Poppy Cultivation and Potential Opium Production



to create opportunities for legitimate economic livelihoods for Afghan farmers and laborers through initiatives that provide micro-credit alternatives and subsistence loans, legal crop substitution options, and cash-for-work programs for migrant workers. Where possible, programs will be focused on projects to redevelop the education, health, public safety, social services, telecommunications, and transportation infrastructure of Afghanistan.

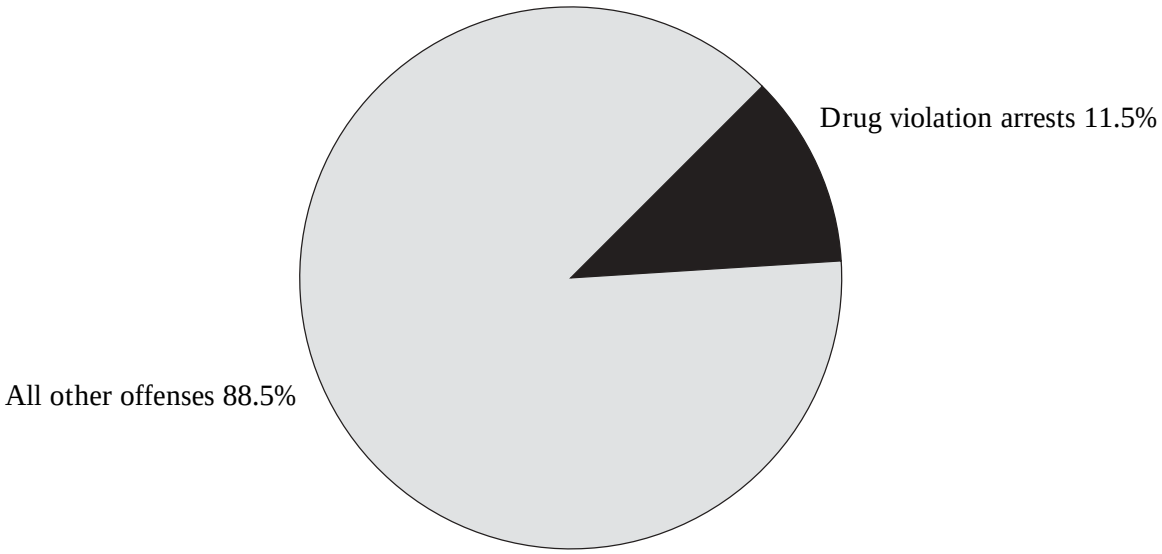
To be successful in Afghanistan, the international community will have to provide a long-term commitment to both the counternarcotics efforts and the broader challenge of nation building. These activities all involve multilateral international efforts, in which the United States is one of many participants.

Developments in Western Europe

The market for illegal drugs is international in scope—the world trade in cocaine now includes significant satellite markets in Europe. Consumption of Asian-produced heroin is also widespread throughout European Union nations. Any market-based understanding of the drug trade must account for the operation of these markets, which, if left unfettered, have the capacity to buffer U.S.-led efforts to disrupt the drug trade in this hemisphere.

The United States is thus watching closely as the debate in several European countries

Figure 14: Drug Violation Arrests Accounted for 11% of All Arrests in 2001



Source: Uniform Crime Reports

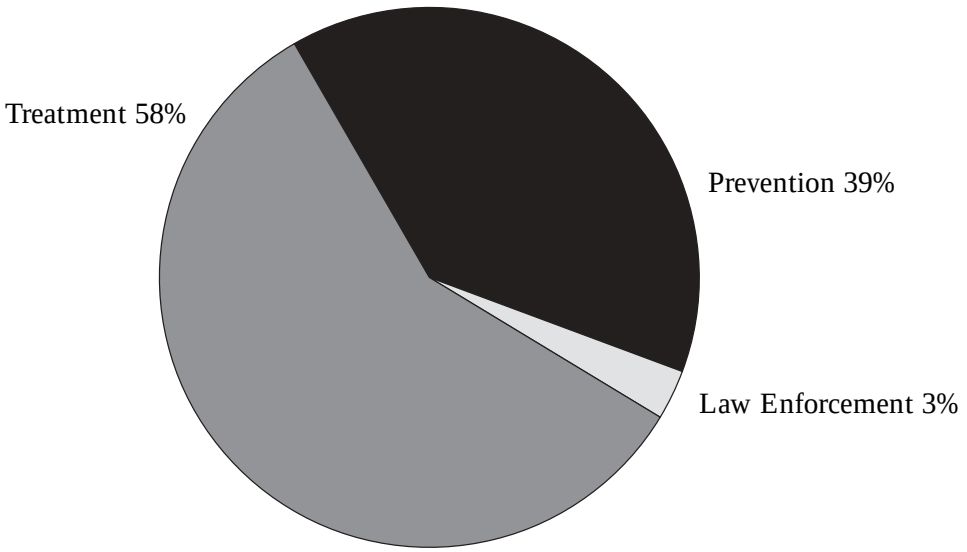
increasingly frames the drug issue as a public health rather than a law enforcement problem. As discussed in detail earlier, a closer look at the drug problem reveals the difficulty of disentangling the two. The fact is, some nations may face an increase in both public health and law enforcement difficulties as a consequence of policies being adopted.

Decriminalization policies are being promoted as precisely what they are not—a public health response to the drug problem. These "tolerant" approaches are contrasted with the supposedly more "punitive" drug policy in the United States. As a recent media report put it, "The trend in Western Europe is to decriminalize all drugs, including heroin and cocaine, and treat drug use as a health problem rather than a crime."

There are two ironies in this characterization. First is the notion that U.S. policy is driven solely by the desire to punish, when, in fact, drug arrests account for a small fraction of total arrests (see Figure 14) and U.S. prevention and treatment programs are the most developed and best funded in the world (President Bush has pledged to increase the drug treatment budget by $1.6 billion over five years.) U.S. medical research on treatment and prevention, led by NIDA, is unsurpassed and heavily outweighs the amounts spent on enforcement- and interdiction-related research (see Figure 15).

The second irony is the posture that such "harm reduction" approaches represent a genuine public health approach. No policy can seriously be considered in the public good if it advances

Figure 15: Federal Research & Development Spending for Treatment and Prevention (FY 2004 Request)



Total Dollars = $1,059 million

the contagion of drug use. Yet that is precisely the effect of harm reduction actions such as marijuana decriminalization: as the drug becomes more available, acceptable, and cheap, it draws in greater numbers of vulnerable youth.

The United States will continue to engage this issue in various multilateral forums, including the U.S.-E.U. Demand Reduction Seminar, which has led to a commitment to exchange ideas and experiences in combating drug use and drug dependence. Other important multilateral fora include the European Monitoring Center for Drugs and Drug Addiction.

National Drug Control Strategy:

APPENDIXES

National Drug Control Budget Summary

Drug Control Funding: Agency Summary, FY 2002–FY 2004 (Budget Authority in Millions)

	FY 2002 Final BA	FY 2003 Request	FY 2004 Request
Department of Defense[1]	$852.6	$871.9	$817.4
Department of Education	669.3	634.3	584.3
Department of Health & Human Services			
National Institute on Drug Abuse	885.2	960.0	995.6
Substance Abuse and Mental Health Services Administration	2,304.4	2,372.6	2,575.3
Total HHS	**3,189.6**	**3,332.6**	**3,570.9**
Department of Homeland Security			
Border and Transportation Security	1,183.6	1,271.8	1,372.9
U.S. Coast Guard	609.7	596.1	669.1
Total DHS	**1,793.3**	**1,867.9**	**2,041.9**
Department of Justice			
Bureau of Prisons	39.4	43.5	45.2
Drug Enforcement Administration	1,562.5	1,659.6	1,677.3
Interagency Crime and Drug Enforcement[2]	446.5	470.3	541.8
Office of Justice Programs	893.2	286.7	301.5
Total DOJ	**2,941.5**	**2,460.1**	**2,565.8**
ONDCP			
Operations	25.2	25.5	27.3
High Intensity Drug Trafficking Area Program	221.3	206.4	206.4
Counterdrug Technology Assessment Center	42.3	40.0	40.0
Other Federal Drug Control Programs	239.3	251.3	250.0
Total ONDCP	**528.1**	**523.1**	**523.6**
Department of State			
Bureau of International Narcotics and Law Enforcement Affairs	871.9	877.5	876.9
Department of Veterans Affairs			
Veterans Health Administration	635.7	663.7	690.5
Other Presidential Initiatives[3]	3.0	8.0	8.0
Total Federal Drug Budget	**$11,485**	**$11,239.0**	**$11,679.3**

[1] The FY 2003 funding level for the Department of Defense reflects enacted appropriations.
[2] The FY 2004 Budget proposes the merger of the Treasury ICDE account into Justice's ICDE account. This merger is reflected retrospectively.
[3] This includes $5 million for the Corporation for National Service's Parents Drug Corps beginning in FY 2003 and $3 million for SBA's Drug-Free Workplace programs for all three fiscal years.

Acknowledgments

Consultation

The Office of National Drug Control Policy Reauthorization Act of 1998 requires the ONDCP Director 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 2002, ONDCP consulted with both houses of Congress and 28 federal agencies. At the state and local level, 55 Governors were consulted, as well as the National Governors Association, U.S. Conference of Mayors, and 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 United States 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
Hillary Rodham Clinton – NY
Thad Cochran – MS
Susan M. Collins – ME
Mark Dayton – MN
Mike DeWine – OH
Christopher J. Dodd – CT
Byron 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
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
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Pat Roberts – KS
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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

Members of the United States House of Representatives

Robert B. Aderholt – AL
Thomas H. Allen – ME
Joe Baca – CA
Brian Baird – WA
Cass Ballenger – NC
Bob Barr – GA
Joe Barton – TX
Doug Bereuter – NE
Shelley Berkley – NV
Marion Berry – AR
Judy Biggert – IL
Rod R. Blagojevich – IL
Henry Bonilla – TX
Mary Bono – CA
Leonard Boswell – IA
Dan Burton – IN
Ken Calvert – CA
Chris Cannon – UT
Howard Coble – NC
Christopher Cox – CA
Elijah E. Cummings – MD
Randy “Duke” Cunningham – CA
Danny K. Davis – IL
Jo Ann Davis – VA
Nathan Deal – GA
Norman D. Dicks – WA
Cal Dooley – CA
Jennifer Dunn – WA
Jo Ann Emerson – MO
Lane Evans – IL
Ernie L. Fletcher – KY
Elton Gallegly – CA
Jim Gibbons – NV
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Kay Granger – TX
Melissa Hart – PA
J. Dennis Hastert – IL
J.D. Hayworth – AZ
Wally Herger – CA
Van Hilleary – TN
Darlene Hooley – OR
Stephen Horn – CA
John N. Hostettler – IN
Steny H. Hoyer – MD
Duncan L. Hunter – CA
Henry J. Hyde – IL
Jay Inslee – WA
Johnny Isakson – GA
Ernest J. Istook – OK
Jack Kingston – GA
Mark Steven Kirk – IL
Jim Kolbe – AZ
Tom Lantos – CA
Rick Larsen – WA
Tom Latham – IA

Jim Leach – IA
Ron Lewis – KY
Frank LoBiondo – NJ
Frank D. Lucas – OK
Jim Matheson – UT
Robert Matsui – CA
Karen McCarthy – MO
Jim McDermott – WA
Scott McInnis – CO
Buck McKeon – CA
Carrie Meek – FL
John L. Mica – FL
Dan Miller – FL
Jerry Moran – KS
Sue Myrick – NC
George R. Nethercutt – WA
Anne Meagher Northup – KY
Tom Osborne – NE
Doug Ose – CA
Mike Pence – IN
John E. Peterson – PA
Richard Pombo – CA
Rob Portman – OH
David E. Price – NC
George P. Radanovich – CA
Silvestre Reyes – TX
Harold Rogers – KY
Mike Rogers – MI
Ileana Ros-Lehtinen – FL
Mike Ross – AR
Steven B. Rothman – NJ
Loretta Sanchez – CA
Bernard Sanders – VT
Max Sandlin – TX
Bob Schaffer – CO
Janice D. Schakowsky – IL
Pete Sessions – TX
Don Sherwood – PA
Ronnie Shows – MS
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Adam Smith – WA
Chris Smith – NJ
Lamar S. Smith – TX
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John E. Sweeney – NY
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Jim Turner – TX
Tom Udall – NM
Peter J. Visclosky – IN
Greg Walden – OR
Zach Wamp – TN
Wes Watkins – OK
J.C. Watts – OK
Dave Weldon – FL
Roger F. Wicker – MS
Heather Wilson – NM
Frank R. Wolf – VA
David Wu – OR

Federal Agencies

Department of Defense
Department of Education
Department of Health and Human Services
Department of the Interior
Department of Justice
Department of Labor
Department of State
Department of Transportation
Department of the Treasury
Department of Veterans Affairs
Corporation for National and Community Service
Small Business Administration
Bureau of Alcohol, Tobacco, and Firearms
Defense Intelligence Agency
Drug Enforcement Administration
Federal Bureau of Investigation

Federal Bureau of Prisons
Immigration and Naturalization Service
National Institute on Drug Abuse
National Institutes of Health
Substance Abuse and Mental Health Services Administration
U.S. Agency for International Development
U.S. Coast Guard
U.S. Forest Service
U.S. Marshals Service
U.S. Secret Service

Foreign Governments and International Organizations

Brazil
Canada
Colombia
Mexico
Peru
International Narcotics Control Board
Organization of American States
United Nations Office on Drugs and Crime

Governors

Lincoln C. Almond – RI
Juan Babauta – MP
Roy E. Barnes – GA
Jeb Bush – FL
Sila Calderón – PR
Benjamin J. Cayetano – HI
Gray Davis – CA
Howard Dean – VT
Michael F. Easley – NC
John M. Engler – MI
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Jim Geringer – WY
Parris Glendening – MD
Bill Graves – KA
Kenny Guinn – NV
Carl Gutierrez – GU
Jim Hodges – SC
John Hoeven – ND
Bob Holden – MO
Mike Huckabee – AR
Jane Dee Hull – AZ
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Paul Patton – KY
Rick Perry – TX
John Rowland – CT
George Ryan – IL
Mark Schweiker – PA
Jeanne Shaheen – NH
Don Siegelman – AL
Don Sundquist – TN
Tauese Sunia – AS
Jane Swift – MA
Bob Taft – OH
Charles Turnbull – VI
Thomas Vilsack – IA
Jesse Ventura – MN
Mark Warner – VA
Robert Wise, Jr. – WV

Mayors

Michael Bloomberg – New York, NY
Lee Brown – Houston, TX
Willie Brown – San Francisco, CA
Richard Daley – Chicago, IL
Manuel Diaz – Miami, FL
Shirley Franklin – Atlanta, GA
Ron Gonzales – San Jose, CA
Dick Greco – Tampa, FL
James Hahn – Los Angeles, CA
Vera Katz – Portland, OR
Thomas Menino – Boston, MA
Laura Miller – Dallas, TX
Richard Murphy – San Diego, CA
Thomas Murphy – Pittsburgh, PA
Greg Nickles – Seattle, WA
Martin O'Malley – Baltimore, MD
Skip Rimsza – Phoenix, AZ
R.T. Rybak – Minneapolis-St. Paul, MN
Jorge Santini – San Juan, PR
John Street – Philadelphia, PA
Wellington Webb – Denver, CO
Anthony Williams – Washington, DC
Francis Slay – St. Louis, MO

Other Organizations and Individuals

Abt Associates
Addiction Research and Treatment Corporation
AFL-CIO
Alcohol and Drug Problems Association of North America
America Cares
American Association for the Treatment of Opioid Dependence
American Correctional Association
American Enterprise Institute
American Federation of Government Employees
American Federation of Teachers
American Medical 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
Arizona Science Center
Association of Flight Attendants
Auburn University
Boy Scouts of America
Boys & Girls Clubs of America
Brandeis University Institute for Health Policy
Brookhaven National Laboratory
Brookings Institution
Brownsville Police Department
Caliber Associates
California Institute of Technology
California Narcotics Officers' Association
California Regional Primate Center
Californians for Drug-Free Youth
Canada Customs and Revenue Agency
Carnegie Mellon University
Carnevale Associates
Catholic Charities USA
Center for Alcohol and Drug Research and Education
Center for Media Education
Center for Media Literacy
Center for Problem Solving Courts
Centers for Family Life
Century Foundation
Chesterfield County Police Department
Children's Hospital of Philadelphia
Child Welfare League of America
Church of Jesus Christ of Latter-Day Saints

Civitan International
Colorado Department of Human Services
Colorado Justice Information Network
Columbia University
Community Anti-Drug Coalitions of America
Congress of National Black Churches
Harry F. Connick
Cornell University
Council of State Governments
County Executives of America
D.A.R.E. America
Direct Impact
Drug and Alcohol Service Providers Organization of Pennsylvania
Drug Free America Foundation
Drug Free Pennsylvania
Drug Watch International
DuPont Associates, PA
DynMeridian
Employee Assistance Professionals Association
Employee Health Programs
Empower America
Emory University
Entertainment Industries Council
Family Research Council
Federal Law Enforcement Officers Association
Fellowship of Christian Athletes
Florida Chamber of Commerce
Fraternal Order of Police
Gamma Metrics
Georgetown University
Georgia State University Department of Psychology
Girl Scouts of the USA
Harvard University
Heritage Foundation
Hillsborough County Sheriff's Office
Hispanic American Police Command Officers Association
Houston Advanced Research Center
Independent Order of Odd Fellows
Institute of Biological Detection Systems
Institute for Defense Analyses
Institute for a Drug-Free Workplace
Institute on Global Drug Policy
Institute for Social Research
Institute for Youth Development
Integrated Systems Research Corporation
International Association of Chiefs of Police
International Association of Lions Clubs
International Brotherhood of Police Officers
Iowa Board of Parole
Jewish Council for Public Affairs
Johns Hopkins University
Johnson Institute Foundation
Join Together
Joint Center for Political and Economic Studies
Junior Chamber International
Kansas City, Missouri, Police Department
Kiwanis International
Lawrence Livermore National Laboratory
Legal Action Center
Lewin Group
Los Angeles County Sheriff's Department
David M. Luitweiler
Major City Chiefs Association
Massachusetts General Hospital
Massachusetts Institute of Technology
Maximizing Adolescent Potentials
Mayo Clinic
Miami Coalition
Michigan State Police Investigative Services Bureau
Milton S. Eisenhower Foundation
Minneapolis Police Department
Montana State University
Montreal Neurological Institute
Moose International
Mothers Against Drunk Driving
National Alliance of State Drug Enforcement Agencies

National Asian Pacific American Families Against Substance Abuse
National Association of Alcoholism and Drug Abuse Counselors
National Association of Attorneys General
National Association for Children of Alcoholics
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
National Association of Neighborhoods
National Association of Police Organizations
National Association of Secondary School Principals
National Association of State Alcohol and Drug Abuse Directors
National Association of Student Assistance Professionals
National Black Child Development Institute
National Center on Addiction and Substance Abuse at Columbia University
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 Legislatures
National Council of Juvenile and Family Court Judges
National Council of State Legislatures
National Crime Prevention Council
National Criminal Justice Association
National Development and Research Institutes
National District Attorneys Association
National Exchange Club
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 Neurological Disorders and Stroke
National League of Cities
National Legal Aid & Defender Association
National Library of Medicine
National Masonic Foundation for Children
National Mental Health Association
National Narcotic Officers' Associations' Coalition
National Opinion Research Center
National Organization of Black Law Enforcement Executives
National Parents and Teachers Association
National Pharmaceutical Council
National Prevention Network
National Research Council
National School Boards Association
National Sheriffs' Association
National Treatment Consortium
National Troopers Coalition
Naval Research Laboratory
New York State Psychiatric Institute
New York University School of Medicine
Northwestern University
Operation PAR
Oregon Partnership
Oregon Health & Science University
Orthodox Union
Parents' Resource Institute for Drug Education
Partnership for a Drug-Free America
Penn State University
Phoenix House

Physicians for Prevention
Pima County Sheriff's Department
Police Executive Research Forum
Police Foundation
Prevention, Intervention, and Treatment Coalition for Health
Prevention Think Tank
Prevention Through Service Alliance
Quota International
RAND Drug Policy Research Center
Research Triangle Institute
Robert Wood Johnson Foundation
Robert Wood Johnson Medical School
Office of the Rockland County District Attorney
Safe Streets
Sandia National Laboratories
Science Applications International Corporation
Scott Newman Center
Betty Sembler
South Carolina Law Enforcement Division
Southern Christian Leadership Conference
Stanford University School of Medicine
Substance Abuse Program Administrators Association
Support Center for Alcohol and Drug Research and Education
Texas Commission on Alcohol and Drug Abuse
Therapeutic Communities of America
Torrey Mesa Research Institute
Treatment Alternatives for Safe Communities
Treatment Research Institute
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 Hospitals of Cleveland
University of Arizona
University of California, Los Angeles
University of California, San Diego
University of Chicago
University of Cincinnati
University of Colorado Health Sciences Center
University of Delaware Center for Drug and Alcohol Studies
University of Florida
University of Iowa
University of Kentucky Center for Prevention Research
University of Maryland
University of Miami School of Medicine
University of Minnesota
University of New Mexico
University of North Dakota
University of Pennsylvania
University of Pittsburgh School of Medicine
University of South Florida
University of Texas
Urban Institute Justice Policy Center
U.S. Anti-Doping Agency
Wake Forest University School of Medicine
Walsh Group
Washington Business Group on Health
Wayne State University School of Medicine
Western Kentucky University
White Bison
Whitehead Institute
Workers Assistance Program
Yale School of Public Health
YMCA of America

Office of National Drug Control Policy
Washington, D.C. 20503

National Drug Control Strategy

Data Supplement

The White House
February 2003

National Drug Control Strategy

DATA SUPPLEMENT

The White House
February 2003

MESSAGE FROM THE DIRECTOR

One year ago, the President's National Drug Control Strategy set the goals of reducing past-month, or "current," use of illegal drugs by 10 percent over 2 years and 25 percent over 5 years.

Allocating resources intelligently requires us to be able to measure the results of such goals. We need to focus not on perceived needs but on what works; our decisions must be based on performance, and we must select priorities.

Three priorities were identified to help achieve our core goals—Stopping Use Before It Starts, Healing America's Drug Users, and Disrupting the Market.

The ultimate success of our efforts should be judged by whether they are helping drive down drug use. The effectiveness of our priorities, by contrast, will be judged by numerous complimentary measures, many of which are contained in this companion volume to the National Drug Control Strategy.

John P. Walters
Director
Office of National Drug Control Policy

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Introduction and Legislative History

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 (the Data Subcommittee) 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* 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;

* The text is quoted directly from PL 105-277.

(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 immuno-deficiency virus and other infectious diseases as a result of drug use;

(III) the extent of drug-related crime and criminal activity; and

(VI) 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 volume contain the most current drug-related data on the areas the 1998 ONDCP Reauthorization Act requires ONDCP to assess.

Improving Federal Drug-Related Data Systems

ONDCP supports improvements to enhance the policy relevance of federal drug-related data systems. The Data Subcommittee has supported the following innovations:

- The National Institute of Justice is expanding and revising the Drug Use Forecasting program into the Arrestee Drug Abuse Monitoring (ADAM) system. Plans call for the expansion of ADAM to 75 sites with probability-based samples representative of the respective metropolitan areas. The new ADAM instrument includes questions to promote the estimation of the prevalence of drug abuse among arrestee populations comparable to those generated for the general household population. The first ten new ADAM sites were funded by ONDCP in 1998.

- The Substance Abuse and Mental Health Services Administration (SAMHSA) enlarged the sample for the National Household Survey on Drug Abuse (NHSDA)—reaching nearly quadruple the size—permitting, for the first time, estimation of drug-use prevalence at the state level. The first wave of new data became available in August 2000.

- The Center for Substance Abuse Treatment (CSAT) began implementation in FY 2002 of the National Treatment Outcome Monitoring System (NTOMS). NTOMS combines the work of two data systems funded by ONDCP: the Drug Evaluation Network System, which provides real-time data on treatment admission; and the Random Access Monitoring of Narcotics Addicts system, which estimates the size and characteristics of chronic drug-using populations. NTOMS will provide essential data on treatment effectiveness, waiting time, and chronic users.

- Center for Substance Abuse Prevention (CSAP) has several activities to promote state data systems. For example, 20 states now voluntarily collect common process and capacity data using software developed under Minimum Data Set I (MDSI), which permits collection from the provider through the substate, state, and federal system levels. Similarly, states can voluntarily report on five common outcome measures in the pilot SAPT block grant application for FY 2000.

- SAMHSA's Office of Applied Studies (OAS) is undertaking a redesign of the Drug Abuse Warning Network (DAWN) system, in efforts to maintain alignment with the health care delivery system. DAWN is an important source of national and local data on substance abuse derived from information on visits to hospital emergency departments (EDs) and drug-related deaths identified by medical examiners (MEs). DAWN collects data on the demographic characteristics of substance abusers and the specific drugs involved in each drug-related ED visit or death. The new design will begin initial phase-in in 2003 with the following:

  1) expanding the sample of emergency departments to include 45 metropolitan areas,

  2) establishing a sentinel hospital system for early reporting,

3) changing the criteria for identifying a DAWN case, and

4) converting from paper to electronic forms.

- ONDCP and the Department of Justice are leading an interagency effort to develop drug availability models—from source countries through availability in the United States—for cocaine, heroin, marijuana, and methamphetamine. Results from this project are providing critical measures enabling assessment of the Nation's supply-reduction programs.

Description of Data Sources

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

National Household Survey on Drug Abuse

(Source for Tables 1, 2, 4, 38, 57, and 58)

The NHSDA measures the prevalence of drug and alcohol use among household members ages twelve and older. Topics include drug use, health, and demographics. In 1991, it was expanded to include college students in dormitories, people 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; 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 and ethnic subgroups groups and single-year age categories. These and further changes have caused breaks in trend data after 1998 and after 2001.

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

(Source for Tables 3, 39, 40, 47, and 48)

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 and both yearly and weekly expenditures for drugs, which are then combined with drug price/purity data to calculate trends in total national drug expenditures and consumption. Abt Associates 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 the details.

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

(Source for Tables 5–10)

The *Monitoring the Future* (MTF) study provides information on drug use trends and 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 MTF 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 11–13, 15, 17, and 78–79)

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 oversampled 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 who have been expelled from regular high school because of illegal activity or behavioral problems.

PRIDE USA Survey

(Source for Table 14)

The National Parents' Resource Institute for Drug Education (PRIDE) conducts an annual survey of drug use by middle and high school students. The PRIDE survey collects data from students in 6th through 12th grades and is conducted during the school year between September and June. Participating schools are sent the questionnaires with detailed instructions for administering the anonymous self-report instrument. Schools participate on a voluntary basis or in compliance with a school or state request. The study conducted during the 2001–2002 school year involved approximately 101,000 students in 21 states.

Current Population Survey

(Source for Table 16)

As mandated by the U.S. Constitution, Article 1, Section 2, the U.S. Bureau of the Census has conducted a census every ten years since 1790. The primary purpose of the census is to provide population counts needed to apportion seats in the U.S. House of Representatives and subsequently determine state legislative district boundaries.

The information collected also provides insight on population size and a broad range of demographic background information on the population living in each geographic area. The individual information in the census is grouped together into statistical totals. Information such as the number of people in a given area, their ages, educational background, and the characteristics of their housing enable government, business, and industry to plan more effectively.

Substance Abuse Among Probationers and Inmates

(Source for Table 18)

Conducted by the Bureau of Justice Statistics (BJS), 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 five or six 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 19–21)

The National Survey of Homeless Assistance Providers and Clients gives 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 by other interested parties. The survey was conceived, developed, and funded by twelve federal agencies under the auspices of the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council. The Census Bureau carried out the data collection on behalf of the sponsoring agencies. The survey, released in December 1999, offers 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 22 and 23)

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 which was 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 Tables 24 and 25)

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 mother's 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 26 and 72–76)

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 policymakers to examine drug use patterns and trends and assess health hazards associated with drug abuse. Data are available on deaths and emergency department episodes by type of drug, reason for taking the drug, demographic characteristics of the user, and metropolitan area. NIDA maintained DAWN from 1982 through 1991; SAMHSA has maintained it since 1992.

HIV/AIDS Surveillance Report

(Source for Tables 27 and 28)

The HIV/AIDS Surveillance Reports 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. The Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, a component of CDC, publishes it semiannually. Data on mode of exposure to HIV are of interest to the Strategy in light of the role of injection drug use in HIV transmission.

Reported Tuberculosis in the United States

(Source for Table 29)

The TB Surveillance Reports 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 Division of TB Elimination, National Center for HIV, STD, and TB Prevention, a component of CDC, publishes the reports annually. The reports also include information on injection drug use and non-injection drug use among TB cases.

Summary of Notifiable Diseases

(Source for Table 30)

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 individuals 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 31 and 32)

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

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

(Source for Table 33)

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 Census Bureau. 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 33)

The National Prisoner Statistics Program provides midyear estimates and year-end counts of federal and state prisoners, some of whom may be in local facilities or facilities located in other states.

The Monetary Value of Saving a High-Risk Youth

(Source for Tables 34 and 35)

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

Uniform Facility Data Set/National Drug and Alcoholism Treatment Unit Survey

(Source for Tables 36, 37, and 59)

The Uniform Facility Data Set (UFDS) measures the location, scope, and characteristics of drug abuse and alcoholism treatment facilities throughout the United States. The survey collects data on unit ownership, type, and scope of services provided; sources of funding; 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 twelve months prior to 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.

Estimation of Cocaine Availability, 1996–1998

(Source for Table 40)

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 41)

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 typically measured and is not recorded in 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 Tables 42 and 56)

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 the FBI, DEA, Customs Service, Border Patrol, and Coast Guard. The FDSS database includes drug seizures by other federal agencies (e.g., 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 DEA since 1988.

DEA, 1982–1999

(Source for Tables 43 and 70)

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

International Narcotics Control Strategy Report

(Source for Tables 40, 44–46, and 49–55)

The International Narcotics Control Strategy Report (INCSR) provides the President with information on the steps taken by the main illicit drug-producing and transit 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 48)
This research was supported by ONDCP's Office of Planning and Budget. 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 System to Retrieve Information on Drug Evidence
(Source for Table 56)
The System to Retrieve Information on Drug Evidence (STRIDE) is operated by DEA and provides laboratory analyses of street-level drug purchases and of drugs removed from the marketplace where DEA participated in the seizure(s). The system also provides analyses of drug evidence and their physical and chemical attributes to determine geographic origins. It offers indicators of drug availability in the form of long-term trends in the prices and purities of drug exhibits.

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program
(Source for Tables 60–69)
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. ADAM 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 each 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 71)
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. Staff 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 (EID).

The European School Survey Project on Alcohol and Other Drugs: Alcohol and Other Drug Use Among Students in 30 European Countries
(Source for Table 77)
The European School Survey Project on Alcohol and Other Drugs was jointly published by the Swedish Council for Information on Alcohol and Other Drugs, CAN Council of Europe, and Co-Operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group). Under this project, data on drug use prevalence were collected from annual school surveys in up to 30 European countries and the United States in 1995 and 1999. The target age of youth surveyed was 15 years, 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 USE

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Year	Ages 12 and older					Adolescent (Ages 12–17)		
	Current use of any illicit drug[2]	Current cocaine use[2]	Occasional cocaine use[3]	Current marijuana use[2]	Lifetime heroin use	Current use of any illicit drug[2]	Current marijuana use[2]	Lifetime inhalant use[4]
1979	25,400	4,700	—	23,800	2,300	4,100	3,374	—
1982	—	4,500	—	21,500	1,800	2,800	2199	—
1985	23,300	5,700	7,100	18,600	1,800	3,200	2,189	—
1988	15,000	3,100	5,100	12,400	1,700	1,900	1,102	—
1990	13,500	1,700	3,700	10,900	1,500	1,600	875	—
1991	13,400	2,000	3,800	10,400	2,400	1,400	722	—
1992	12,000	1,400	3,000	9,700	1,700	1,300	696	—
1993	12,300	1,400	2,700	9,600	2,100	1,400	845	—
1994	12,600	1,400	2,400	10,100	2,100	1,800	1,315	1,500
1995	12,800	1,500	2,500	9,800	2,500	2,400	1,828	1,600
1996	13,000	1,700	2,600	10,100	2,400	2,000	1,600	1,300
1997	13,900	1,500	2,600	11,100	2,000	2,600	2,116	1,600
1998	13,600	1,800	2,400	11,000	2,400	2,300	1,878	1,400
1999-CAI	13,829	1,552	1,926	10,458	3,054	2,265	1,676	2,118
2000-CAI	14,027	1,213	1,732	10,714	2,779	2,264	1,678	2,079
2001-CAI	15,910	1,676	1,995	12,122	3,091	2,556	1,889	2,038

— Data not available.

[1] In 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.

[2] Data for past-month (current) use.

[3] Less than monthly use.

[4] Prior 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 (1992–2001), *National Household Survey on Drug Abuse.*

Table 2. Percentages Reporting Use of Selected Illegal Drugs, 1979–2001[1]

Year	Ages 12 and older					Adolescent (Ages 12–17)		
	Current use of any illicit drug[2]	Current cocaine use[2]	Occasional cocaine use[3]	Current marijuana use[2]	Lifetime heroin use	Current use of any illicit drug[2]	Current marijuana use[2]	Lifetime inhalant use[4]
1979	14.1	2.6	—	13.2	1.3	16.3	14.2	—
1982	—	2.4	—	11.5	1.0	—	9.9	—
1985	12.1	3.0	3.7	9.7	0.9	13.2	10.2	—
1988	7.7	1.6	2.6	6.2	0.9	8.1	5.4	—
1990	6.7	0.9	1.8	5.4	0.8	7.1	4.4	—
1991	6.6	1.0	1.9	5.1	1.2	5.8	3.6	—
1992	5.8	0.7	1.5	4.7	0.8	5.3	3.4	—
1993	5.9	0.7	1.3	4.6	1.0	5.7	4.0	—
1994	6.0	0.7	1.2	4.8	1.0	8.2	6.0	7.0
1995	6.1	0.7	1.2	4.7	1.2	10.9	8.2	7.4
1996	6.1	0.8	1.2	4.7	1.1	9.0	7.1	5.9
1997	6.4	0.7	1.2	5.1	0.9	11.4	9.4	7.2
1998	6.2	0.8	1.1	5.0	1.1	9.9	8.3	6.1
1999-PAPI	7.0	0.8	—	5.4	—	9.0	7.0	—
1999-CAI	6.3	0.7	0.9	4.7	1.4	9.8	7.2	9.1
2000-CAI	6.3	0.5	0.8	4.8	1.2	9.7	7.2	8.9
2001-CAI	7.1	0.7	0.9	5.4	1.4	10.8	8.0	8.6

— Data not available.

[1] In 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.

[2] Data for past-month (current) use.

[3] Less than monthly use.

[4] Prior 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 (1992–2001), *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* (December 2001).

Table 4. Drug Use by Current Employment Status,[1] 1995–2001[2] (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	8.2	16.2	3.3
2000 CAI	6.3	7.7	16.9	3.6
2001 CAI	6.9	9.1	17.1	3.9
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	6.2	14.4	2.6
2001 CAI	5.4	7.6	14.1	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	0.5	0.9	1.8	0.3
2001 CAI	0.8	1.1	3.5	0.4

[1] Data on current employment is for persons age 18 and older. Estimates for 2000 and 2001 are based on a revised definition of employment and are not comparable with estimates by employment published in prior NHSDA reports.

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

[3] "Other" is meant to include persons who are retired or disabled, or are homemakers or students, as well as any other category not mentioned.

Source: Substance Abuse and Mental Health Services Administration, *National Household Survey on Drug Abuse* (1995–2001).

Table 5. Trends in 30-Day Prevalence of Selected Drugs Among 8th Graders, Monitoring the Future Study, 1991–2002 (Percent Prevalence)

Selected drug	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2001-2002 Change
Marijuana/hashish	3.2	3.7	5.1	7.8	9.1	11.3	10.2	9.7	9.7	9.1	9.2	8.3	-0.9
Inhalants[1]	4.4	4.7	5.4	5.6	6.1	5.8	5.6	4.8	5.0	4.5	4.0	3.8	-0.2
Hallucinogens	0.8	1.1	1.2	1.3	1.7	1.9	1.8	1.4	1.3	1.2	1.6	1.2	-0.4
LSD	0.6	0.9	1.0	1.1	1.4	1.5	1.5	1.1	1.1	1.0	1.0	0.7	-0.3
Cocaine	0.5	0.7	0.7	1.0	1.2	1.3	1.1	1.4	1.3	1.2	1.2	1.1	-0.1
Stimulants	2.6	3.3	3.6	3.6	4.2	4.6	3.8	3.3	3.4	3.4	3.2	2.8	-0.4
Alcohol (any use)[2]	25.1	26.1	24.3	25.5	24.6	26.2	24.5	23.0	24.0	22.4	21.5	19.6	-1.9s
Approximate Ns	17,500	18,600	18,300	17,300	17,500	17,800	18,600	18,100	16,700	17,300	16,200	15,100	

Notes: Level of significance of difference between the two most recent classes: s=.05. Any inconsistency between the 2001–2002 change estimate and the respective prevalence estimates is due to rounding.

[1] Unadjusted for underreporting of amyl and butyl nitrites.

[2] 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 is based on all forms.

Source: Institute for Social Research, University of Michigan, *Monitoring the Future* study (December 2002).

Table 6. Trends in 30-Day Prevalence of Selected Drugs Among 10th Graders, Monitoring the Future Study, 1991–2002 (Percent Prevalence)

Selected drug	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2001-2002 Change
Marijuana/hashish	8.7	8.1	10.9	15.8	17.2	20.4	20.5	18.7	19.4	19.7	19.8	17.8	-1.9s
Inhalants[1]	2.7	2.7	3.3	3.6	3.5	3.3	3.0	2.9	2.6	2.6	2.4	2.4	-0.1
Hallucinogens	1.6	1.8	1.9	2.4	3.3	2.8	3.3	3.2	2.9	2.3	2.1	1.6	-0.4
LSD	1.5	1.6	1.6	2.0	3.0	2.4	2.8	2.7	2.3	1.6	1.5	0.7	-0.8sss
Cocaine	0.7	0.7	0.9	1.2	1.7	1.7	2.0	2.1	1.8	1.8	1.3	1.6	+0.3
Stimulants	3.3	3.6	4.3	4.5	5.3	5.5	5.1	5.1	5.0	5.4	5.6	5.2	-0.4
Alcohol (any use)[2]	42.8	39.9	38.2	39.2	38.8	40.4	40.1	38.8	40.0	41.0	39.0	35.4	-3.6ss
Approximate Ns	14,800	14,800	15,300	15,800	17,000	15,600	15,500	15,000	13,600	14,600	14,000	14,300	

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.

[1] Unadjusted for underreporting of amyl and butyl nitrites.

[2] 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 is based on all forms.

Source: Institute for Social Research, University of Michigan, *Monitoring the Future* study (December 2002).

Table 7. Trends in 30-Day Prevalence of Selected Drugs Among 12th Graders, Monitoring the Future Study, 1991–2002 (Percent Prevalence)

Selected drug	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2001	2001–2002 Change
Marijuana/hashish	13.8	11.9	15.5	19.0	21.2	21.9	23.7	22.8	23.1	21.6	22.4	21.5	-0.9
Inhalants[1]	2.4	2.3	2.5	2.7	3.2	2.5	2.5	2.3	2.0	2.2	1.7	1.5	-0.2
Hallucinogens	2.2	2.1	2.7	3.1	4.4	3.5	3.9	2.8	3.5	3.5	3.3	2.3	-1.0ss
LSD	1.9	2.0	2.4	2.6	4.0	2.5	3.1	3.2	2.7	1.6	2.3	0.7	-1.6sss
Cocaine	1.4	1.3	1.3	1.5	1.8	2.0	2.3	2.4	2.6	2.1	2.1	2.3	+0.2
Stimulants	3.2	2.8	3.7	4.0	4.0	4.1	4.8	4.6	4.5	5.0	5.6	5.5	-0.2
Alcohol (any use)[2]	54.0	51.3	48.6	50.1	51.3	50.8	52.7	52.0	51.0	50.0	49.8	48.6	-1.2
Approximate Ns	15,000	15,800	16,300	15,400	15,400	14,300	15,400	15,200	13,600	13,300	12,800	12,900	

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.

[1] Unadjusted for underreporting of amyl and butyl nitrites. Data for 12th graders only is based on five of six questionnaire forms; N is five-sixths of N indicated.

[2] 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 is based on all forms.

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

Table 8. Trends in Harmfulness of Drugs as Perceived by 8th Graders, Monitoring the Future Study, 1991–2002

Drug Behavior	Percentage saying "great risk"[1]												
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2001–2002 Change
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	28.2	+0.5
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	46.0	-0.3
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	71.7	-0.5
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	47.4	-1.2
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	69.7	-0.2
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	43.2	-0.7
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	64.9	-0.9
Approximate N	17,437	18,662	18,366	17,394	17,501	17,926	18,765	18,100	16,700	17,300	16,200	15,100	

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

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

[2] 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 2002).

Table 9. Trends in Harmfulness of Drugs as Perceived by 10th Graders, Monitoring the Future Study, 1991–2002

Drug Behavior	Percentage saying "great risk"[1]												
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2001–2002 Change
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	19.9	+2.0s
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	32.0	+0.8
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	60.8	-2.0
Try crack once or twice[2]	70.4	69.6	66.6	64.7	60.9	60.9	59.2	58.0	57.8	56.1	57.1	57.4	+0.3
Take crack occasionally[2]	87.4	86.4	84.4	83.1	81.2	80.3	78.7	77.5	79.1	76.9	77.3	75.7	-1.7
Try cocaine powder once or twice[2]	59.1	59.2	57.5	56.4	53.5	53.6	52.2	50.9	51.6	48.8	50.6	51.3	+0.7
Take cocaine powder occasionally[2]	82.2	80.1	79.1	77.8	75.6	75.0	73.9	71.8	73.6	70.9	72.3	71.0	-1.4
Approximate N	14,719	14,808	15,298	15,880	17,006	15,670	15,640	15,000	13,600	14,600	14,000	14,300	

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

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

[2] 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 2002).

Table 10. Trends in Harmfulness of Drugs as Perceived by 12th Graders, Monitoring the Future Study, 1991–2002

Drug Behavior	Percentage saying "great risk"[1]												
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2001–2002 Change
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	16.1	+0.8
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	23.2	-0.3
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	53.0	-4.4s
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	50.8	+1.4
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	65.6	+0.2
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	49.5	+0.5
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	64.4	+1.2
Approximate N	2,549	2,684	2,759	2,591	2,603	2,449	2,579	2,500	2,300	2,130	2,173	2,198	

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

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

Source: Institute for Social Research, University of Michigan, *Monitoring the Future* study (December 2002).

Table 11. Percentage of High School Students Who Used Selected Illicit Drugs by Sex, Race/Ethnicity, and Grade, Youth Risk Behavior Survey, 1990–2001

Drug Use Behavior and Year	Sex		Race/Ethnicity			Grade Level				All Groups
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9th	10th	11th	12th	
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
2001	46.5	38.4	42.8	40.2	44.7	32.7	41.7	47.2	51.5	42.4
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
2001	27.9	20.0	24.4	21.8	24.6	19.4	24.8	25.8	26.9	23.9
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
2001	10.3	8.4	9.9	2.1	14.7	7.2	8.6	10.4	12.1	9.4
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
2001	4.7	3.7	4.2	1.3	7.1	3.7	4.2	4.4	4.5	4.2
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
2001	6.0	3.9	5.3	3.2	4.2	5.8	4.9	4.3	4.3	5.0
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
2001	3.1	1.6	2.4	1.6	2.5	2.5	2.6	1.9	2.1	2.3

— Data not available.

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

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

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, 1999, and 2001," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 12. Percentage of High School Students Who Used Alcohol or Cigarettes by Sex, Race/Ethnicity, and Grade, Youth Risk Behavior Survey, 1990–2001

Drug Use Behavior and Year	Sex		Race/Ethnicity			Grade Level				All Groups
	Male	Female	White, non-His-panic	Black, non-His-panic	His-panic	9th	10th	11th	12th	
Episodic heavy drinking[1]										
1990	43.5	30.4	—	—	—	27.7	35.7	39.6	44.0	36.9
1991	36.0	26.0	—	—	—	—	—	—	—	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
2001	33.5	26.4	34.0	11.1	30.1	24.5	28.2	32.2	36.7	29.9
Current cigarette[2]										
1990	—	—	—	—	—	—	—	—	—	—
1991	28.0	27.0	—	—	—	—	—	—	—	28.0
1993	29.8	31.2	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
2001	29.2	27.7	31.9	14.7	26.6	23.9	26.9	29.8	35.2	28.5

— Data not available.

[1] Drank five or more drinks of alcohol on at least one occasion on one or more days during the last 30 days.

[2] Used one or more times during the past 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, 1999, and 2001," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 13. Percentage of High School Students Who Reported Engaging in Drug-Related Behaviors by Sex, Race/Ethnicity, and Grade, Youth Risk Behavior Survey, 1993–2001

Drug Use Behavior and Year	Sex		Race/Ethnicity			Grade Level				All Groups
	Male	Female	White, non-His-panic	Black, non-His-panic	His-panic	9th	10th	11th	12th	
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
2001	8.0	2.9	4.8	6.1	7.4	5.5	5.8	5.1	4.9	5.4
Offered, sold, or were 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
2001	34.6	22.7	28.3	21.9	34.2	29.0	29.0	28.7	26.9	28.5
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
2001	13.2	7.5	9.5	11.4	12.9	11.6	12.1	8.5	7.8	10.2

– Data not available.

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

[2] During the 12 months preceding the survey.

Sources: "Youth Risk Behavior Surveillance—United States (1993, 1995, 1997, 1999, and 2001)," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 14. Prevalence of Monthly Drug Use Among 6th–8th, 9th–12th, and 12th graders, PRIDE 1994–1995 through 2001–2002

	Monthly use (Percent)								
	1994–1995	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002	Change[1]
Cigarettes									
6th–8th	15.7	17.2	17.3	15.6	13.2	9.6	9.0	7.3	–1.7*
9th–12th	31.3	33.4	34.7	33.9	31.1	28.7	27.6	22.6	–5.0*
12th	34.6	36.2	38.3	40.7	37.5	36.3	35.5	28.7	–6.8*
Beer									
6th–8th	11.8	12.5	12.1	10.7	10.2	8.7	7.9	6.9	–1.0*
9th–12th	33.3	34.3	34.4	31.9	31.5	30.9	30.9	27.5	–3.4*
12th	40.6	41.2	41.7	41.0	39.9	39.1	40.1	36.2	–3.9*
Wine coolers									
6th–8th	9.8	10.8	10.8	9.9	9.6	8.7	7.7	7.0	–0.7*
9th–12th	23.1	22.3	22.3	21.4	22.9	22.0	22.3	20.6	–1.7*
12th	25.6	22.9	23.7	23.9	25.5	24.7	25.3	24.1	–1.2
Liquor									
6th–8th	8.5	9.0	9.1	8.0	8.0	6.5	6.0	5.1	–0.9*
9th–12th	27.4	28.2	28.7	26.9	28.1	27.6	28.7	25.1	–3.6*
12th	32.5	32.8	34.0	34.1	35.3	35.4	37.0	33.4	–3.6*
Marijuana									
6th–8th	5.7	8.1	8.6	7.1	6.5	5.2	5.3	4.7	–0.6*
9th–12th	18.5	22.3	22.7	20.8	20.3	19.3	20.5	18.5	–2.0*
12th	20.9	24.3	24.4	23.6	23.1	23.4	24.2	21.9	–2.3*
Cocaine									
6th–8th	1.2	1.5	1.7	1.6	1.5	1.3	1.2	1.3	+0.1
9th–12th	2.6	2.9	3.0	3.1	3.2	2.9	3.0	2.7	–0.3*
12th	2.9	3.6	3.6	4.0	4.1	3.6	4.2	3.8	–0.4
Uppers									
6th–8th	2.0	2.4	2.6	2.5	2.1	1.7	1.6	1.4	–0.2*
9th–12th	5.1	5.2	5.3	5.4	5.0	5.2	5.7	3.9	–1.8*
12th	5.6	5.8	5.6	6.3	5.8	6.2	7.2	4.8	–2.4*
Downers									
6th–8th	1.5	1.9	2.1	1.9	1.7	1.4	1.5	1.4	–0.1
9th–12th	3.4	3.8	3.8	4.2	4.0	4.1	4.6	3.9	–0.7*
12th	3.6	4.1	3.9	4.9	4.5	4.8	5.9	4.7	–1.2*
Inhalants									
6th–8th	2.9	3.5	3.7	3.3	2.7	2.3	2.1	1.9	–0.2
9th–12th	3.5	3.4	3.1	3.1	3.0	2.7	2.7	2.3	–0.4*
12th	3.0	3.1	2.7	2.8	3.0	2.7	3.1	2.5	–0.6*
Hallucinogens									
6th–8th	1.5	1.8	2.0	1.8	1.7	1.4	1.3	1.2	–0.1
9th–12th	4.1	4.5	4.2	3.9	4.2	3.6	3.9	2.7	–1.2*
12th	4.8	5.1	4.6	4.5	5.2	4.4	5.3	3.6	–1.7*

[1] Difference between the 2000–2001 and 2001–2002 surveys. Changes marked with * are statistically significant at the .05 level.

	Sample sizes							
Grade	1994–1995	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002
6th–8th	92,453	58,596	68,071	68,149	58,619	59,243	37,653	48,026
9th–12th	105,788	70,964	73,006	86,201	79,460	55,075	38,151	53,856
12th	20,698	14,261	15,532	15,816	16,366	11,680	8,136	10,876

Source: *PRIDE Questionnaire Report*, 1994–1995, 1995–1996, 1996–1997, 1997–1998, 1998–1999, 1999–2000, 2000–2001, and 2001–2002.

Table 15. 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-His-panic	Black, non-His-panic	His-panic	9th	10th	11th	12th	
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[1]	67.7	59.8	78.6	43.3	53.0	64.5	64.3	64.8	62.2	64.1

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

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

[3] Drank 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 16. Annual High School Dropout Rates[1] for Grades 10–12 by Sex, Race, and Hispanic Origin, 1980–2000

	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	
		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
1993r[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

[1] Numbers in thousands; civilian noninstitutionalized population.

[2] "All races" includes whites, blacks, and other races not shown separately.

[3] Hispanics may be of any race.

[4] r = 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 17. Past-Month Drug Use for Youth Ages 12–21, by Age, Dropout Status, Type of Drug Used, and Race/Ethnicity: 1992 Youth Risk Behavior Survey (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 18. Substance Abuse among Probationers, State Prison Inmates, and Federal Prison Inmates

	Number	Ever Used (%)	Used Regularly (%)[1]	Used Month Prior to Offense (%)	Used at Time of Offense (%)
Probation (1995)[2]	2,065,896	69.4	43.4	31.8	13.5
State prison inmates (1997)[3]	1,059,607	83.0	69.6	56.5	32.6
Federal prison inmates (1997)[3]	88,018	72.9	57.3	44.8	22.4
Jail inmates (1996)[4]	318,068	84.5	67.2	55.0	35.6

[1] "Regular use" is defined as once a week or more for at least a month.

[2] *Substance Abuse of Adults on Probation*, 1995 (March 1998).

[3] *Substance Abuse Among State and Federal Prisoners*, 1997 (December 1998).

[4] *Drug Use, Testing, and Treatment in Jails*, 1996. Convicted jail inmates only (May 2000). 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 19. 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: *Homelessness: Programs and the People They Serve*, Interagency Council on the Homeless, U.S. Department of Housing and Urban Development (1999).

Table 20. 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: *Homelessness: Programs and the People They Serve*, Interagency Council on the Homeless, U.S. Department of Housing and Urban Development (1999).

Table 21. Substance Use Experiences by Homeless Status, 1996

	Currently homeless (%) (N=2938)	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: *Homelessness: Programs and the People They Serve,* Interagency Council on the Homeless, U.S. Department of Housing and Urban Development (1999).

DRUG USE CONSEQUENCES

Table 22. Estimated Direct[1] Costs to Society of Drug Abuse, 1992–2000 (2000 $, Millions)

Year	Health care costs	Other costs	Total Direct Costs
1992	13,132	26,579	39,711
1993	13,095	26,406	39,501
1994	12,959	28,078	41,037
1995	12,630	30,300	42,930
1996	12,402	29,782	42,184
1997	12,821	32,383	45,204
1998	13,435	33,513	46,948
1999[2]	14,165	35,050	49,215
2000[2]	14,899	35,274	50,173

[1] "Direct costs" include health care costs attributable to drug abuse and other costs which include the cost of goods and services lost to crime and social welfare costs.

[2] Figures for 1999 and 2000 are projections based on observed trends for 1992 through 1998.

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

Table 23. Estimated Indirect[1] Costs to Society of Drug Abuse, 1992–2000 (2000 $, Millions)

Year	Premature death	Drug abuse related illness	Institution-alization/ hospital-ization	Productivity loss of victims of crime	Incarceration	Crime careers	Total
1992	17,679	17,231	1,792	2,498	21,721	23,287	84,208
1993	24,857	16,220	1,769	2,932	22,819	23,277	91,874
1994	25,167	18,204	1,933	2,934	24,236	22,251	94,996
1995	25,633	19,817	2,091	2,656	25,678	22,536	98,411
1996	21,375	21,997	1,664	2,530	26,949	25,782	100,296
1997	17,791	21,128	1,763	2,432	28,877	28,227	100,218
1998	17,351	24,175	1,866	2,262	31,477	25,725	102,855
1999[2]	17,823	24,832	1,890	2,164	33,515	26,424	106,648
2000[2]	18,256	25,435	1,915	2,217	35,601	27,066	110,491

[1] "Indirect costs" are productivity losses attributable to drug abuse.

[2] Figures for 1999 and 2000 are projections based on observed 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 24. Number of Deaths from Drug-Induced Causes,[1] by Sex and Race: U.S., 1979–2000[2]

Year	Both sexes	Male	Female	White	All non-white	Black[3]
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
2000 ICD-10	19,698	13,125	6,573	16,371	3,327	3,032

[1] Causes 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 from 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.

[2] In 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.

[3] Black 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; 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; and Minino, A.M., Arias, E., Kochanek, K.D., Murphy, S.L., and Smith, B.L., "Deaths: Final Data for 2000," *National Vital Statistics Reports*, 50 (15) Hyattsville, MD: Centers for Disease Control and Prevention/National Center for Health Statistics (2002).

Table 25. Death Rates per 100,000 Population from Drug-Induced Causes,[1] by Sex and Race: U.S., 1979–2000[2]

Year	Both sexes	Male	Female	White	All non-white	Black[3]
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
2000 ICD-10	7.2	9.7	4.7	7.2	6.8	8.6

[1] Causes 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 from 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.

[2] In 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.

[3] Black 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; 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; and Minino, A.M., Arias, E., Kochanek, K.D., Murphy, S.L., and Smith, B.L., "Deaths: Final Data for 2000," *National Vital Statistics Reports*, 50 (15) Hyattsville, MD: Centers for Disease Control and Prevention/National Center for Health Statistics (2002).

Table 26. Trends in Drug-Related Emergency Room Episodes and Selected Drug Mentions, 1988–2001

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*	518,880	899,600	143,337	63,158	40,034
1995*	513,519	900,287	135,711	69,556	45,259
1996*	513,993	906,366	152,420	72,980	53,770
1997*	526,818	942,382	161,083	70,712	64,720
1998*	542,432	981,764	172,011	75,688	76,842
1999*	554,767	1,014,243	168,751	82,192	87,068
2000*	601,563	1,099,306	174,881	94,804	96,426
2001	638,484	1,165,367	193,034	93,064	110,512

* In 2001, SAMHSA published recalculated trend data from 1994. Caution must be used in comparing trend data from 1993 and earlier to 1994 and later.

Source: *Drug Abuse Warning Network*, National Institute on Drug Abuse (1988–1991) and Substance Abuse and Mental Health Services Administration (1992–2001).

Table 27. Estimated Number of Persons Living with AIDS[1] by Sex and Exposure Category, 1993–2001

	Exposure Category								
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemo-philia/co-agulation disorder	Hetero-sexual contact	Receipt of blood trans-fusion[2]	Risk not reported or identified	Total	Percent drug-related[3]
Male adult/adolescent									
1993	86,074	34,157	14,038	1,607	6,141	865	964	143,846	33.5%
1994	94,249	39,646	15,128	1,687	7,952	883	912	160,457	34.1%
1995	100,131	43,635	16,007	1,710	9,812	922	900	173,117	34.5%
1996	109,335	47,754	16,885	1,718	12,247	987	928	189,854	34.0%
1997	120,951	52,599	18,227	1,771	15,021	1,070	968	210,607	33.6%
1998	131,184	56,450	19,265	1,803	17,725	1,176	1,015	228,618	33.1%
1999	141,080	60,075	20,107	1,830	20,500	1,281	1,061	245,934	32.6%
2000	151,212	63,756	20,756	—	23,412	—	4,348	263,484	32.1%
2001	162,151	67,336	21,520	—	26,660	—	4,453	282,250	31.5%
Female adult/adolescent									
1993	N/A	13,843	N/A	91	11,837	732	365	26,868	51.5%
1994	N/A	16,244	N/A	109	15,172	812	366	32,703	49.7%
1995	N/A	18,311	N/A	133	18,498	843	367	38,152	48.0%
1996	N/A	20,279	N/A	160	22,596	923	400	44,358	45.7%
1997	N/A	22,557	N/A	196	27,016	1,010	445	51,224	44.0%
1998	N/A	24,307	N/A	224	31,225	1,107	483	57,346	42.4%
1999	N/A	25,737	N/A	243	35,366	1,206	520	63,072	40.8%
2000	N/A	27,395	N/A	—	40,111	—	2,183	69,689	39.3%
2001	N/A	29,145	N/A	—	45,128	—	2,423	76,696	38.0%

— Data not available.

N/A Not applicable.

[1] Excludes 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.

[2] Includes receipt of blood components or tissue.

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

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report: U.S. HIV and AIDS cases reported through December 2001,* 13 (2), Table 30.

Table 28. Estimated Number of Deaths of Persons with AIDS[1] by Sex and Exposure Category, 1993–2001

	Exposure Category								
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemo-philia/co-agulation disorder	Hetero-sexual contact	Receipt of blood trans-fusion[2]	Risk not reported or identified	Total	Percent drug-related[3]
Male adult/adolescent									
1993	24,032	9,403	3,208	359	1,636	311	164	39,113	32.2%
1994	25,669	10,584	3,571	349	2,064	303	140	42,680	33.2%
1995	25,241	11,008	3,504	333	2,457	258	99	42,900	33.8%
1996	16,877	8,685	2,601	248	2,161	216	64	30,852	36.6%
1997	8,703	5,441	1,470	137	1,511	108	41	17,411	39.7%
1998	7,083	4,704	1,274	120	1,277	79	24	14,561	40.1%
1999	6,524	4,486	1,268	107	1,334	69	33	13,821	40.6%
2000	5,831	4,014	1,190	—	1,313	—	207	12,555	41.4%
2001	5,513	3,670	1,075	—	1,307	—	171	11,736	40.4%
Female adult/adolescent									
1993	N/A	3,184	N/A	17	2,678	234	77	6,190	51.4%
1994	N/A	3,749	N/A	27	3,525	220	56	7,577	49.5%
1995	N/A	3,867	N/A	32	4,048	228	55	8,230	47.0%
1996	N/A	3,314	N/A	30	3,472	165	31	7,102	46.7%
1997	N/A	2,170	N/A	20	2,317	91	18	4,616	47.0%
1998	N/A	1,958	N/A	14	2,080	70	16	4,138	47.3%
1999	N/A	2,068	N/A	17	2,125	73	20	4,303	48.1%
2000	N/A	1,882	N/A	—	2,063	—	100	4,045	46.5%
2001	N/A	1,660	N/A	—	2,048	—	93	3,801	43.7%

— Data not available.

N/A Not applicable.

[1] Excludes 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

Table 29. Reported Tuberculosis Cases and Percent of Cases in Injecting and Noninjecting Drug Users, 1996–2001

Tuberculosis Cases	1996	1997	1998	1999	2000	2001
Total	21,337	19,851	18,361	17,531	16,377	15,989
Number with information on injecting drug use	18,467	17,678	16,849	16,331	15,495	14,871
Percent with information on injecting drug use	86.5	89.1	91.8	93.2	94.6	93.0
Injecting drug users (%)[1]	3.8	3.3	2.9	2.6	2.5	2.3
With information on noninjecting drug use (number)	18,265	17,555	16,730	16,232	15,454	14,780
Percent with information on noninjecting drug use	85.6	88.4	91.1	92.6	94.4	92.4
Noninjecting drug users (%)[1]	7.7	7.8	7.7	7.1	7.5	7.2

[1] Injecting 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, 1996–2001.*

Table 30. Reported Hepatitis Cases, 1995–2000

	1995	1996	1997	1998	1999	2000
			Number of Reported Cases			
Hepatitis A	31,582	31,032	30,021	23,229	17,047	13,397
Hepatitis B	10,805	10,637	10,416	10,258	7,694	8,036
Hepatitis C	4,576	3,716	3,816	3,518	3,111	3,197
			Reported Cases per 100,000 Population			
Hepatitis A	12.13	11.70	11.22	8.59	6.25	4.91
Hepatitis B	4.19	4.01	3.90	3.80	2.82	2.95
Hepatitis C	1.78	1.41	1.43	1.30	1.14	1.17

Source: Centers for Disease Control and Prevention. Summary of Notifiable Diseases, United States, 2000. *Morbidity and Mortality Weekly Report* 49 (53) (June 2002).

Table 31. Total Crime, Violent Crime, and Property Crime, 1989–2001

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	802	11,558,475	4,318.7
1998	12,485,714	4,619.3	1,533,887	567.5	16,914	682	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	11,608,070	4,124.8	1,425,486	506.5	15,586	589	10,182,854	3,618.3
2001	11,849,006	4,160.5	1,436,611	504.4	15,980	558	10,412,395	3,656.1

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

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

[3] Offenses reported to law enforcement agencies.

[4] Per 100,000 population.

Source: Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States: Uniform Crime Reports* (1990–2002).

Table 32. Total Estimated Arrests and Drug Arrests, 1989–2001

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]	Posses-sion	Sale[4]	Posses-sion	Sale[4]	Posses-sion
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
2001	13,699,254	1,586,902	11.5	9.7	23.1	5.2	40.4	4.5	17.1

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

[2] Percentages may not add to 100 because of rounding.

[3] Includes heroin or cocaine and their derivatives.

[4] Includes sale/manufacture of drugs.

Source: Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States: Uniform Crime Reports*, *1989* to *2001* (1990–2002).

Table 33. Adult Drug Offenders in Custody of State or Federal Prisons, 1989–2001

	All Offenders			Prisoners who are drug offenders (%)		Estimated number of drug offenders	
Year	State	Federal	Total State and Federal	Federal	State	State[1]	Federal[2]
1989	629,995	53,387	683,382	49.9	19.1	120,100	25,300
1990	684,544	58,838	743,382	53.5	21.7	148,600	30,470
1991	728,605	63,930	792,535	55.9	21.3	155,200	36,782
1992	778,495	72,071	850,566	58.9	21.6	168,100	42,879
1993	828,566	80,815	909,381	59.2	21.4	177,000	48,997
1994	904,647	85,500	990,147	60.5	21.4	193,500	49,507
1995	989,004	89,538	1,078,542	59.9	21.5	212,800	51,737
1996	1,032,440	95,088	1,127,528	60.2	21.0	216,900	55,194
1997	1,074,809	101,755	1,176,564	60.0	20.7	221,900	58,610
1998	1,113,672	110,793	1,224,555	58.7	20.7	231,000	63,011
1999[3]	1,156,293	125,682	1,281,975	61.0	21.1	244,100	68,360
2000	1,176,269	133,921	1,310,190	57.3	20.8	244,800	73,389
2001	1,181,128	143,337	1,324,465	—	—	—	—

— Data not available.

[1] The number of inmates by offense was estimated and rounded to the nearest 100.

[2] All data are for sentenced inmates, regardless of sentence length. All data is from the Bureau of Justice Statistics Federal Justice Database. Data for 1990 through 1995 is for December 31; data for 1996 through 2000 is for September 30.

[3] In 1999, 15 States expanded their reporting criteria to include inmates held in privately operated facilities. Comparable number in 1999 are 1,135,194 for State prisons and 121,854 for Federal prisons (for a total of 1,257,048).

Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 2001* (August 2002); *Prisoners in 2000* (August 2001); *Prisoners in 1999* (August 2000); *Prisoners in 1998* (August 1999); and *Prisoners in 1997* (August 1998). *Correctional Populations in the United States*, 1996 and 1997.

Table 34. 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 35. 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).

DRUG TREATMENT

Table 36. One-Day Census of Clients in Treatment, by Facility Ownership, 1980–2002[1]

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	242,184	552,092	151,989	40,549	12,082	n/c	1,000,896
2002[2]	308,737	646,802	158,384	39,921	9,939	1,046	1,164,829

n/c: Not collected.

[1] 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.

[2] Preliminary data.

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, 2002).

Table 37. One-Day Census of Clients in Alcohol and/or Drug Abuse Treatment, by Age Group and by Type of Care, 1987–2002[1]

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	10,443	98,906	109,349	74,474	817,073	891,547	1,000,896
2002[3]	11,681	109,074	120,755	82,717	961,357	1,044,074	1,164,829

[1] The 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.

[2] Totals include persons of unknown age.

[3] Preliminary data.

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, 2002).

Table 38. 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, 2000–2001 (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			
	2000	2001	2000	2001	2000	2001	2000	2001
Totals	4,655	6,096	774	1,054	3,881	5,042	16.6	17.3
Age								
12–17	1,074	1,146	122	116	951	1,029	11.4	10.2
18–25	1,645	2,191	142	237	1,503	1,954	8.6	10.8
26 and older	1,937	2,760	510	700	1,427	2,059	26.3	25.4
Sex								
Male	2,749	3,839	411	562	2,337	3,276	15.0	14.6
Female	1,907	2,258	363	491	1,544	1,766	19.0	21.8
Hispanic origin/race								
Not Hispanic:								
White Only	3,235	4,179	577	626	2,659	3,553	15.0	17.8
Black	632	785	118	225	514	560	28.7	*
American Indian/or Alaska Native only	46	58	4	*	42	36	*	*
Native Hawaiian or other Pacific Islander	10	9	3	0	7	9	*	*
Asian only	54	108	1	3	54	105	*	*
More than one race	103	140	21	*	82	94	*	*
Hispanic	574	817	51	130	523	687	15.9	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: Substance Abuse and Mental Health Services Administration (2000–2001), *National Household Survey on Drug Abuse*.

DRUG USER EXPENDITURES AND AVAILABILITY

Table 39. 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* (December 2001).

Table 40. 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 represent point estimates derived from ONDCP's *Sequential Transition and Reduction (STAR) Model.*

[1] Retail 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* (March 2002); and Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000* (December 2001).

Table 41. 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

[1] Quantities purchased at the "retail" level.

[2] Quantities purchased at the "dealer" level.

[3] 2000 data is preliminary, based on the first two quarters of data.

Source: Office of National Drug Control Policy, *The Price of Illicit Drugs, 1981–2000* (October 2001).

Table 42. Federal-wide Cocaine, Heroin, Methamphetamine, and Cannabis Seizures, 1989–2002 (Kilograms)

Year	Cocaine	Heroin	Metham-phetamine	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	118,436	1,458	2,559	827,149	241
1999	132,063	1,151	2,779	1,075,154	797
2000	106,619	1,674	3,470	1,235,938	10,867
2001	105,885	2,493	3,770	1,215,131	159
2002[1]	60,874	1,587	1,282	676,577	33

— Data not available.

[1] Figures for 2002 are for January through September only.

Source: Drug Enforcement Administration, *Federal-wide Drug Seizure System*, 1989–2002 (October 2002).

Table 43. Eradicated Domestic Cannabis by Plant Type, 1982–2001 (Plants in Thousands)

	Cultivated Plants Outdoors[1]	Ditchweed	Cultivated 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	132,408	233	134,924
1999	3,205	130,192	208	133,605
2000	2,598	139,581	217	142,396
2001	3,069	569,713	236	573,018

— Data not available.

Note: Data for eradication supported through DEA Office of Domestic Cannabis Eradication and Suppression Program.

[1] May include tended ditchweed.

Source: DEA Office of Domestic Cannabis Eradication and Suppression Program, Drug Enforcement Administration, 1982–2001.

Table 44. Estimated Worldwide Potential Net Production of Opium Gum, 1987–2001 (Metric Tons)

Year	Afghan-istan	India	Iran[1]	Paki-stan	Total Southwest Asia	Burma	China	Laos	Thailand	Viet-nam	Total Southeast Asia	Colom-bia	Leb-anon[2]	Guate-mala	Mexico	Sub-total	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	5,229
1997	2,184	30	—	85	2,299	2,365	—	210	25	45	2,645	66	—	—	64	130	5,074
1998	2,340	—	—	66	2,406	1,750	—	140	16	20	1,926	61	—	—	93	154	4,486
1999	2,861	—	—	37	2,898	1,090	—	140	6	11	1,247	75	—	—	60	135	4,280
2000	3,656	—	—	11	3,667	1,085	—	210	6	15	1,316	—	—	—	27	27	5,010
2001	74	—	—	5	79	865	—	200	6	15	1,086	—	—	—	71	71	1,236

— Data not available.

[1] Although 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.

[2] There 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* (1988–2002).

Table 45. Estimated Worldwide Potential Net Production of Cannabis, 1987–2001 (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	17,455
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
2001	7,400	4,000	—	—	3,500	14,900

— Data not available.

[1] Cannabis 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* (1988–2002).

Table 46. Estimated Worldwide Potential Net Production of Coca Leaf, 1987–2001 (Metric Tons)

Year	Bolivia	Colombia[1]	Peru	Ecuador
1987	79,200	20,500	191,000	400
1988	79,500	27,200	187,700	400
1989	78,200	33,900	186,300	270
1990	77,000	32,100	196,900	170
1991	78,000	30,000	222,700	40
1992	80,300	29,600	223,900	100
1993	84,400	31,700	155,500	100
1994	89,800	35,800	165,300	—
1995	85,000	229,300	183,600	—
1996	75,100	302,900	174,700	—
1997	70,100	347,000	130,200	—
1998	52,900	437,600	95,600	—
1999	22,800	521,400	69,200	—
2000	26,800	583,000	54,400	—
2001	20,200	583,000	52,600	—

— Data not available.

[1] Coca and cocaine yield figures were revised upward in 1999, beginning with 1995 data (using data on “wet” fresh leaf; all other data is for “dry” leaf), 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* (1988–2002).

Table 47. 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

[1] Estimated.

Source: Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000* (December 2001).

Table 48. 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 $, 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

[1] Retail values for 1999 and 2000 are projected.

Sources: Office of National Drug Control Policy, *Estimating Heroin Availability* (2000). Retail value data is from Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988–2000* (March 2002).

Table 49. Amount of Coca Leaf Cultivated and Eradicated, Calendar Years 1987–2001 (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
2001	19,900[1]	—	37,900	—	—	3,900

— Data not available.

[1] Mid-year 2001 estimate.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2002). Data for 1992–2001 is from the March 2002 report.

Table 50. Amount of Opium Poppy Cultivated and Eradicated, Calendar Years 1990–2001 (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	26,100	2,065	—	15	15,000
1999	51,500	2,767	99,300	21,800	1,643	—	1	11,500
2000	64,510	2,219	108,700	23,150	1,647	1,254	1	9,500
2001	1,685	1,697	105,000	22,000	1,652	2,583	1	11,800
				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
2001	—	1,484	9,317	—	832		1	15,350

— Data not available.

[1] The eradication figures shown for 1992–2001 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* (1990–2002). Data for 1992–2001 is from the March 2002 report.

Table 51. Amount of Cannabis Cultivated and Eradicated by Foreign Countries, Calendar Years 1990–2001 (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	—
2001	11,500	—	5,000	33,300	332	—

— Data not available.

[1] The eradication figures shown for 1992–2001 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* (1988–2002). Data for 1992–2001 is from the March 2002 report.

Table 52. Amount of Cocaine Seized by Foreign Countries, Calendar Years 1990–2001 (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	110	6	10	18
2001	130	7	17	29

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report (*March 2002).

Table 53. Amount of Heroin Seized by Foreign Countries, Calendar Years 1990–2001 (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	—
2001	6,000	4,700	417	2,053	—	—	52	478	798	2

— Data not available.

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2002). Data for 1992–2001 is from the March 2002 report.

Table 54. Amount of Marijuana Seized by Foreign Countries, Calendar Years 1990–2001 (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	93
1998	1,062	36	69	65	6	29
1999	1,459	56	65	81	45	26
2000	1,619	56	46	108	7	37
2001	2,007	68	80	53	8	20

Source: U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (1988–2002). Data for 1992–2001 is from the March 2002 report.

Table 55. Number of Drug Labs Destroyed by Foreign Countries, Calendar Years 1990–2001

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	Metham-phetamine	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	893	1	2	156	10	2	—	—	0	14	2
2000	620	2	—	—	—	0	—	—	0	9	0
2001	877	1	—	—	—	4	—	18	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* (1988–2002). Data for 1992–2001 is from the March 2002 report.

Table 56. DEA-Reported Seizures of MDMA, 1998–2001 (Dosage Units)

	FDSS[1]	STRIDE[2]
1998	—	143,613
1999	—	1,054,973
2000	—	3,341,648
2001	4,661,252	5,575,431

[1] Federal-wide Drug Seizure System.

[2] System To Retrieve Information On Drug Evidence.

Sources: FDSS, Unpublished data (October 2002) and STRIDE, Unpublished data (October 2002).

Table 57. Estimated Numbers (Thousands) and Percentages of Past-Month Users of Illicit Drugs, by State or Jurisdiction,[1] Age 12 and Older, Annual Averages Based on 1999 and 2000

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	
	Number	Prediction interval	Percent	Prediction interval	Number	Prediction interval	Percent	Prediction interval	Number	Prediction interval	Percent	Prediction interval
United States[3]	13,968		6.3		10,675		4.8		3,658		1.6	
Alabama	196	(158 - 238)	5.4	(4.4 - 6.6)	140	(108 - 177)	3.8	(3.0 - 4.9)	64	(45 - 89)	1.8	(1.2 - 2.4)
Alaska	43	(36 - 50)	8.8	(7.5 - 10.3)	31	(25 - 37)	6.4	(5.2 - 7.7)	11	(8 - 14)	2.2	(1.6 - 3.0)
Arizona	233	(189 - 283)	6.1	(5.0 - 7.4)	173	(134 - 219)	4.5	(3.5 - 5.8)	81	(60 - 105)	2.1	(1.6 - 2.8)
Arkansas	117	(97 - 139)	5.4	(4.5 - 6.5	84	(66 - 106)	3.9	(3.1 - 4.9)	32	(24 - 43)	1.5	(1.1 - 2.0)
California	1,954	(1,74E - 2,179)	7.6	(6.8 - 8.5)	1,459	(1,285 - 1,648)	5.7	(5.0 - 6.4)	443	(365 - 533)	1.7	(1.4 - 2.1)
Colorado	300	(248 - 357)	8.9	(7.4 - 10.6)	264	(214 - 320)	7.8	(6.3 - 9.5)	83	(62 - 108)	2.5	(1.9 - 3.2)
Connecticut	196	(160 - 236)	7.3	(5.9 - 8.8)	154	(122 - 192)	5.7	(4.5 - 7.1)	41	(29 - 56)	1.5	(1.1 - 2.1)
Delaware	53	(44 - 63)	8.5	(7.1 - 10.0)	45	(37 - 55)	7.2	(5.9 - 8.8)	16	(11 - 22)	2.5	(1.7 - 3.5)
District of Columbia	30	(25 - 36)	7.1	(5.8 - 8.5)	22	(17 - 28)	5.2	(4.1 - 6.6)	9	(6 - 12)	2.1	(1.5 - 2.9)
Florida	745	(656 - 842)	5.9	(5.2 - 6.7)	597	(514 - 688)	4.7	(4.1 - 5.5)	213	(172 - 260)	1.7	(1.4 - 2.1)
Georgia	396	(318 - 484)	6.3	(5.1 - 7.7	281	(218 - 354)	4.5	(3.5 - 5.6)	113	(81 - 152)	1.8	(1.3 - 2.4)
Hawaii	75	(60 - 91)	7.7	(6.2 - 9.4)	59	(45 - 75)	6.1	(4.7 - 7.8)	18	(11 - 26)	1.8	(1.2 - 2.7)
Idaho	58	(47 - 69)	5.4	(4.4 - 6.4)	44	(35 - 54)	4.1	(3.3 - 5.1)	14	(10 - 19)	1.3	(1.0 - 1.8)
Illinois	612	(547 - 681)	6.3	(5.6 - 7.0)	465	(411 - 524)	4.8	(4.2 - 5.4)	147	(120 - 179)	1.5	(1.2 - 1.8)
Indiana	293	(242 - 350)	5.9	(4.9 - 7.1	219	(175 - 270)	4.4	(3.5 - 5.5)	71	(52 - 94)	1.4	(1.1 - 1.9)
Iowa	102	(83 - 124)	4.3	(3.5 - 5.2	67	(52 - 84)	2.8	(2.2 - 3.5)	32	(24 - 42)	1.3	(1.0 - 1.7)
Kansas	110	(90 - 133)	5.1	(4.2 - 6.2)	79	(63 - 98)	3.7	(2.9 - 4.6)	32	(23 - 43)	1.5	(1.1 - 2.0)
Kentucky	192	(159 - 229)	5.9	(4.9 - 7.0)	138	(111 - 169)	4.2	(3.4 - 5.2)	54	(41 - 71)	1.7	(1.2 - 2.2)
Louisiana	216	(179 - 258)	6.1	(5.1 - 7.3	133	(106 - 164)	3.7	(3.0 - 4.6)	61	(45 - 81)	1.7	(1.3 - 2.3)
Maine	72	(61 - 84)	6.9	(5.8 - 8.1)	62	(51 - 75)	6.0	(4.9 - 7.2)	14	(10 - 18)	1.3	(1.0 - 1.7)
Maryland	242	(196 - 296)	5.7	(4.6 - 7.0	190	(149 - 238)	4.5	(3.5 - 5.6)	55	(39 - 75)	1.3	(0.9 - 1.8)
Massachusetts	581	(480 - 692)	11.4	(9.4 - 13.6)	463	(377 - 557)	9.0	(7.4 - 10.9)	105	(75 - 143)	2.1	(1.5 - 2.8)
Michigan	545	(491 - 603)	6.9	(6.2 - 7.6)	448	(397 - 503)	5.7	(5.0 - 6.4)	122	(100 - 147)	1.5	(1.3 - 1.9)
Minnesota	236	(195 - 280)	6.0	(5.0 - 7.1)	187	(152 - 225)	4.7	(3.9 - 5.7)	65	(48 - 84)	1.6	(1.2 - 2.1)
Mississippi	118	(97 - 141)	5.2	(4.3 - 6.3	72	(57 - 88)	3.2	(2.5 - 3.9)	34	(24 - 47)	1.5	(1.1 - 2.1)
Missouri	239	(194 - 288)	5.3	(4.3 - 6.4	196	(155 - 242)	4.3	(3.4 - 5.4)	59	(42 - 79)	1.3	(0.9 - 1.8)
Montana	49	(41 - 57)	6.3	(5.3 - 7.5	38	(31 - 45)	4.9	(4.0 - 5.9)	12	(9 - 15)	1.5	(1.2 - 2.0)

See notes at end of table (continued).

Table 57 (cont.). Estimated Numbers (in Thousands) and Percentages of Past Month Users of Illicit Drugs, by State or Jurisdiction,[1] Age 12 and Older, Annual Averages Based on 1999 and 2000

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	
	Number	Prediction interval	Percent	Prediction interval	Number	Prediction interval	Percent	Prediction interval	Number	Prediction interval	Percent	Prediction interval
Nebraska	61	(50 - 75)	4.5	(3.6 - 5.5)	47	(38 - 59)	3.5	(2.7 - 4.3)	20	(14 - 26)	1.4	(1.1 - 1.9)
Nevada	114	(92 - 139)	7.5	(6.1 - 9.1)	81	(64 - 100)	5.3	(4.2 - 6.6)	32	(23 - 45)	2.1	(1.5 - 3.0)
New Hampshire	66	(55 - 77)	6.6	(5.5 - 7.7)	60	(49 - 72)	6.0	(4.9 - 7.2)	14	(11 - 18)	1.4	(1.1 - 1.8)
New Jersey	410	(339 - 491)	6.1	(5.1 - 7.3)	310	(247 - 383)	4.6	(3.7 - 5.7)	98	(71 - 133)	1.5	(1.1 - 2.0)
New Mexico	105	(87 - 126)	7.1	(5.9 - 8.5)	88	(71 - 107)	5.9	(4.8 - 7.3)	41	(31 - 53)	2.8	(2.1 - 3.6)
New York	855	(754 - 966)	5.8	(5.1 - 6.5)	665	(580 - 759)	4.5	(3.9 - 5.1)	221	(178 - 270)	1.5	(1.2 - 1.8)
North Carolina	422	(345 - 510)	6.7	(5.5 - 8.1)	347	(273 - 434)	5.5	(4.3 - 6.9)	100	(74 - 133)	1.6	(1.2 - 2.1)
North Dakota	22	(18 - 27)	4.2	(3.4 - 5.1)	17	(13 - 21)	3.2	(2.5 - 3.9)	7	(5 - 9)	1.3	(1.0 - 1.7)
Ohio	520	(464 - 580)	5.6	(5.0 - 6.3)	399	(352 - 451)	4.3	(3.8 - 4.9)	140	(114 - 171)	1.5	(1.2 - 1.9)
Oklahoma	137	(108 - 170)	5.0	(4.0 - 6.2)	83	(63 - 106)	3.0	(2.3 - 3.9)	40	(29 - 55)	1.5	(1.0 - 2.0)
Oregon	212	(174 - 253)	7.5	(6.2 - 9.0)	184	(147 - 225)	6.5	(5.2 - 8.0)	42	(31 - 56)	1.5	(1.1 - 2.0)
Pennsylvania	591	(519 - 669)	5.9	(5.1 - 6.6)	451	(395 - 513)	4.5	(3.9 - 5.1)	145	(118 - 175)	1.4	(1.2 - 1.7)
Rhode Island	67	(56 - 79)	8.1	(6.8 - 9.6)	59	(48 - 71)	7.2	(5.9 - 8.7)	14	(10 - 18)	1.7	(1.2 - 2.3)
South Carolina	160	(130 - 196)	5.2	(4.2 - 6.3)	125	(97 - 156)	4.0	(3.1 - 5.1)	51	(36 - 69)	1.6	(1.2 - 2.2)
South Dakota	29	(24 - 35)	4.8	(3.9 - 5.7)	23	(18 - 29)	3.7	(3.0 - 4.6)	10	(7 - 12)	1.6	(1.2 - 2.0)
Tennessee	275	(224 - 332)	5.9	(4.9 - 7.2)	200	(157 - 248)	4.3	(3.4 - 5.4)	84	(59 - 115)	1.8	(1.3 - 2.5)
Texas	774	(691 - 863)	4.9	(4.3 - 5.4)	536	(467 - 611)	3.4	(2.9 - 3.8)	310	(262 - 365)	2.0	(1.6 - 2.3)
Utah	85	(69 - 103)	5.0	(4.1 - 6.1)	54	(41 - 68)	3.2	(2.4 - 4.0)	25	(19 - 33)	1.5	(1.1 - 1.9)
Vermont	43	(36 - 51)	8.5	(7.1 - 10.0)	37	(31 - 44)	7.3	(6.1 - 8.6)	9	(7 - 12)	1.8	(1.3 - 2.3)
Virginia	271	(218 - 332)	4.8	(3.9 - 5.9)	232	(180 - 294)	4.1	(3.2 - 5.2)	84	(62 - 111)	1.5	(1.1 - 2.0)
Washington	356	(291 - 431)	7.5	(6.1 - 9.1)	267	(211 - 332)	5.6	(4.5 - 7.0)	71	(51 - 95)	1.5	(1.1 - 2.0)
West Virginia	73	(60 - 88)	4.7	(3.9 - 5.6)	54	(42 - 68)	3.5	(2.7 - 4.4)	20	(15 - 27)	1.3	(1.0 - 1.7)
Wisconsin	293	(246 - 343)	6.7	(5.6 - 7.9)	230	(189 - 273)	5.2	(4.3 - 6.3)	76	(57 - 97)	1.7	(1.3 - 2.2)
Wyoming	24	(20 - 29)	5.7	(4.7 - 6.8)	19	(15 - 23)	4.4	(3.5 - 5.4)	6	(5 - 8)	1.5	(1.2 - 2.0)

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

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

[2] "Any illicit drug" includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used nonmedically.

[3] This estimate 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.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *State Estimates of Substance Use from the 2000 National Household Survey on Drug Abuse: Volume 1. Findings* (October 2002).

Table 58. 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 (credible) intervals are generated by Markov Chain Monte Carlo techniques.

[1] This estimate 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.

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

Table 59. 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, October 1, 2000, and March 29, 2002

State or jurisdiction	Substance abuse problem											
	Total				Both alcohol and drug abuse				Drug abuse only			
	1997	1998	2000	2002[2]	1997	1998	2000	2002[2]	1997	1998	2000	2002[2]
Clients in treatment	916,637	1,030,028	972,728	1,152,317	376,482	509,784	473,096	551,748	299,593	275,320	280,531	357,125
Alabama	10,664	8,933	8,632	10,981	2,385	4,274	3,028	4,157	5,808	2,929	4,207	5,190
Alaska	5,261	2,915	2,762	2,862	2,101	1,439	1,289	1,603	894	215	295	241
Arizona	12,307	19,804	25,709	25,220	4,297	8,795	10,787	10,910	4,612	5,883	7,074	8,335
Arkansas	4,129	7,006	3,112	4,295	1,652	4,096	1,623	2,462	1,588	1,480	1000	1158
California	88,876	126,340	103,314	155,683	36,421	57,515	46,467	72,175	39,646	41,512	36,531	47,887
Colorado	13,530	24,079	28,698	32,282	4,388	10,890	11,349	14,411	4,297	4,280	5,400	5,412
Connecticut	15,592	16,037	17,917	20,413	5,949	7,079	7,438	8,086	7,199	6,192	8,190	9,470
Delaware	3,567	3,767	3,789	4,077	2,256	1,912	2,386	3,096	624	1,059	617	584
District of Columbia	8,201	6,499	6,145	5,487	2,722	3,949	2,714	2,253	4,033	1,654	2,568	2,671
Florida	41,663	45,591	43,505	46,764	19,358	24,867	22,851	21,919	13,908	11,961	11,783	16,362
Georgia	16,118	15,775	12,845	18,929	7,299	7,231	6,479	9,072	4,883	4,452	3,304	5,350
Hawaii	2,177	3,012	2,601	3,627	893	1,700	1,310	1,769	784	663	899	1103
Idaho	2,464	2,896	2,811	4,104	1,717	1,858	1,852	2,549	360	430	349	615
Illinois	39,040	45,872	41,231	45,036	17,967	22,638	17,587	18,240	10,839	12,088	13,398	16,364
Indiana	18,458	16,855	15,420	28,065	7,597	7,384	7,828	14,384	4,334	3,695	3,152	5,892
Iowa	5,373	7,287	5,602	8,262	2,580	3,646	2,865	4,683	870	1,028	876	1396
Kansas	8,288	8,951	12,041	9,066	3,906	5,022	7,774	5,161	1,637	1,557	1,811	1,760
Kentucky	12,119	14,656	17,950	17,656	4,093	6,597	7,951	8,073	3,365	2,712	4,017	4,296
Louisiana	12,185	16,991	11,303	12,447	6,273	9,664	5,732	5,879	3,595	4,162	4,034	4,536
Maine	8,188	8,577	4,830	18,428	3,948	4,306	2,527	3,006	1,496	1,195	705	13807
Maryland	23,794	23,960	30,420	35,486	10,088	11,001	12,809	14,446	8,868	7,921	11,803	14,231
Massachusetts	33,219	42,508	34,413	40,208	13,984	23,781	16,973	18,516	10,235	9,871	10,960	13,776
Michigan	49,788	48,963	43,394	51,582	18,123	19,858	17,422	22,690	14,135	13,266	12,235	14,170
Minnesota	7,593	10,403	8,294	10,306	3,621	5,532	4,035	5,342	1,275	2,227	2,054	2,704
Mississippi	5,334	8,877	7,525	5,498	2,515	5,028	4,556	3,111	1,391	1,882	1,137	1,040
Missouri	11,090	17,596	17,359	18,822	5,789	11,330	9,936	11,197	2,740	2,913	4,072	4,108
Montana	2,298	2,470	1,898	2,585	1,135	1,326	841	1550	482	317	304	354

See notes at end of table (continued).

Table 59 (cont.). 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, October 1, 2000, and March 29, 2002

State or jurisdiction	Substance abuse problem											
	Total				Both alcohol and drug abuse				Drug abuse only			
	1997	1998	2000	2002[2]	1997	1998	2000	2002[2]	1997	1998	2000	2002[2]
Nebraska	4,197	5,515	4,559	5,281	2,140	3,065	2,293	3,360	444	746	903	855
Nevada	5,279	7,962	7,292	7,095	1,697	4,678	3,599	2,812	2,158	1,590	2,278	2,707
New Hampshire	2,507	3,374	3,253	3,051	1,028	1,741	1,814	1,417	465	312	477	455
New Jersey	20,594	24,666	23,011	31,316	9,147	11,999	9,904	12,819	7,928	8,882	9,930	15,337
New Mexico	6,452	10,304	9,800	10,378	2,469	4,280	4,123	4,668	1,132	2,051	2,527	2,924
New York	127,272	115,870	116,030	150,273	35,175	49,495	56,107	74,824	64,260	49,257	44,644	54,695
North Carolina	17,379	25,358	30,547	29,452	8,358	13,535	15,385	14,495	3,427	4,538	6,062	8,284
North Dakota	2,086	3,011	1,290	1,878	856	1,418	617	1003	242	365	86	218
Ohio	40,401	42,490	37,956	39,071	20,864	23,839	20,980	22,174	7,950	7,413	7,238	7,612
Oklahoma	7,572	8,750	7,346	8,631	2,511	3,480	4,034	4,946	2,415	2,587	1,324	1,902
Oregon	22,627	18,116	21,564	23,823	10,731	9,644	12,243	13,412	5,154	4,631	5,079	5,625
Pennsylvania	36,382	36,536	37,334	38,565	17,957	21,460	20,447	21,365	10,231	8,282	10,285	11,199
Rhode Island	5,084	6,390	5,884	5,804	1,874	2,957	2,152	1,773	1,914	2,143	2,831	2,821
South Carolina	10,862	9,648	11,942	12,002	3,943	3,661	5,523	5,395	2,513	2,443	2,439	3,220
South Dakota	1,880	2,785	1,797	2,640	739	1,261	917	1403	229	205	163	964
Tennessee	13,166	12,903	8,217	10,059	6,113	5,111	3,271	4,807	4,069	4,502	3,165	3,638
Texas	40,693	47,379	44,293	36,500	14,860	28,033	25,480	19,437	14,346	11,108	12,453	12,099
Utah	13,621	11,650	6,250	8,818	5,771	5,815	3,150	5,154	3,709	3,431	1,888	2,080
Vermont	1,638	2,577	2,734	2,426	721	1,414	1,402	1,389	215	317	320	377
Virginia	21,039	20,888	22,677	23,357	10,839	10,595	12,029	10,979	4,810	4,431	4,625	6,557
Washington	31,260	31,953	32,974	36,783	17,295	18,864	19,093	21,102	4,392	4,438	5,636	6,360
West Virginia	4,704	4,658	4,869	4,551	1,159	1,630	1,890	2,376	748	792	782	817
Wisconsin	16,535	18,916	15,316	20,209	6,333	8,279	6,855	8,645	2,659	3,089	2,397	3,958
Wyoming	2,091	1,709	2,273	2,025	845	812	1,378	1,140	285	223	224	262

[1] Excludes 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.

[2] Preliminary data.

Source: Substance Abuse and Mental Health Services Administration, *Uniform Facility Data Set Survey* (UFDS) (1997 and 1998); *National Survey of Substance Abuse Treatment Services* (N-SSATS) (2000, 2002).

Table 60. Percentage[1] of Adult Male Booked Arrestees Who Used Any Drug,[2] by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001[3]
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	65	63
Albuquerque	—	—	—	—	—	—	—	65	64	65	64
Anchorage	—	—	—	—	—	—	—	43	54	52	52
Atlanta	63	69	72	69	74	80	72	66	77	70	—
Birmingham	63	64	68	69	73	70	67	67	64	65	63
Charlotte-Metro	—	—	—	—	—	—	—	—	—	68	66
Chicago	74	69	81	79	79	82	80	74	74	—	84
Cleveland	56	64	64	66	65	67	64	65	71	72	69
Dallas	56	59	62	57	60	63	63	63	61	55	52
Denver	50	60	64	67	66	71	71	69	67	64	62
Des Moines	—	—	—	—	—	—	—	57	56	55	57
Detroit	55	58	63	66	67	66	62	68	65	70	64
Ft. Lauderdale	61	64	61	58	58	67	73	74	64	62	—
Honolulu	—	—	—	—	—	—	—	—	—	63	59
Houston	65	59	59	48	58	64	63	60	60	57	—
Indianapolis	45	52	60	69	64	74	63	67	64	64	66
Kansas City	—	—	—	—	—	—	—	—	—	—	69
Laredo	—	—	—	—	—	—	—	57	58	59	49
Las Vegas	—	—	—	—	—	—	—	57	60	59	60
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	69
New Orleans	59	60	62	63	66	67	67	67	69	69	68
New York City[4]	73	77	78	82	83	78	79	77	75	80	76
Oklahoma City	—	—	—	—	—	—	—	69	64	71	68
Omaha	36	48	54	59	54	63	62	60	62	63	69
Philadelphia	74	78	76	76	76	69	67	79	70	72	71
Phoenix	42	47	62	65	63	59	64	63	64	66	69
Portland, OR	61	60	63	65	65	66	71	72	64	64	68
Sacramento	—	—	—	—	—	—	—	71	68	74	73
St. Louis	59	64	68	74	77	75	74	72	—	—	—
Salt Lake City	—	—	—	—	—	—	—	60	60	54	54
San Antonio	49	54	55	52	51	57	52	56	50	53	57
San Diego	75	77	78	79	72	71	73	69	64	64	62
San Jose	58	50	54	55	52	48	51	48	55	53	62
Seattle	—	—	—	—	—	—	—	65	66	64	64
Spokane	—	—	—	—	—	—	—	62	62	58	62
Tucson	—	—	—	—	—	—	—	63	68	69	63
Tulsa	—	—	—	—	—	—	—	—	—	—	61
Washington, D.C.	59	60	60	64	64	66	69	65	69	—	—

— Data not available.

[1] Percent 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.

[3] In 2001, the definition of "any drug" pertains to any one of the NIDA-5 drugs (cocaine, opiates, marijuana, methamphetamine, and PCP), thus these numbers are not directly comparable to prior years.

[4] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 61. Percentage[1] of Adult Male Booked Arrestees Who Used Marijuana, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	45	47
Albuquerque	—	—	—	—	—	—	—	36	37	47	38
Anchorage	—	—	—	—	—	—	—	33	38	38	38
Atlanta	12	22	26	25	32	37	36	26	44	38	—
Birmingham	16	22	28	28	36	44	43	39	39	45	49
Charlotte	—	—	—	—	—	—	—	—	—	44	48
Chicago	23	26	40	38	41	47	48	42	45	—	50
Cleveland	12	17	23	28	29	37	46	37	43	49	47
Dallas	19	28	28	33	37	44	44	43	39	36	33
Denver	25	34	36	39	33	42	42	41	44	41	40
Des Moines	—	—	—	—	—	—	—	42	43	42	43
Detroit	18	27	37	38	42	46	44	47	48	50	48
Ft. Lauderdale	28	32	30	29	33	38	38	44	39	43	—
Honolulu	—	—	—	—	—	—	—	—	—	30	30
Houston	17	24	24	23	29	33	24	36	38	36	—
Indianapolis	23	35	42	39	38	51	44	45	48	49	50
Kansas City	—	—	—	—	—	—	—	—	—	—	49
Laredo	—	—	—	—	—	—	—	39	33	29	26
Las Vegas	—	—	—	—	—	—	—	26	28	33	35
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	54
New Orleans	16	19	25	28	32	40	38	38	40	47	45
New York City[2]	18	22	21	24	28	38	32	39	41	41	41
Oklahoma City	—	—	—	—	—	—	—	53	48	57	51
Omaha	26	38	42	44	42	52	33	44	51	48	56
Philadelphia	18	26	32	32	34	39	41	45	41	49	43
Phoenix	22	22	31	29	29	28	30	32	36	34	40
Portland, OR	33	28	30	27	29	35	38	37	35	36	36
Sacramento	—	—	—	—	—	—	—	44	44	50	48
St. Louis	16	21	28	36	39	52	48	50	—	—	—
Salt Lake City	—	—	—	—	—	—	—	37	35	34	34
San Antonio	20	28	32	30	34	39	34	41	36	41	41
San Diego	33	35	40	36	35	40	38	36	36	39	36
San Jose	25	24	27	30	27	27	29	25	34	36	38
Seattle	—	—	—	—	—	—	—	35	39	38	35
Spokane	—	—	—	—	—	—	—	43	44	40	42
Tucson	—	—	—	—	—	—	—	39	45	45	44
Tulsa	—	—	—	—	—	—	—	—	—	—	48
Washington, D.C.	11	20	26	30	32	40	39	38	35	—	—

— Data not available.

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

[2] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 62. Percentage[1] of Adult Male Booked Arrestees Who Used Cocaine, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	25	30
Albuquerque	—	—	—	—	—	—	—	39	43	35	37
Anchorage	—	—	—	—	—	—	—	20	26	22	19
Atlanta	57	58	59	57	57	59	51	51	51	49	—
Birmingham	52	49	51	50	49	43	39	41	37	33	29
Charlotte	—	—	—	—	—	—	—	—	—	44	32
Chicago	61	56	53	57	51	52	49	45	42	—	41
Cleveland	48	53	48	48	42	41	27	37	40	38	35
Dallas	43	41	44	35	31	32	32	29	34	28	30
Denver	30	38	41	40	44	44	40	40	41	35	34
Des Moines	—	—	—	—	—	—	—	18	16	11	9
Detroit	41	37	34	34	30	27	23	28	27	24	22
Ft. Lauderdale	44	46	43	41	39	44	51	50	41	31	—
Honolulu	—	—	—	—	—	—	—	—	—	16	11
Houston	56	41	41	29	40	39	40	36	36	32	—
Indianapolis	22	23	32	47	39	42	31	34	34	31	32
Kansas City	—	—	—	—	—	—	—	—	—	—	34
Laredo	—	—	—	—	—	—	—	37	42	45	35
Las Vegas	—	—	—	—	—	—	—	24	30	23	21
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	28
New Orleans	50	49	48	47	47	46	46	46	44	35	37
New York City[2]	62	62	66	68	68	56	58	47	44	49	45
Oklahoma City	—	—	—	—	—	—	—	27	26	22	22
Omaha	14	16	19	26	19	24	21	25	22	18	20
Philadelphia	62	63	56	54	51	40	34	45	39	31	37
Phoenix	20	26	30	28	27	32	32	31	32	32	27
Portland, OR	30	35	33	32	30	34	37	29	23	22	27
Sacramento	—	—	—	—	—	—	—	18	16	18	18
St. Louis	48	50	50	50	51	43	41	35	—	—	—
Salt Lake City	—	—	—	—	—	—	—	20	22	18	16
San Antonio	31	32	31	31	24	28	26	27	23	20	30
San Diego	45	45	37	30	28	27	21	19	17	15	14
San Jose	33	28	23	19	18	16	14	8	14	12	13
Seattle	—	—	—	—	—	—	—	36	33	31	32
Spokane	—	—	—	—	—	—	—	18	18	15	19
Tucson	—	—	—	—	—	—	—	39	40	41	36
Tulsa	—	—	—	—	—	—	—	—	—	—	20
Washington, D.C.	49	44	37	38	35	33	33	33	38	—	—

— Data not available.

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

[2] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 63. Percentage[1] of Adult Male Booked Arrestees Who Used Opiates, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	7	4
Albuquerque	—	—	—	—	—	—	—	8	14	12	16
Anchorage	—	—	—	—	—	—	—	2	3	4	4
Atlanta	3	4	3	2	3	3	2	1	4	3	—
Birmingham	5	3	4	4	2	4	5	4	4	10	6
Charlotte	—	—	—	—	—	—	—	—	—	2	3
Chicago	21	19	28	27	22	20	22	18	20	—	22
Cleveland	3	3	4	3	5	3	4	6	4	4	4
Dallas	4	4	4	3	5	5	4	2	5	3	5
Denver	2	2	4	4	5	5	4	4	3	3	5
Des Moines	—	—	—	—	—	—	—	3	1	3	2
Detroit	8	8	8	7	7	7	5	7	9	8	7
Ft. Lauderdale	1	1	1	1	2	2	3	2	1	2	—
Honolulu	—	—	—	—	—	—	—	—	—	7	3
Houston	3	3	2	3	5	8	10	8	6	7	—
Indianapolis	3	4	4	3	2	3	3	2	3	3	5
Kansas City	—	—	—	—	—	—	—	—	—	—	0
Laredo	—	—	—	—	—	—	—	11	11	10	11
Las Vegas	—	—	—	—	—	—	—	3	5	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	5
New Orleans	4	4	5	5	7	7	11	13	14	16	16
New York City[2]	14	18	20	19	20	17	19	16	15	21	19
Oklahoma City	—	—	—	—	—	—	—	2	2	3	5
Omaha	2	2	2	2	1	1	2	2	0	2	3
Philadelphia	11	12	11	14	12	11	11	18	15	12	13
Phoenix	5	5	6	6	8	9	9	6	8	7	6
Portland, OR	9	11	11	12	15	13	14	16	13	14	11
Sacramento	—	—	—	—	—	—	—	3	4	3	8
St. Louis	6	7	9	11	11	10	10	11	—	—	—
Salt Lake City	—	—	—	—	—	—	—	8	9	7	5
San Antonio	16	15	14	13	10	10	10	10	10	10	9
San Diego	17	16	16	12	8	9	7	9	9	6	8
San Jose	8	4	6	6	5	5	6	4	4	6	3
Seattle	—	—	—	—	—	—	—	17	14	10	10
Spokane	—	—	—	—	—	—	—	9	7	8	8
Tucson	—	—	—	—	—	—	—	7	9	9	6
Tulsa	—	—	—	—	—	—	—	—	—	—	2
Washington, D.C.	10	11	10	9	8	9	10	10	16	—	—

— Data not available.

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

[2] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 63. Percentage[1] of Adult Male Booked Arrestees Who Used Opiates, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	7	4
Albuquerque	—	—	—	—	—	—	—	8	14	12	16
Anchorage	—	—	—	—	—	—	—	2	3	4	4
Atlanta	3	4	3	2	3	3	2	1	4	3	—
Birmingham	5	3	4	4	2	4	5	4	4	10	6
Charlotte	—	—	—	—	—	—	—	—	—	2	3
Chicago	21	19	28	27	22	20	22	18	20	—	22
Cleveland	3	3	4	3	5	3	4	6	4	4	4
Dallas	4	4	4	3	5	5	4	2	5	3	5
Denver	2	2	4	4	5	5	4	4	3	3	5
Des Moines	—	—	—	—	—	—	—	3	1	3	2
Detroit	8	8	8	7	7	7	5	7	9	8	7
Ft. Lauderdale	1	1	1	1	2	2	3	2	1	2	—
Honolulu	—	—	—	—	—	—	—	—	—	7	3
Houston	3	3	2	3	5	8	10	8	6	7	—
Indianapolis	3	4	4	3	2	3	3	2	3	3	5
Kansas City	—	—	—	—	—	—	—	—	—	—	0
Laredo	—	—	—	—	—	—	—	11	11	10	11
Las Vegas	—	—	—	—	—	—	—	3	5	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	5
New Orleans	4	4	5	5	7	7	11	13	14	16	16
New York City[2]	14	18	20	19	20	17	19	16	15	21	19
Oklahoma City	—	—	—	—	—	—	—	2	2	3	5
Omaha	2	2	2	2	1	1	2	2	0	2	3
Philadelphia	11	12	11	14	12	11	11	18	15	12	13
Phoenix	5	5	6	6	8	9	9	6	8	7	6
Portland, OR	9	11	11	12	15	13	14	16	13	14	11
Sacramento	—	—	—	—	—	—	—	3	4	3	8
St. Louis	6	7	9	11	11	10	10	11	—	—	—
Salt Lake City	—	—	—	—	—	—	—	8	9	7	5
San Antonio	16	15	14	13	10	10	10	10	10	10	9
San Diego	17	16	16	12	8	9	7	9	9	6	8
San Jose	8	4	6	6	5	5	6	4	4	6	3
Seattle	—	—	—	—	—	—	—	17	14	10	10
Spokane	—	—	—	—	—	—	—	9	7	8	8
Tucson	—	—	—	—	—	—	—	7	9	9	6
Tulsa	—	—	—	—	—	—	—	—	—	—	2
Washington, D.C.	10	11	10	9	8	9	10	10	16	—	—

— Data not available.

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

[2] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 64. Percentage[1] of Adult Male Booked Arrestees Who Used Methamphetamine, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	0.0	0.0
Albuquerque	—	—	—	—	—	—	—	3.4	5.1	4.7	9.5
Anchorage	—	—	—	—	—	—	—	0.0	0.5	0.2	0.8
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	0.2
Charlotte	—	—	—	—	—	—	—	—	—	1.4	0.5
Chicago	0.0	0.0	0.0	0.1	0.0	—	0.3	0.2	0.0	—	0.2
Cleveland	0.0	0.0	0.0	0.0	0.0	—	0.0	0.0	0.0	0.1	0.1
Dallas	0.6	0.9	2.0	2.0	2.2	—	2.6	3.3	2.5	2.1	1.7
Denver	0.8	1.0	1.2	2.1	4.1	—	5.0	5.2	3.0	2.6	3.4
Des Moines	—	—	—	—	—	—	—	10.2	14.0	18.6	22.0
Detroit	0.1	0.0	0.0	0.0	0.0	—	0.0	0.2	0.0	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	37.4
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	0.6
Kansas City	—	—	—	—	—	—	—	—	—	—	1.0
Laredo	—	—	—	—	—	—	—	0.0	0.2	0.0	0.0
Las Vegas	—	—	—	—	—	—	—	13.8	16.2	17.8	20.5
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	2.4
New Orleans	0.2	0.2	0.0	0.1	0.0	—	0.0	0.2	0.1	0.2	0.0
New York City[2]	0.2	0.0	0.1	0.3	0.0	—	0.0	0.0	0.0	0.0	0.1
Oklahoma City	—	—	—	—	—	—	—	8.0	8.7	11.3	10.9
Omaha	0.1	0.5	1.4	3.3	7.8	—	9.7	10.2	7.8	11.0	15.6
Philadelphia	0.5	0.5	0.4	0.1	0.4	—	0.6	0.6	0.2	0.0	0.0
Phoenix	4.5	5.1	15.6	25.4	22.0	—	16.4	16.4	16.6	19.1	25.3
Portland, OR	7.5	5.9	11.3	16.3	18.1	—	15.9	18.1	19.8	21.4	20.4
Sacramento	—	—	—	—	—	—	—	24.6	27.6	29.3	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	17.2
San Antonio	1.3	0.8	0.6	1.0	1.1	—	1.7	2.0	1.8	0.2	2.6
San Diego	18.0	23.7	35.5	41.0	36.0	—	39.6	33.2	26.0	26.3	27.9
San Jose	6.6	5.9	15.3	19.9	16.3	—	18.4	19.7	24.4	21.5	30.2
Seattle	—	—	—	—	—	—	—	6.4	9.0	9.2	11.1
Spokane	—	—	—	—	—	—	—	15.8	20.1	20.4	19.5
Tucson	—	—	—	—	—	—	—	4.0	5.8	6.9	5.4
Tulsa	—	—	—	—	—	—	—	—	—	—	0.0
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 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 65. Percentage[1] of Adult Female Booked Arrestees Who Used Any Drug,[2] by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000[3]	2001[4]
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	50	63
Albuquerque	—	—	—	—	—	—	—	73	74	58	66
Anchorage	—	—	—	—	—	—	—	58	56	46	55
Atlanta	70	65	74	72	68	77	74	—	77	72	—
Birmingham	62	59	55	63	57	59	67	74	53	53	—
Charlotte	—	—	—	—	—	—	—	—	—	—	69
Chicago	—	—	—	—	—	—	—	72	77	80	—
Cleveland	79	74	77	82	71	70	57	58	68	68	71
Dallas	56	66	61	63	58	58	53	49	56	39	—
Denver	54	61	66	68	66	69	69	69	69	71	64
Des Moines	—	—	—	—	—	—	—	67	53	59	60
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	50
Houston	59	54	53	48	50	54	45	52	43	52	—
Indianapolis	54	50	58	69	72	72	67	67	69	72	67
Laredo	—	—	—	—	—	—	—	33	22	31	35
Las Vegas	—	—	—	—	—	—	—	70	72	61	53
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	56
New York City[5]	77	85	83	90	84	83	81	82	81	75	77
Oklahoma City	—	—	—	—	—	—	—	—	65	67	64
Omaha	—	—	—	58	56	51	54	60	62	53	64
Philadelphia	75	78	79	76	77	81	75	77	76	59	—
Phoenix	61	63	62	67	63	65	66	71	67	66	72
Portland, OR	68	73	74	74	68	74	78	74	68	69	73
Sacramento	—	—	—	—	—	—	—	73	75	85	81
St. Louis	54	70	69	76	69	73	70	69	—	—	—
Salt Lake City	—	—	—	—	—	—	—	69	66	59	49
San Antonio	45	44	42	39	41	44	37	38	31	—	—
San Diego	73	72	78	76	73	62	73	64	67	66	67
San Jose	52	56	51	61	50	53	53	42	61	69	71
Seattle	—	—	—	—	—	—	—	81	70	74	—
Spokane	—	—	—	—	—	—	—	68	71	42	—
Tucson	—	—	—	—	—	—	—	57	58	71	58
Washington, D.C.	75	72	71	67	65	58	57	65	—	—	—

— Data not available.

[1] Percent 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.

[3] Data for 2000 are unweighted and not based on probability sampling.

[4] In 2001, the definition of "any drug" pertains to any one of the NIDA-5 drugs (cocaine, opiates, marijuana, methamphetamine, and PCP), thus these numbers are not directly comparable to prior years.

[5] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 66. Percentage[1] of Adult Female Booked Arrestees Who Used Marijuana, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000[2]	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	30	40
Albuquerque	—	—	—	—	—	—	—	24	24	18	25
Anchorage	—	—	—	—	—	—	—	23	31	28	31
Atlanta	8	13	16	15	13	26	28	—	34	26	—
Birmingham	10	13	12	17	12	22	25	18	26	18	—
Charlotte	—	—	—	—	—	—	—	—	—	—	19
Chicago	—	—	—	—	—	—	—	20	27	26	—
Cleveland	7	11	13	16	11	22	22	27	28	24	28
Dallas	11	24	19	22	21	44	28	24	27	21	—
Denver	16	19	24	22	21	27	32	30	34	34	33
Des Moines	—	—	—	—	—	—	—	15	34	36	40
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	14
Houston	8	12	15	13	18	26	17	20	23	27	—
Indianapolis	22	26	25	22	24	31	30	31	38	38	38
Laredo	—	—	—	—	—	—	—	13	9	17	14
Las Vegas	—	—	—	—	—	—	—	22	23	25	24
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	25
New York City[3]	11	12	19	15	16	19	25	23	26	28	32
Oklahoma City	—	—	—	—	—	—	—	—	39	45	41
Omaha	—	—	—	28	24	33	33	28	36	33	36
Philadelphia	14	15	20	18	20	21	21	24	26	22	—
Phoenix	14	15	20	22	19	22	21	25	26	23	27
Portland, OR	28	17	17	19	16	26	19	23	23	26	24
Sacramento	—	—	—	—	—	—	—	28	33	26	28
St. Louis	8	11	15	15	18	29	31	32	—	—	—
Salt Lake City	—	—	—	—	—	—	—	29	23	25	19
San Antonio	9	16	16	15	16	19	17	18	16	—	—
San Diego	20	25	25	20	20	23	24	27	29	27	28
San Jose	13	18	17	18	12	19	17	14	26	31	34
Seattle	—	—	—	—	—	—	—	38	28	48	—
Spokane	—	—	—	—	—	—	—	27	32	25	—
Tucson	—	—	—	—	—	—	—	22	24	29	29
Washington, D.C.	6	8	9	10	18	23	19	29	—	—	—

— Data not available.

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

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

[3] Data before the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 67. Percentage[1] of Adult Female Booked Arrestees Who Used Cocaine, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000[2]	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	23	44
Albuquerque	—	—	—	—	—	—	—	59	56	41	46
Anchorage	—	—	—	—	—	—	—	50	36	24	23
Atlanta	66	58	68	62	62	63	61	—	62	58	—
Birmingham	44	46	41	50	48	39	49	57	34	42	—
Charlotte	—	—	—	—	—	—	—	—	—	—	63
Chicago	—	—	—	—	—	—	—	56	64	59	—
Cleveland	76	66	69	74	63	52	39	41	50	52	50
Dallas	45	48	43	46	44	36	34	30	40	24	—
Denver	41	50	47	51	52	53	50	50	51	47	45
Des Moines	—	—	—	—	—	—	—	24	22	18	13
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	10
Houston	52	44	43	36	32	34	29	37	23	32	—
Indianapolis	26	25	36	56	54	52	45	43	45	45	41
Laredo	—	—	—	—	—	—	—	33	21	22	27
Las Vegas	—	—	—	—	—	—	—	35	50	28	27
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	38
New York City[3]	66	72	70	80	71	69	62	67	65	53	57
Oklahoma City	—	—	—	—	—	—	—	—	35	27	27
Omaha	—	—	—	34	30	28	17	36	32	22	28
Philadelphia	64	67	61	61	59	69	58	61	60	41	—
Phoenix	45	49	38	36	33	42	33	40	43	35	32
Portland, OR	40	54	47	43	40	46	45	37	33	30	37
Sacramento	—	—	—	—	—	—	—	31	30	37	30
St. Louis	47	62	62	69	57	55	53	44	—	—	—
Salt Lake City	—	—	—	—	—	—	—	20	26	15	22
San Antonio	25	25	24	22	24	23	18	20	19	—	—
San Diego	40	37	36	18	28	22	23	20	23	26	17
San Jose	30	32	19	23	16	21	16	10	20	8	15
Seattle	—	—	—	—	—	—	—	57	48	39	—
Spokane	—	—	—	—	—	—	—	32	31	8	—
Tucson	—	—	—	—	—	—	—	41	41	49	35
Washington, D.C.	68	64	62	55	46	40	39	40	—	—	—

— Data not available.

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

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

[3] Data prior to the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 68. Percentage[1] of Adult Female Booked Arrestees Who Used Opiates, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000[2]	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	8	13
Albuquerque	—	—	—	—	—	—	—	15	31	14	19
Anchorage	—	—	—	—	—	—	—	4	2	8	9
Atlanta	4	5	4	4	3	3	3	—	5	3	—
Birmingham	11	4	4	3	3	6	5	18	4	4	—
Charlotte	—	—	—	—	—	—	—	—	—	—	4
Chicago	—	—	—	—	—	—	—	27	32	40	—
Cleveland	6	5	4	4	6	6	4	1	8	7	5
Dallas	9	8	10	7	5	5	5	5	7	5	—
Denver	2	5	6	5	6	5	6	3	3	6	2
Des Moines	—	—	—	—	—	—	—	6	3	7	8
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	4
Houston	4	4	4	6	3	4	5	7	7	3	—
Indianapolis	11	7	4	5	7	3	3	5	5	6	7
Laredo	—	—	—	—	—	—	—	0	2	7	10
Las Vegas	—	—	—	—	—	—	—	14	9	5	6
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	8
New York City[3]	21	24	23	30	19	27	20	22	21	19	14
Oklahoma City	—	—	—	—	—	—	—	—	3	5	4
Omaha	—	—	—	2	2	3	4	5	0	1	8
Philadelphia	9	11	14	18	14	16	16	15	14	11	—
Phoenix	17	15	14	12	12	13	8	7	12	7	6
Portland, OR	17	22	19	21	18	26	27	25	19	22	21
Sacramento	—	—	—	—	—	—	—	8	5	11	11
St. Louis	7	7	16	8	8	7	9	5	—	—	—
Salt Lake City	—	—	—	—	—	—	—	14	15	9	16
San Antonio	21	14	14	14	13	13	9	9	10	—	—
San Diego	21	17	20	13	12	10	12	7	11	8	9
San Jose	7	9	8	10	10	9	12	5	13	4	7
Seattle	—	—	—	—	—	—	—	17	20	17	—
Spokane	—	—	—	—	—	—	—	17	13	8	—
Tucson	—	—	—	—	—	—	—	7	9	17	10
Washington, D.C.	16	19	21	13	16	11	11	10	—	—	—

— Data not available.

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

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

[3] Data prior to the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 69. Percentage[1] of Adult Female Booked Arrestees Who Used Methamphetamine, by Location, 1991–2001

Location	Year										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000[2]	2001
Albany (Capital Area)	—	—	—	—	—	—	—	—	—	0.0	0.0
Albuquerque	—	—	—	—	—	—	—	2.4	8.9	5.7	4.6
Anchorage	—	—	—	—	—	—	—	0.0	0.0	0.8	1.0
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	—
Charlotte	—	—	—	—	—	—	—	—	—	—	0.0
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	0.2
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	4.3
Des Moines	—	—	—	—	—	—	—	24.2	22.4	20.5	27.5
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	36.1
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	0.7
Laredo	—	—	—	—	—	—	—	0.0	0.0	0.0	0.0
Las Vegas	—	—	—	—	—	—	—	24.3	17.9	20.5	15.5
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	0.0
New York City[3]	0.0	0.0	0.0	0.0	0.2	—	0.0	0.0	0.0	0.0	0.7
Oklahoma City	—	—	—	—	—	—	—	—	11.3	16.2	15.8
Omaha	—	—	2.7	2.7	10.3	—	13.3	13.6	11.1	13.2	10.3
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	32.3
Portland, OR	11.5	7.3	21.4	21.4	19.7	—	20.7	22.3	24.8	23.5	20.4
Sacramento	—	—	—	—	—	—	—	29.2	32.4	29.6	42.6
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	18.8
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	37.4
San Jose	7.1	11.3	23.3	23.3	23.6	—	24.9	21.1	31.6	40.8	38.2
Seattle	—	—	—	—	—	—	—	5.2	9.5	21.7	—
Spokane	—	—	—	—	—	—	—	22.0	26.6	8.3	—
Tucson	—	—	—	—	—	—	—	2.5	9.6	9.0	12.4
Washington, D.C.	0.0	0.0	0.0	0.0	0.0	—	0.0	0.5	—	—	—

— Data not available.

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

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

[3] Data prior to the third quarter of 1998 pertains 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); 2001 data from *Drug Use and Related Matters Among Adult Arrestees, 2001*, ADAM, NIJ.

Table 70. Eradicated Domestic Cannabis by Plant Type, by State, 2001 (Number of Plants)

State or jurisdiction	TOTAL	INDOOR		OUTDOOR		Bulk Processed Marijuana	Ditchweed Eradicated
	Cultivated Plants Eradicated	Plots Eradicated	Cultivated Plants Eradicated[1]	Grows Seized	Cultivated Plants Eradicated		
Total U.S.	3,304,760	37,926	3,068,632	2,379	236,128	25,321	569,712,725
Alabama	38,597	1,407	38,474	4	123	1,394	—
Alaska	9,128	1	86	135	9,042	48	—
Arizona	2,960	28	2,810	10	150	23	29
Arkansas	39,503	264	39,197	23	306	11	—
California	1,199,818	1,900	1,086,809	372	113,009	5,254	—
Colorado	4,170	75	1,948	20	2,222	303	134,169
Connecticut	1,320	32	1,191	2	129	3	—
Delaware	1,361	14	1,283	4	78	0	363
Florida	28,206	341	13,055	210	15,151	3,242	—
Georgia	57,534	315	56,372	27	1,162	52	—
Hawaii	525,413	11,934	525,041	7	372	139	—
Idaho	1,509	5	123	11	1,386	29	—
Illinois	32,965	422	30,961	50	2,004	608	3,098,808
Indiana	27,567	1,399	24,383	94	3,184	275	212,904,736
Iowa	1,375	17	1,036	8	339	2,730	14,520
Kansas	2,721	51	1,546	10	1,175	136	100,472
Kentucky	421,724	8,856	413,851	54	7,873	3,113	—
Louisiana	3,814	110	3,348	23	466	5	—
Maine	11,036	192	9,314	42	1,722	74	—
Maryland	4,054	122	3,670	33	384	113	—
Massachusetts	1,763	61	1,353	6	410	350	—
Michigan	32,037	154	27,135	59	4,902	244	—
Minnesota	3,552	18	1,432	42	2,120	163	4,506,438
Mississippi	10,110	163	10,080	6	30	720	—
Missouri	12,027	346	9,865	67	2,162	228	61,982,618
Montana	1,866	8	903	12	963	132	—
Nebraska	80	2	15	5	65	2	1,676,655
Nevada	7,732	9	3,593	22	4,139	272	—
New Hampshire	900	31	686	12	214	11	200
New Jersey	1,013	61	831	10	182	1,708	—
New Mexico	6,310	13	4,784	9	1,526	49	—
New York	7,664	232	6,381	37	1,283	460	470
North Carolina	89,900	1,462	88,925	18	975	205	—
North Dakota	3,860	5	3,765	5	95	5	2,755,431
Ohio	34,010	1,976	32,103	25	1,907	343	—
Oklahoma	6,163	100	6,149	1	14	13	15,817,993
Oregon	7,928	213	2,644	130	5,284	126	—
Pennsylvania	6,358	532	4,588	164	1,770	54	—
Rhode Island	156	2	32	2	124	0	—
South Carolina	9,927	122	9,228	15	699	5	—
South Dakota	3,454	2	3,420	3	34	278	263,260,015
Tennessee	479,391	2,696	477,904	14	1,487	430	—
Texas	50,110	867	40,133	94	9,977	814	712,000
Utah	1,849	6	113	7	1,736	9	—
Vermont	3,769	163	3,351	19	418	133	109
Virginia	16,170	283	13,279	54	2,891	332	0
Washington	49,246	155	23,467	216	25,779	0	—
West Virginia	36,135	564	35,287	30	848	114	2,567,110
Wisconsin	6,360	191	2,653	154	3,707	484	180,589
Wyoming	145	4	35	2	110	85	—

— Data not available.

[1] May include tended ditchweed.

Source: Drug Enforcement Administration, Office of Domestic Cannabis Eradication and Suppression Program. Unpublished data (2002).

Table 71. Methamphetamine Lab Seizures, by State: 1995–2002

State	1995	1996	1997	1998	1999	2000	2001	2002[1]
Total U.S.	327	879	1,362	1,387	1,918	6,922	13,092	8,129
Alabama	2	5	4	1	26	81	165	161
Alaska	0	1	0	0	10	19	14	25
Arizona	16	83	129	222	364	375	313	189
Arkansas	19	74	164	148	130	209	385	175
California	108	155	178	118	164	1,625	1,869	1,338
Colorado	13	17	26	51	85	126	229	207
Connecticut	0	0	0	0	0	0	0	1
Delaware	1	0	1	0	0	1	0	0
District of Columbia	0	0	1	0	0	0	0	0
Florida	3	0	1	6	13	15	29	82
Georgia	3	4	10	3	21	52	51	50
Hawaii	0	0	3	0	2	4	3	5
Idaho	1	3	3	4	1	88	128	62
Illinois	0	5	14	45	67	112	319	303
Indiana	0	1	4	3	3	217	500	280
Iowa	4	10	22	19	16	208	560	417
Kansas	16	43	43	29	44	379	852	514
Kentucky	1	3	1	8	6	87	170	241
Louisiana	1	1	1	3	6	14	16	86
Maine	0	0	0	1	0	2	2	0
Maryland	0	0	0	0	1	0	2	0
Massachusetts	0	0	0	3	0	0	1	0
Michigan	3	2	4	3	7	18	119	97
Minnesota	10	14	14	21	20	102	144	105
Mississippi	0	1	0	5	9	95	216	284
Missouri	37	235	396	315	195	628	2,137	882
Montana	1	1	2	1	16	20	66	40
Nebraska	1	1	1	7	7	35	213	139
Nevada	23	37	19	15	20	244	254	53
New Hampshire	0	0	0	1	0	1	2	1
New Jersey	0	1	3	0	0	0	1	1
New Mexico	4	7	20	26	44	48	101	78
New York	0	0	0	0	1	1	8	19
North Carolina	0	0	2	1	4	13	33	27
North Dakota	1	1	1	0	6	22	83	93
Ohio	0	1	7	6	14	27	87	59
Oklahoma	8	71	106	102	200	300	584	183
Oregon	2	8	10	25	10	237	589	355
Pennsylvania	2	12	6	5	1	8	15	6
Rhode Island	0	0	0	0	0	0	2	2
South Carolina	0	0	0	0	0	5	9	25
South Dakota	1	1	2	0	1	7	18	21
Tennessee	2	2	22	50	60	221	479	334
Texas	10	12	24	31	101	341	585	229
Utah	29	63	112	91	204	203	158	91
Vermont	0	0	0	0	0	0	0	0
Virginia	0	0	2	1	8	1	5	4
Washington	2	1	4	8	23	708	1,487	773
West Virginia	0	0	0	1	4	11	14	28
Wisconsin	2	2	0	0	0	2	45	40
Wyoming	1	1	0	8	4	10	30	24

Note: Federal seizures only.

[1] 2002 data extends through October.

Source: El Paso Intelligence Center. Unpublished data.

Table 72. Estimated Number of Emergency Department Drug Episodes, by Metropolitan Area, 1993–2001

Metro area	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total U.S.	460,910	518,880	513,519	513,933	526,818	542,432	554,767	601,563	638,484
Atlanta	7,728	10,660	11,063	9,400	8,003	10,717	10,189	11,112	14,456
Baltimore	13,474	15,863	15,966	15,994	12,755	13,736	14,171	11,505	11,625
Boston	12,644	15,374	16,067	13,537	12,224	13,657	11,669	14,902	16,853
Buffalo	2,522	2,745	2,714	3,587	2,812	2,683	2,711	2,899	3,356
Chicago	17,978	21,484	21,883	23,522	26,875	26,206	26,154	30,327	32,647
Dallas	4,739	5,141	5,230	4,975	6,194	7,198	6,245	6,796	6,500
Denver	3,791	4,951	4,606	3,416	4,332	4,087	4,815	4,944	5,468
Detroit	19,169	17,653	18,626	20,796	17,604	17,477	16,125	17,042	19,265
L.A.-Long Beach	20,611	19,250	19,258	20,275	17,187	17,103	20,677	25,286	24,669
Miami-Hialeah	5,588	5,908	6,417	6,283	6,283	6,426	7,128	8,560	8,886
Minn.-St. Paul	4,558	4,364	4,325	4,828	4,957	4,328	4,643	5,197	6,521
New Orleans	4,092	4,737	5,867	5,844	5,209	5,088	4,459	4,664	3,729
New York	45,116	42,980	40,792	40,468	37,111	36,141	30,662	31,882	32,307
Newark	9,216	9,394	10,870	9,909	8,893	8,944	8,301	7,747	7,217
Philadelphia	19,801	17,731	20,501	21,628	23,225	24,924	24,413	23,431	25,790
Phoenix	5,930	6,808	7,910	7,431	7,327	7,058	8,291	9,072	10,084
St. Louis	4,020	6,038	5,657	6,179	5,664	5,719	6,336	6,908	8,216
San Diego	5,310	5,043	4,660	5,806	6,747	6,982	7,036	7,094	6,962
San Francisco	11,763	12,115	10,161	9,533	9,424	9,068	8,928	7,857	8,575
Seattle	7,266	10,363	8,505	8,471	10,587	8,327	8,424	11,115	11,495
Washington, D.C.	12,339	14,152	11,830	11,720	11,193	11,596	10,282	10,303	10,566
National panel	223,256	266,126	260,611	260,331	282,212	294,967	313,108	342,920	363,297

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: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1994–2001* (August 2002). Data for 1993 is from *Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network* (July 2001).

Table 73. Estimated Number of Emergency Department Cocaine Mentions, by Metropolitan Area, 1993–2001

Metro Area	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total U.S.	123,423	143,337	135,711	152,420	161,083	172,011	168,751	174,881	193,034
Atlanta	4,384	6,190	6,515	5,434	4,244	5,980	5,236	6,229	8,891
Baltimore	7,643	8,882	8,603	8,515	6,253	6,871	6,921	4,943	4,930
Boston	3,912	4,810	5,267	4,106	3,332	4,526	3,560	4,099	4,933
Buffalo	974	1,136	1,333	2,203	1,526	1,225	1,119	1,018	1,220
Chicago	8,640	10,733	10,702	12,688	14,373	13,642	13,399	14,879	16,202
Dallas	1,345	1,442	1,457	1,393	1,778	2,586	2,106	2,180	1,770
Denver	968	1,273	1,144	811	1,072	1,154	1,382	1,342	1,343
Detroit	8,991	8268	8,763	10,435	8,093	8,617	7,699	7,870	7,730
L.A.-Long Beach	5,362	5,069	4,980	5,708	4,703	5,779	6,768	9,094	9,999
Miami-Hialeah	2,662	2,748	3,078	3,104	3,254	3,553	4,018	4,383	4,641
Minn.-St. Paul	457	562	465	674	736	775	814	841	1,105
New Orleans	1,686	1,883	2,018	2,380	2,363	2,395	2,139	1,998	1,422
New York	21,085	20,145	19,715	21,592	20,202	19,549	14,799	14,250	13,898
Newark	3,825	4,228	4,658	4,436	3,571	3,743	3,124	2,726	2,631
Philadelphia	9,943	8,481	9,502	10,383	11,202	13,048	12,434	10,497	11,358
Phoenix	838	1,057	1,165	1,382	1,337	1,486	1,877	1,775	1,752
St. Louis	1,220	2,329	1,841	1,852	1,494	2,073	2,329	2,403	3,080
San Diego	869	667	644	906	844	971	1,063	1,002	812
San Francisco	3,035	3,227	2,560	2,310	1,979	1,843	1,935	2,054	2,482
Seattle	1,760	3,029	2,158	2,143	2,850	2,399	2,519	3,338	3,409
Washington, D.C.	4,275	4,849	3,542	3,881	3,223	3,718	3,150	2,830	2,894
National panel	29,550	42,329	35,601	46,084	62,654	66,078	70,360	75,130	86,532

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: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1994–2001* (August 2002). Data for 1993 is from *Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network* (July 2001).

Table 74. Estimated Number of Emergency Department Heroin/Morphine Mentions, by Metropolitan Area, 1993–2001

Metro Area	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total U.S.	63,232	63,158	69,556	72,890	70,712	75,688	82,192	94,804	93,064
Atlanta	250	443	404	388	384	473	414	485	848
Baltimore	5,719	7,471	8,207	8,093	5,863	6,711	6,999	5,405	4,481
Boston	2,319	2,563	2,956	2,729	2,500	2,738	2,861	3,867	4,358
Buffalo	279	314	379	443	468	538	522	681	607
Chicago	3,581	4,737	4,702	6,268	8,602	9,316	9,629	12,454	11,902
Dallas	297	242	264	331	505	500	428	478	443
Denver	276	472	463	336	465	492	629	666	769
Detroit	2,380	2,160	2,390	3,188	3,028	2,879	2,653	3,328	3,870
L.A.-Long Beach	3,724	2,928	3,060	3,278	2,471	2,601	2,923	3,177	2,878
Miami-Hialeah	251	258	333	388	591	767	917	1,452	1,666
Minn.-St. Paul	138	65	83	105	138	145	182	228	338
New Orleans	140	191	263	303	422	510	649	982	530
New York	11,351	11,129	10,706	11,132	9,481	9,218	9,302	11,009	10,644
Newark	4,526	4,493	5,681	5,386	4,364	5,072	4,733	4,399	3,718
Philadelphia	2,478	2,385	3,839	3,864	3,712	3,445	4,087	4,661	5,362
Phoenix	487	472	485	632	827	873	839	841	777
St. Louis	215	392	369	489	447	622	851	1,084	1,309
San Diego	842	687	675	970	911	984	1,063	1,031	733
San Francisco	3,694	3,654	3,113	3,132	2,719	2,360	3,050	2,756	2,790
Seattle	1,727	2,137	2,023	2,418	2,894	2,421	2,470	2,490	1,927
Washington, D.C.	1,414	1,254	1,295	1,527	1,689	2,097	1,771	1,946	1,888
National panel	17,146	14,711	17,866	17,490	18,231	20,926	26,220	31,384	31,226

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: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1994–2001* (August 2002). Data for 1993 is from *Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network* (July 2001).

Table 75. Estimated Number of Emergency Department Marijuana/Hashish Mentions, by Metropolitan Area, 1993–2001

Metro area	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total U.S.	28,873	40,034	45,259	53,770	64,720	76,842	87,068	96,426	110,512
Atlanta	849	1,544	1,671	1,547	1,577	2,633	2,515	2,431	3,486
Baltimore	625	770	945	1,194	1,402	1,495	1,679	1,620	1,786
Boston	1,185	1,859	2,401	2,127	1,768	2,907	1,960	2,945	3,423
Buffalo	138	219	295	512	472	451	493	553	561
Chicago	1,366	2,226	2,922	3,531	4,424	5,002	4,555	5,398	5,186
Dallas	367	470	549	553	916	1,510	1,172	1,225	1,049
Denver	202	395	497	288	505	578	677	817	979
Detroit	2,716	2,955	3,875	4,210	3,742	4,335	4,100	4,344	5,017
LA-Long Beach	1,745	1,656	1,706	2,132	2,084	3,422	5,472	5,846	5,729
Miami-Hialeah	472	713	966	1,011	1,024	1,113	1,283	1,768	1,932
Minn.-St. Paul	391	411	469	543	604	490	625	803	1,200
New Orleans	610	884	1,025	1,247	1,345	1,196	1,044	1,068	814
New York	2,092	2,578	2,974	3,571	3,839	3,682	3,491	3,544	3,501
Newark	436	628	742	627	500	532	533	539	647
Philadelphia	1,955	2,086	3,059	3,432	4,560	5,302	5,465	4,928	5,496
Phoenix	226	451	474	610	741	727	1,028	1,073	1,284
St. Louis	155	897	861	924	1,109	1,338	1,639	1,763	2,311
San Diego	479	512	480	626	970	1,128	923	955	1,107
San Francisco	451	500	506	424	388	391	469	627	704
Seattle	406	910	993	899	1,663	936	808	1,414	1,596
Washington, D.C.	2,102	2,712	2,035	2,167	2,394	2,360	2,516	2,510	2,135
National panel	9,905	14,658	15,814	21,595	28,693	35,314	44,621	50,255	60,569

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: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1994–2001* (August 2002). Data for 1993 is from *Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network* (July 2001).

Table 76. Estimated Number of Emergency Department Methamphetamine/Speed Mentions, by Metropolitan Area, 1993–2001

Metro area	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total U.S.	9,926	17,537	15,933	11,002	17,154	11,486	10,447	13,505	14,923
Atlanta	55	95	147	135	214	162	83	109	172
Baltimore	5	4	4	6	7	6	10	6	6
Boston	15	4	7	—	13	6	12	14	14
Buffalo	7	8	6	9	8	9	7	5	4
Chicago	20	17	34	28	29	31	22	—	45
Dallas	79	152	203	115	159	186	100	135	111
Denver	55	139	175	105	292	120	101	110	98
Detroit	24	17	15	22	—	0	—	—	—
LA-Long Beach	1,226	1,399	1,276	1,268	1,229	786	910	1,375	1,517
Miami-Hialeah	4	8	5	9	10	16	9	15	27
Minn.-St. Paul	42	57	93	108	217	109	112	153	321
New Orleans	10	12	18	22	26	25	23	27	—
New York	16	21	23	21	32	36	17	31	—
Newark	1	—	—	—	—	7	—	6	0
Philadelphia	110	91	91	66	101	48	47	67	60
Phoenix	481	802	777	725	800	446	341	600	604
St. Louis	29	51	76	39	67	66	104	162	115
San Diego	929	911	686	666	976	721	584	747	673
San Francisco	992	1,301	1,106	934	1,012	616	554	591	611
Seattle	177	309	258	195	479	266	353	540	395
Washington, D.C.	20	33	24	11	—	16	33	62	24
National panel	5,628	12,106	10,909	6,518	11,483	7,808	7,025	8,750	10,126

— 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: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1994–2001* (August 2002). Data for 1993 is from *Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network* (July 2001).

Table 77. Alcohol and Other Drug Use Among Students[1] 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.

[1] Students surveyed were in the 15–16 year age range, approximately equivalent to 10th graders in the United States.

[2] Former 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 78. Percentage of High School Students Who Used Selected Drugs by State, Youth Risk Behavior Survey, 1999 and 2001 State Surveys[1]

State	Current use[2]								Episodic heavy drinking[3]		Lifetime Use	
	Marijuana		Cocaine		Inhalant		Cigarette				Illegal steroid use	
	1999	2001	1999	2001	1999	2001	1999	2001	1999	2001	1999	2001
Alabama	22.2	18.8	3.2	2.4	4.4	4.0	36.6	23.7	29.0	25.0	5.3	4.8
Alaska	30.7	—	4.1	—	4.3	—	33.9	—	34.4	—	5.0	—
Arkansas	24.4	22.6	4.6	4.1	4.8	4.4	39.6	34.7	33.4	30.0	5.0	6.9
Colorado	—	[30.2]	—	[5.0]	—	[3.8]	—	[26.7]	—	[34.3]	—	[4.7]
Connecticut	[27.8]	—	[3.6]	—	[3.7]	—	[31.2]	—	[27.5]	—	[4.1]	—
Delaware	29.0	26.3	2.7	2.4	4.0	3.2	32.2	24.2	27.1	27.3	3.2	4.8
Florida	[23.1]	23.1	[5.4]	4.0	[4.4]	4.4	[27.4]	21.5	[27.9]	24.8	[4.9]	5.0
Hawaii	24.7	[20.5]	3.3	[2.4]	3.9	[3.2]	27.9	[15.0]	26.8	[18.8]	2.5	[2.8]
Idaho	—	17.5	—	3.2	—	3.6	—	19.1	—	27.2	—	3.6
Illinois	[21.5]	[20.0]	[2.6]	[2.5]	[4.7]	[3.5]	[34.0]	[25.3]	[33.1]	[28.4]	[2.7]	[3.2]
Indiana	—	[26.7]	—	[3.6]	—	[4.2]	—	[28.5]	—	[29.5]	—	[5.9]
Iowa	[18.5]	[16.5]	[3.0]	[3.7]	[3.2]	[3.3]	[35.8]	[29.7]	[39.6]	[37.0]	[3.3]	[4.3]
Kentucky	[23.6]	[20.4]	[4.1]	[3.8]	[5.7]	[4.1]	[41.5]	[33.0]	[36.8]	[28.3]	[5.1]	[5.5]
Louisiana	[20.2]	[18.9]	[3.2]	[3.8]	[3.7]	[4.7]	[33.3]	[25.0]	[29.4]	[29.3]	[5.6]	[6.3]
Maine	[30.9]	27.2	[3.8]	4.1	[5.6]	4.3	[31.2]	24.8	[35.1]	31.5	[6.1]	5.5
Massachusetts	30.6	30.9	4.3	—	4.1	—	30.3	26.0	32.6	32.7	4.6	4.8
Michigan	25.9	24.3	3.4	3.6	4.2	3.6	34.1	25.7	29.9	29.3	4.0	4.3
Mississippi	18.9	17.4	2.1	2.3	4.5	3.4	31.5	23.6	25.4	22.1	4.4	4.4
Missouri	25.6	24.4	2.7	3.4	3.0	3.6	32.8	30.3	32.0	34.1	3.5	5.3
Montana	25.5	27.1	4.0	4.0	4.4	4.2	35.0	28.5	43.6	41.4	4.1	5.3
Nebraska	[15.6]	[18.5]	[2.3]	[2.1]	[3.5]	[2.3]	[37.3]	[30.5]	[40.8]	[39.0]	[2.6]	[2.6]
Nevada	25.9	26.6	4.9	5.5	5.1	5.0	32.6	25.2	35.6	32.4	4.0	6.4
New Hampshire	[30.3]	[28.4]	[3.4]	[4.7]	[5.2]	[5.6]	[34.1]	—	[33.2]	[32.1]	[4.3]	[5.3]
New Jersey	[22.7]	24.9	[2.4]	4.2	[4.3]	5.1	[33.8]	29.4	[30.2]	32.6	[2.1]	4.7
New Mexico	[31.2]	—	[8.5]	—	[6.5]	—	[36.2]	—	[38.1]	—	[5.9]	—
New York	23.4	[26.7]	3.0	[3.9]	3.7	[5.1]	31.8	[29.8]	28.8	[34.7]	3.7	[5.5]
North Carolina	—	20.8	—	2.7	—	—	—	27.8	—	20.7	—	5.0
North Dakota	18.8	22.0	—	—	3.7	3.8	40.6	35.3	46.2	41.5	2.5	4.3
Ohio	26.1	—	3.4	—	4.3	—	40.3	—	37.4	—	4.2	—
Rhode Island	—	33.2	—	5.5	—	4.7	—	24.8	—	30.7	—	5.4
South Carolina	24.5	[23.9]	3.5	[2.7]	4.1	[4.3]	36.0	[27.6]	25.4	[24.7]	4.6	[4.9]
South Dakota	20.7	18.4	3.3	3.1	—	4.2	43.6	33.1	46.1	36.5	3.2	5.4
Tennessee	26.6	[23.8]	3.8	[3.7]	5.0	[3.8]	37.5	[29.1]	28.5	[27.3]	5.6	[6.6]
Texas	—	21.7	—	6.3	—	4.5	—	28.4	—	31.3	—	5.7
Utah	10.6	9.7	1.5	2.7	3.6	5.1	11.9	8.3	15.8	10.9	4.3	4.2
Vermont	33.7	30.3	5.4	4.1	5.3	—	33.4	23.7	32.4	29.0	5.3	5.1
West Virginia	29.3	—	4.4	—	6.7	—	42.2	—	35.5	—	5.3	—
Wisconsin	21.5	25.1	4.4	3.4	3.8	3.2	38.1	32.6	34.4	34.2	3.4	—
Wyoming	21.4	20.4	3.7	4.3	4.2	4.2	35.2	28.4	39.5	38.1	4.9	5.3

— Data not available.

[1] Percentages are based on weighted data, which is representative of the state, except when enclosed in brackets. Bracketed percentages are based on unweighted data. Caution must be used in interpreting unweighted data since it may not be representative of the state high school population. In 2001, three states with unweighted data (New York, Illinois, and Louisiana) did not include students from at least one of the state's largest school districts.

[2] Use at least once on at least one of the 30 days preceding the survey.

[3] Drank five or more drinks of alcohol on one or more occasions on at least one of the 30 days preceding the survey.

Source: *Morbidity and Mortality Weekly Report*, Youth Risk Behavior Surveillance—United States 1999 (June 2000) and 2001 (June 2002), Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.

Table 79. Percentage of High School Students Who Used Selected Drugs in Selected Cities, Youth Risk Behavior Survey, 1999 and 2001 Local Surveys[1]

Local Area	Current Use[2]								Episodic heavy drinking[3]		Lifetime Use	
	Marijuana		Cocaine		Inhalant		Cigarette				Illegal steroid use	
	1999	2001	1999	2001	1999	2001	1999	2001	1999	2001	1999	2001
Boston	20.5	21.7	2.1	—	2.0	—	17.8	15.4	17.4	18.1	2.5	3.1
Chicago	27.3	28.7	2.7	2.6	3.4	2.5	29.0	24.7	19.3	21.4	3.4	5.2
Dallas	23.2	20.4	4.1	5.2	3.6	3.4	25.0	17.8	21.1	20.7	3.2	3.9
Detroit	20.7	[19.5]	2.0	[2.2]	3.3	[2.8]	17.7	[12.4]	12.6	[11.2]	4.1	[4.7]
District of Columbia	25.7	[20.2]	1.3	[2.8]	2.1	[3.0]	19.9	[13.1]	14.9	[10.6]	1.4	[4.2]
Ft. Lauderdale	20.9	21.8	2.6	2.6	3.2	3.9	21.9	18.3	20.1	21.1	2.9	4.5
Houston	19.0	20.4	3.7	4.3	2.1	3.2	25.4	21.8	20.5	25.4	3.2	5.7
Los Angeles	—	22.5	—	5.9	—	4.6	—	14.5	—	21.9	—	4.4
Miami	19.3	17.0	5.2	4.0	4.0	2.6	20.9	16.9	19.5	19.1	4.2	3.2
Milwaukee	—	[23.7]	—	[3.0]	—	[3.7]	—	[19.8]	—	[19.0]	—	—
New Orleans	21.0	[16.8]	2.4	[2.3]	3.6	[3.3]	17.0	[11.9]	15.2	[12.6]	4.4	[4.5]
New York City	17.3	17.8	1.7	1.2	3.1	2.2	24.1	17.6	16.6	17.9	2.7	2.6
Orlando	—	20.2	—	2.9	—	4.8	—	17.8	—	20.7	—	4.8
Palm Beach	26.3	24.0	5.5	4.5	5.4	4.2	26.1	21.4	31.7	26.1	5.8	5.4
Philadelphia	21.4	21.4	2.1	1.3	2.2	1.8	23.0	15.8	17.0	13.6	3.8	4.1
San Bernardino	[19.4]	17.9	[2.7]	3.6	[3.4]	3.8	[19.9]	12.0	[29.1]	21.1	[4.7]	5.2
San Diego	22.2	22.5	3.2	3.8	4.1	3.3	23.1	17.1	22.3	24.3	3.4	5.2
San Francisco	[15.2]	18.3	[1.6]	—	[3.1]	3.1	[18.7]	13.3	[11.4]	13.2	[2.2]	2.3
Seattle	26.2	—	—	—	2.6	—	25.9	—	21.5	—	—	—

— Data not available.

[1] Percentages are based on weighted data, which is representative of the local area, except when enclosed in brackets. Bracketed percentages are based on unweighted data. Caution must be used in interpreting unweighted data since it may not be representative of the local area high school population.

[2] Use at least once on at least one of the 30 days preceding the survey.

[3] Drank five or more drinks of alcohol on one or more occasions on at least one of the 30 days preceding the survey.

Source: *Morbidity and Mortality Weekly Report*, Youth Risk Behavior Surveillance—United States, 1999 (June 2000) and 2001 (June 2002), Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.

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)
Data Subcommittee	Advisory Committee on Research, Data, and Evaluation; Subcommittee on Data, Research, and Interagency Coordination Improving Federal Drug-Related Data Systems
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DSM-IV	Diagnostic and Statistical Manual, fourth edition
DUF	Drug Use Forecasting program
ED	hospital 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
FinCEN	Financial Crimes Enforcement Network
HIDTA	High Intensity Drug Trafficking Areas program
HIV	human immunodefiency 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
OCDETF	Organized Crime Drug Enforcement Task Force
ONDCP	Office of National Drug Control Policy

PAPI	paper and pencil interview
PRIDE	Parents' Resource Institute for Drug Education
RSAT	Residential Substance Abuse Treatment program
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment (a Federal block grant program)
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
TCE	Targeted Capacity Expansion program
THC	delta-9-tetrahydrocannabinol (the principal psychoactive ingredient of marijuana)
UCR	Uniform Crime Reports
UFDS	Uniform Facility Data Set
YRBS	Youth Risk Behavior Survey
YRBSS	Youth Risk Behavior Surveillance System

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