IS DRUG USE UP OR DOWN? WHAT ARE THE IMPLICATIONS?

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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IS DRUG USE UP OR DOWN? WHAT ARE THE IMPLICATIONS?

TUESDAY, SEPTEMBER 19, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2203, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Ose, and Mink.

Staff present: Sharon Pinkerton, staff director and chief counsel; Steve Dillingham, special counsel; Charley Diaz, congressional fellow; Ryan McKee, clerk; and Sarah Despres, minority counsel.

Mr. MICA. Good morning. I would like to call the hearing to order. The order of business this morning will be first, I will proceed with an opening statement. Then we have two panels we will be hearing from today, and Mrs. Mink would like to move that we leave the record open for a period of 2 weeks for additional statements for Members or interested individuals who, through the Chair, would like their statements or information made part of the official record of these proceedings. With that we will begin, and this morning I will start with my opening statement.

This morning our subcommittee will focus on the question of drug use trends in the United States. Over the past few weeks, administration officials have attempted to put a happy face on what appears, from the information that our subcommittee has received, an increasingly sad situation.

Unfortunately, even information that will be presented by the Office of National Drug Control Policy today, that information indicates that overall drug use has grown from some 6.4 percent in 1997 to 7 percent in 1999.

While marijuana and crack use has decreased slightly among youth, methamphetamine, ecstasy and designer drug use has skyrocketed both for youth and for adults. Our subcommittee must report with great sadness that today, for the first time in the history of the United States, drug-induced deaths have exceeded homicides in our country. This, in fact, is a startling statistic and, in fact, a national tragedy.

I have some charts that I brought with me. This one shows again that sad statistic. For the first time, drug-induced deaths have exceeded murder in the United States of America. Just an unbelievable tragedy.

What is interesting is that data supported by information we received—this is a headline from last week in the Baltimore Sun—the Baltimore Sun said last week they released figures that in 1998 there were 290 overdose victims and 313 homicides, and that they have now reported for the succeeding year that 324 people died of illegal drug overdose in Baltimore as compared to 309 homicides. So overdose deaths exceeds slayings. And this same headline in this urban area has been reported in my suburban area of central Florida.

This is, in fact, a startling statistic and a national tragedy. As chairman of the House Subcommittee on Criminal Justice, Drug Policy, and Human Resources, I open this hearing with a simple message regarding drug use trends. Drug use remains as great a danger today as it has ever been. In fact, since 1998, America is losing more lives each year to drug-induced deaths than to murder. From 1992 to 1998, drug deaths have increased an astounding 45 percent in this country. Unfortunately, law enforcement officials have told me that the death statistic for drug deaths would be even worse if it were not for improvements in emergency room treatments for overdoses. Our hospitals and treatment facilities are being deluged with record numbers of drug overdose admissions. This is in spite of a nearly 52 percent increase in prevention funding over the same period and a 34 percent increase in treatment funding. This is also in spite of a $1 billion national media campaign that we have undertaken and it has been supported by this subcommittee.

Why are we experiencing such an incredible onslaught of drug deaths and drug abuse? First, let me cite these reasons I believe—a lack of national leadership. Second, an unprecedented supply of deadly drugs. Three, high-purity levels. Four, a lack of successful treatment, education and prevention programs. And five, harm and risk from drugs is not understood and the use of drugs is in fact in our society today glorified.

Although we may take some comfort in a declining murder rate, drug-induced deaths are rising. It is critical that we not be complacent in this fight against drugs and drug abuse as progress we have made may soon be lost. In many critical aspects, drug use remains at the highest levels ever. Furthermore, the threat is taking new forms after posing greater and less apparent danger such as popular but deadly club drugs. Accordingly, we must remain committed and work harder and smarter to protect our children, families, and communities from the dangers associated with the drug use trends that we study and will discuss today.

Today's hearing will examine drug trends, consequences, and implications for policies and programs. Yesterday I chaired a hearing in Atlanta, GA that focused on the explosion of so-called club drugs across America. We examined the degree to which the threat is known and being experienced in communities in and around the city of Atlanta. Last week, we saw on the front page of the Baltimore Sun the headlines that drug overdose deaths had surpassed murders in Baltimore. As we will hear today, these trends reflect rising drug-related deaths nationally. Yesterday, I learned from families about tragedies they experienced. Today, we will hear and learn more.

This hearing will focus on two important topics: (1), drug use trends as measured by national surveys and research; and (2), what is being done and should be done by the administration to respond to the drug scourge that continues to wreak destruction across America.

We will hear from the White House Office of National Drug Control Policy [ONDCP], over which this subcommittee has oversight responsibility. ONDCP is responsible for examining data trends, identifying needs, and revising Federal policies and programs to respond to these needs. As the recently released year 2000 ONDCP Performance Measurement Report points out, the information is to be used to hold agencies accountable, including altering their budgets.

This subcommittee is committed to ensuring that the administration takes its responsibility seriously and that reforms are made and actions are taken where needed. Today's hearing is the first opportunity that we have had to examine the performance report and implications for administration policies and programs.

In all candor, the recent performance report, agency press releases, and comments by senior administration officials have highlighted what they consider to be good news and possible progress. I will be the first to state that positive trends are welcomed and desired by everyone. We are very supportive of the hard work being done by the committed individuals on the front line who risk their lives each and every day at Federal, State, and local levels. I commend law enforcement officers, prosecutors, judges, corrections officials, and drug treatment professionals at all levels.

I remain concerned, however, that wrong and misleading messages are being sent regarding the dangers and extent of drug use in America. It is critical that we set the record straight and proceed with the business of working harder and smarter. We cannot afford to lose time, or to squander much-needed Federal resources.

One survey that has received much attention is the National Household Survey on Drug Abuse, or Household Survey. This survey is sponsored by the Substance Abuse and Mental Health Services Administration [SAMHSA], at HHS.

Recently, the administration has highlighted the Household Survey, finding a reported drop in drug use among teens aged 12 to 17 from 1997 to 1999. While this limited decline might be an indication of positive movement, it should be considered in context of other findings. Since 1992, the same household survey shows that from 1992 to 1998, past month drug use by teens in this age group had almost doubled, from approximately 5 to 10 percent. The relevant policy questions are: Why do many more teens now use drugs than 7 years ago? And, how can we get the levels of drug use back down again?

Second, we will look at the findings of the Monitoring the Future [MTF] project, and make comparisons to findings of the Household Survey. MTF is a federally sponsored national survey of students conducted by the University of Michigan's Survey Research Center. Its findings also are examined by ONDCP. The MTF data and trends give us reasons to be alarmed. Looking at the ONDCP Performance Report numbers and graph, reported increases in teen drug use for 8th, 10th and 12th graders are obvious and dramatic.

Since 1992, 8th grade past month drug use more than doubled; 10th grade drug use has almost doubled; and there was an increase of almost two-thirds, or 62 percent, among 12th grade drug users.

What are the implications of this continuing high rate of drug use across America, and what does it mean for our agencies and programs?

Another source of valuable information that we will examine is the data from the Arrestee Drug Abuse Monitoring [ADAM], program, supported by the National Institute of Justice [NIJ], at the Department of Justice. This data is collected from 35 sites in 25 States and the District of Columbia, with plans for expansion.

The data is obtained through drug testing and interviews of arrestees. ADAM's 1999 research data indicates rising drug use among male and female arrestees. More than 60 percent of adult male arrestees tested positive for the presence of illegal drugs. The city figures range from 50 percent in San Antonio to 77 percent in Atlanta. What the data clearly shows is the linkage between crime and drugs continues. That is one reason that I have submitted H.R. 4493—the Drug Treatment Alternative to Prison Act—to meet the treatment needs of eligible nonviolent offenders. I hope the administration supports this bill.

Finally, we will examine other HHS research related to drug use and abuse. As I mentioned, drug-induced deaths continue to climb, surpassing murders. ONDCP's drug policy strategy indicates that drug-related deaths exceed 50,000 annually, that there are more than one-half million emergency department drug-related episodes, and almost a million drug mentions.

These are some of the trends that we will explore today, and that ONDCP must analyze and recommend changes to policies and practices. By most measures, drug use has worsened over the past 7 years. We are also seeing changes in drug preferences and potencies, as well as emerging challenges with dangerous club drugs.

The implications for the administration are now the focus of our attention. What is being done to address these findings? In past hearings, we have identified serious deficiencies in the bureaucratic practices of SAMHSA in areas of management, evaluation, and research.

Now we learn that the Department of Justice bureaucracy has quadrupled in size as a result of increased funding that we approved for State and local assistance. We are receiving reports of grant delays, waste, and deficient evaluations, in addition to less priority being given to drug efforts. In its 1989 discretionary grant programs, the DOJ Bureau of Justice Assistance designed almost every grant to fight drug use. That grant program was named after police officer Edward Byrne, who died fighting drug traffickers. Today, it is difficult to find discretionary drug initiatives at DOJ that are considered to be priorities. How did this happen?

Finally, the many problems we previously identified at the Department of Education in administering the Safe and Drug-Free Schools program appear to continue.

As we will hear from our first witness, the consequences of drug use are enormous. Our efforts to combat it must remain a top priority, and our practices must improve. ONDCP has the central role

in this challenge, and we must oversee the effort. I look forward to hearing from our witnesses today on this important topic.

I am pleased at this time to yield to the gentlelady from Hawaii, our ranking member, Mrs. Mink.

[The prepared statement of Hon. John L. Mica follows:]

Opening Statement
Congressman John L. Mica

"Is Drug Use Up or Down? What are the Implications?"

House Subcommittee on
Criminal Justice, Drug Policy and Human Resources

Rayburn House Office Building -- Hearing Room 2203

September 19, 2000

As Chairman of the House Subcommittee on Criminal Justice, Drug Policy and Human Resources, I open this hearing with a simple message regarding trends that we will examine showing that some drug use is up, and some use is down. My message is this:

Drug use remains as great a danger today as it ever has been! Communities are being threatened, families destroyed, and lives lost. In fact, **since 1998, America is losing more lives to drug-induced deaths than to murders!** While we may take some comfort in a declining murder rate, we should realize that drug-induced deaths continue to increase. It is critical to this nation that we not be complacent in the fight against drugs and abuse of drugs, as progress we make may soon be lost. In many critical aspects, drug use remains at the highest levels ever. Furthermore, the threat is taking new forms, often posing greater and less apparent dangers, such as popular but deadly Club Drugs."

Accordingly, we must remain committed, and work both harder and smarter, to protect our children, families and communities from the dangers associated with the drug use trends that we study and discuss today.

Today's hearing will examine drug trends, consequences and implications for policies and programs. Yesterday, I chaired a hearing in Atlanta, Georgia that focused on the explosion of so-called "Club Drugs" across America. We examined the degree to which the threat is known and being experienced in communities in and around the City of Atlanta. Last week, we saw on the front page of the Baltimore Sun the headlines that drug overdose deaths had surpassed murders in Baltimore. As we will hear today, these trends reflect rising drug-related deaths nationally. Yesterday, I learned from families about tragedies they experienced. Today, we will hear and learn more.

This hearing will focus on two important topics: (1) **Drug use trends** as measured by national surveys and research; and (2) **What is being done and should**

be done by the Administration to respond to the drug scourge that continues to wreak destruction across America.

We will hear from the White House Office of National Drug Control Policy (ONDCP) over which this Subcommittee has oversight responsibility. ONDCP is responsible for examining data and trends, identifying needs, and revising Federal policies and programs to respond to these needs. As the recently released Year 2000 ONDCP Performance Measurement Report ("Performance Report") points out, the information is to be used to hold agencies accountable, including altering their budgets.

This Subcommittee is committed to ensuring that the Administration takes its responsibility seriously, and that reforms are made and actions are taken where needed. Today's hearing is the first opportunity that we have had to examine the "Performance Report" and implications for Administration policies and programs.

In all candor, the recent Performance Report, agency press releases and comments by senior Administration officials have highlighted what they consider to be good news and possible progress. I will be the first to state that positive trends are welcomed and desired by everyone. We are very supportive of the hard work being done by committed individuals on the front-line who risk their lives each and every day at Federal, state and local levels. I commend law enforcement officers, prosecutors, judges, corrections officials, and drug treatment professionals at all levels.

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Recently, the Administration has highlighted the Household Survey finding of a reported drop in drug use among teens aged 12 to 17, from 1997 to 1999. While this limited decline might be an indication of positive movement, it should be considered in context of other findings. Since 1992, the same Household Survey shows that from 1992 to 1998**, past month drug use by teens in this age group had almost doubled (from approximately 5 to 10 percent).** (See ONDCP Performance Report chart, p. 38) The relevant policy questions are**: Why do many more teens now use drugs than seven years ago?** And, **how can we get the levels of drug use back down again?**

Second, we will look at how the findings of the "Monitoring the Future" Project (or MTF), and make comparisons to findings of the Household Survey. MTF is a federally sponsored national survey of students conducted by the University of Michigan's Survey Research Center. It findings also are examined by ONDCP. The

MTF data and trends give us reasons to be alarmed. Looking at the ONDCP Performance Report numbers and graph (P. 10), reported increases in teen drug use for 8th, 10th and 12th graders are obvious and dramatic. Since 1992, eighth grade past month drug use **more than doubled**; 10th grade drug use has **almost doubled**; and there was **an increase of almost two-thirds** (or 63%) among 12th grade drug users. What are the implications of this continuing high rate of drug use across America, and what does it mean for our agencies and programs?

Another source of valuable information that we will examine is the data from the Arrestee Drug Abuse Monitoring Program ("ADAM") supported by the National Institute of Justice (NIJ) at the Department of Justice. This data is collected from 35 sites in 25 states and the District of Columbia, with plans for expansion. The data is obtained through drug testing and interviews of arrestees. ADAM's 1999 research data indicates rising drug use among male and female arrestees. More than 60 percent of adult male arrestees tested positive for the presence of illegal drugs. The city figures range from 50 percent in San Antonio to 77 percent in Atlanta. What the data clearly shows is the linkage between crime and drugs continues. That is one reason that I have submitted H.R. 4493 -- the Drug Treatment Alternative to Prison Act -- to meet the treatment needs of eligible nonviolent offenders. I hope the Administration supports this bill.

Finally, we will examine other HHS research related to drug use and abuse. As I mentioned, **drug-induced deaths** continue to climb, **surpassing murders**. ONDCP's Drug Control Strategy indicates that **drug-related deaths exceed 50,000 annually**, that there are **more than one-half million emergency department (ED) drug-related episodes,** and **almost a million drug mentions.** (Pp. 31 & 32)

These are some of the trends that we will explore today, and that ONDCP must analyze and recommend changes to policies and practices. By most measures, drug use has worsened over the past seven years. We are also seeing changes in drug preferences and potencies, as well as emerging challenges with dangerous "Club Drugs."

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we previously identified at the Department of Education in administering the Safe and Drug-Free Schools program appear to continue.

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Mrs. MINK. Thank you very much, Mr. Chairman.

The subject area that we have been dealing with for the past 2 years, drug consumption in the United States and its devastating consequences, is always a very depressing scene, and the difficulty that we have on this committee is that it does not appear that the massive efforts that we have undertaken, not only through this committee but in other committees in funding various programs, has not made demonstrable successes. We keep hearing the very deplorable rates of consumption among school children and teenagers, and as the chairman pointed out, the increasing numbers of users who end up dead.

One of the things that I think troubles me most is the lack of emphasis on all of the agencies and those committed to this issue in really coming forward with a program that can work. We have tried everything and still the figures are very depressing. And even more depressing, when we talk about people dying from the use of these drugs, and to have it referenced as club drugs, as though it is something fashionable, sociable, and useful. Instead they should be referred to as "killer drugs" or something which characterizes the impact that these drugs have on our society.

Not only are these people dying from the use of drugs, but the implications in the crime statistics are also something that we should pay attention to. Drug users are involved in all sorts of criminal violations in the pursuit of these drugs and trying to find money, stealing and so forth, so the problem is enormous and the progress that this country is making is very discouraging.

And it is not for the lack of interest, I don't believe, on the part of the administration, or the Congress. We simply have not come up with the tools that can produce effective results to lower the usage and to enable the community to deal with it. It is not only a law enforcement problem, it is a community problem, and we have to put our best minds together, particularly with the school children and the teenagers that find themselves hopelessly addicted to these drugs.

So I am very supportive of the chairman's efforts in this regard in trying to enlarge our capacity to understand the nature and scope and size of this problem, and hope that in engaging ourselves in hearings like this that we can come up with useful endeavors that can help this Nation end this scourge.

Thank you very much, Mr. Chairman.

Mr. MICA. I thank the gentlelady.

I am pleased to recognize the gentleman from California, Mr. Ose, for an opening statement at this time.

Mr. OSE. Thank you, Mr. Chairman.

One of the interesting things that I have found in my short tenure here is that the things that are probably the most important that we deal with are those that are not going to get a lot of headlines. Maybe it is because the subject is difficult or ugly or trying or troubling. This is one of those subjects that rarely gets a lot of attention.

In California we are dealing with any number of things, the most current of which is a proposal to further legalize or actually decriminalize the use or possession of illegal narcotics. And the headline on the committee hearing today "Is Drug Use Up or Down?

What are the Implications?" I think are apropos to what I am about to say. And that is that the proposal on our ballot, Prop. 36, is crafted in such a sense as to suggest to the voters that the initiative will provide treatment or counseling, or what have you; but exactly the opposite. What the initiative does is reduce the treatment and reduce the options for people who want to eliminate the scourge of drugs from their lives.

We have a number of things going on at the Federal level, and I know your bill, which I agreed to be a cosponsor of yesterday afternoon, to provide further treatment options, is one of those that we are working on. But that kind of thing is happening across the country at State and local levels to give people the options. The reality is until those of us from Florida or Hawaii or California or wherever say the truth, which is that drug use amongst our youth is a deadly, deadly exercise, until we say that in terms that our kids understand and explain to them that what they are using is not their father's pot or father's crack or their mother's crack or pot, that is not what it is, it is 10 times stronger, and the pharmacological impact on your body is that much worse also.

Mr. Chairman, I don't know of a more important issue that this country faces than the challenge of abuse of drugs. Prop. 36 is just the most current iteration of the politicization of this issue. I would hope that in the course of the debate that Prop. 36 is exposed for the fraud that it is and is voted down in California, and I will do everything that I can to make sure that information is in the public domain. I appreciate you having this hearing. I look forward to the testimony that we are about to hear.

Mr. MICA. I thank the gentlelady and the gentleman for their opening statements, and now we will proceed with our first panel.

Our first panel has two private citizens, Mr. and Mrs. Alumbaugh. They are from Fort Pierce, FL. I just explain again, I think you testified before our subcommittee in Orlando, this is an investigation and oversight subcommittee of the House of Representatives, and in that regard we do swear in our witnesses. If you will stand, please, to be sworn.

[Witnesses sworn.]

Mr. MICA. The witnesses have answered in the affirmative. I am pleased to welcome them to Washington to testify today, because I think it is important that we put a human face on these statistics and figures that we are announcing today; that, in fact, one of those who died in 1988 was their son, Michael, and he was a living, breathing, loved, human being. And this isn't just about bean counting or statistics, it is about people losing their lives in a tragedy beyond belief for parents.

With that, I recognize Debbie Alumbaugh, who is the mother of Michael, for her comments and testimony. Thank you.

STATEMENTS OF MR. AND MRS. ALUMBAUGH, PRIVATE CITIZENS

Mrs. ALUMBAUGH. Thank you, Mr. Mica. We feel it is an honor to be asked to testify before you again. Again, my name is Debbie Alumbaugh, and I am the surviving mother of Michael Tiedemann. He was 15 years old when he died. That was 23 months ago. The cause of Michael's death was aspiration vomitus and GHB toxicity.

GHB, or gamma hydroxybutyrate, is one of the club drugs that we have in our Nation now.

Michael was a sophomore at Westwood High School in Ft. Pierce, FL. He was a black belt in karate and he was also an instructor. He had won several academic awards for reading, mathematics, music, and spelling. He was on the honor roll. He was not a street kid.

On October 1, Michael went to school as any normal day; during his break between second and third periods, he complained to a friend that he had a headache. Another student overheard this and offered Michael, "I have these pills. They will make your headache go away and make you feel better." We believe that since Michael was suffering with a headache, he didn't realize or didn't think this was taking drugs. We found out from the autopsy that he was given methadone in school. He didn't know what he got and the student who gave it did not know what she had.

When Michael came home from school that day, he asked to go to the show with some friends. It was unusual to let him out on a school night, but he was doing well, A's and B's. Before he left, a friend came to the house and they went directly into Michael's room. This was one of his best friends. They were only in his room for 5 minutes, and this is where the transaction of GHB occurred. When Michael came home from the movies, his father looked at him: "Are you on something, son? Did you take something?" Michael denied this. Brad kept asking him and asking him. Finally, Michael admitted they had smoked some pot. Again, some pot. Brad said that he wouldn't lecture him that evening. He was high. It was 1 a.m. He would discuss it in the morning. He never got that chance. Michael died that night in the safest place, alone in his bed.

The next morning the phone rang. The voice on the phone said Michael is not at the bus stop. As Brad walked across our home, he could hear the alarm ringing. Michael did have intentions of getting up to go to school. When he opened the door, he knew our son was dead. The scene was horrendous. Our son was on his back, eyes wide open and glassy. His mouth hung open, his tongue swollen so much his father couldn't shut his mouth. He had vomited from the chemicals in these drugs. GHB is mixed with floor stripper, degreaser and, most recently, red devil lye. His hands were in a clawed position where he tried to roll himself over to save himself and he couldn't because the chemicals in these drugs paralyzed the motor skills.

We didn't know why our son had died and they had to do an autopsy. It took 12 weeks for us to learn why our son had died. GHB leaves the body quickly and it was not in his blood or his urine. They took our son's brain, and that is where they found this deadly drug.

We go to schools and we tell the kids this story. We believe we leave nothing out. There is no antidote for GHB overdose. If you pass out and go into a coma, you will die, unless your body's constitution is strong enough to bring you out. Most are not. There is nothing the doctor or anyone can do to fix you. In the last 3 years in Florida alone, we have lost 174 young people to these drugs. That is 173 tragedies just like ours.

After several months, Michael came to his father in a dream and said, "Dad, it is wrong to destroy the body the way I did. You and mom must tell my story. You don't have a clue about the drugs that my friends and my generation are faced with daily." This put a burden on our hearts until we gathered up enough courage and strength to make the first call. We called St. Andrews where Michael had attended. We went to the school, and as I stood in front of all those beautiful young faces, I started, we are not here to lecture or accuse any of you of being bad kids. We are here to share our experience of losing a good kid to drugs. And that is when Michael's Message Foundation was born.

We tell the students what took our son's life, and then I tell them a little bit about Michael. He was not only a great son but a very loving son. On June 1 of this year, Michael would have been 17 years old. And I testified before Congressman Mica at a hearing in Orlando, FL and today I stand here. It is an honor and a privilege. We have devoted our lives to this.

We have chosen to take our tragedy and to educate our Nation. We have turned our grief into something positive and constructive. Michael's Message Foundation is a nonprofit organization. We do travel to schools. We go from 6th grade through 12th and up into college, sharing our son's story. We also speak at churches, rehab centers, and we speak a lot to at-risk youth activities. Our goal is to take Michael's message nationwide in the hopes of saving another family the heartache these drugs caused our family.

Our children are our future. We feel that Michael's message should be heard by parents and grandparents also, and Michael's voice must be heard, that these drugs kill.

We have been told by students at a charter school that they appreciate drug testing. It gives them a tool that can assist them with peer pressure. We do agree that cameras in school should be used as a tool or deterrent. Kids are not going to tell on the drug dealer.

We just found out recently that many children knew what our son had taken that day. Yet no one came forward, no one was the hero and said anything. Their lives are at risk. They are afraid of being hurt or killed. Again, education plays a key role not only in informing the kids that it is wrong, but death is the major consequence to these drugs.

I am here today in the hopes that laws will be made to punish the individuals who make and distribute these deadly drugs. No one was arrested for our son's death.

After sharing Michael's message, students come up and ask what happened to the person that supplied the drugs. Well, in July, this young man who allegedly gave the GHB was arrested on school grounds with a half pound of marijuana, pills, and paraphernalia, yet again endangering the lives of our students. Did this young man learn nothing from our son's death? Our kids are begging for help. They often share with us that they are scared, telling this with tears rolling down their faces, and this echoes in our minds.

Thank you again for asking us here today. Let's unite and make our schools, communities, and our Nation safer and better for everyone. Thank you.

Mr. MICA. Thank you for your testimony, Mrs. Alumbaugh. Mr. Alumbaugh, did you have comments that you wanted to make? You are recognized.

Mr. ALUMBAUGH. We do feel that the schools would be better for everyone, instead of the old saying that our school is drug free, we feel that they do make a major bust at a school, that the school be rewarded in some way via a camera to set up in their school. Or after a few years after this, sometimes we get the schools cleared out from the drug problem. Eventually there could be computers put in the schools. But right now we definitely need some cameras in there because they are not going to tell on Johnny.

Mrs. ALUMBAUGH. And the people who run the schools turn a blind eye because they don't want their school to be labeled a bad school.

[The prepared statement of Mr. and Mrs. Alumbaugh follows:]

MICHAEL'S MESSAGE FOUNDATION, INC

My name is Debbie Alumbaugh, I am the surviving mother of Michael Tiedemann, he was 15 years old when he died, that was twenty-three months ago. We lost Michael to the date-rape/designer drug **GHB** (Gamma Hydroxybutyrate) The cause of Michael's death was aspiration vomitus and GHB Toxicity.

Michael was a sophomore at Westwood High School in Ft. Pierce, Fl. He was a black belt in karate, and was also an instructor. He had won several academic awards for reading, music, mathematics and spelling. He was on the honor roll.

On October 1, 1998 Michael went to school as any normal day, during the break between 2nd & 3rd periods, he complained to a friend of a headache. Another student over heard this conversation, and offered, " Michael, I have these pills, they will make your headache go away and make you feel better." Michael made a wrong choice, he accepted these pills. We found out from the autopsy that it was **Methadone.**

Michael asked if he could go to the show with some friends, this was unusual for a school night, but he was doing well in school making A's & B's. Before he left, a friend came to the house, they went directly to Michael's room. This is when the transaction of **GHB** occurred. When they returned home from the show, Michael's father Brad, looked at his son and asked "Are you on something son?, Did you take something?" He replied no dad. After continuous questioning, he finally admitted that they had smoked some pot. Brad decided not to lecture Michael this late,

he would talk to him tomorrow. Brad never got that chance. Michael died that night. In his safest place of all places, all alone in his bed.

The next morning, the phone rang. "Brad, Michael is not at the bus stop the voice said.' Brad got up to wake Michael. He could hear Michael's alarm blaring, Michael did have intentions of getting up. When he opened the door, he knew our son was dead. The scene was horrendous. Our son was on his back, eyes wide open, glassy. His mouth hung open, his tongue so swollen, his father couldn't close his mouth. He had vomited from the chemicals in these designer drugs, dried vomit ran down his chin into a puddle in his collar bone. His hands were in a clawed position, where he had tried to roll himself over but couldn't, because these drugs paralyze your motor skills. Because we didn't know why our son had died, there had to be an autopsy. It took twelve weeks for us to learn why our son had died, none of his friends would come forward, there was nothing in his blood or urine. **GHB** leaves the body very quickly. They took our sons brain, that is where they found this drug. There is no antidote for **GHB** Overdose, if you pass out and go into a coma, you will die. Unless your bodies constitution is strong enough to pull you out. Most are not. There is nothing the Doctor or anyone can do to fix you.

In the last three years, we have lost 174 young people to these designer/club drugs in Florida alone. That is 173 tragedies just like ours.

After several months, Michael came to his father in a dream. He said "Dad it is wrong for us to destroy the body the way I did. You and Mom must tell my story. You don't have a clue about the drugs that my friends and my generation are faced with daily. This put a burden on Michael's father and I until one day we gathered up enough courage and strength to make the first call.

Brad called St., Andrews, where Michael had attended school. We went to the school, and as I stood in front of all of these young beautiful faces, I started "We are not here to lecture or accuse any of you of being bad kids." We are here to share our experience of losing a child to drugs." That is when Michael's Message Foundation was born. I tell the students what took our sons life, and then tell them a little about Michael. I tell

them he was not only a great son, but a loving son. June 1st, Michael would have been 17. I testified before Congressman Mica at a hearing in Orlando, Fl. and told the panel of our tragedy. Today, I stand here. What an honor to have this privilege.

We have devoted our lives to this. We have chosen to take our tragedy and educate our nation. We have turned our grief into something positive and constructive. Michael's Message Foundation is a non-profit organization, and contributions are tax deductible.

We travel to schools from 6th grade to 12th, and on into college sharing our son's story. We also speak at churches, Rehab Centers and At Risk Youth Activities. Our goal is to take Michael's Message Nationwide, in the hopes of saving another family the heartache and devastation these drugs have caused our family. Our children are our future. We feel that Michael's Message should be heard by parents and grandparents also. Michael's voice must be heard.

We have been told by students at a Charter School, they appreciate drug testing. They are able to use this as a tool against peer pressure. We agree that camera's in schools as a tool or deterrent. Kids are not going to tell on the drug dealer, their lives are at risk, just as in our world.
Again, education plays a key role, not only informing the kids that it is wrong, but death is a consequence of this activity.

I am here today, with the hope that laws will be made to punish the individuals who make and distribute these deadly drugs. No one was arrested for our sons death. After sharing Michael's Message, students come up to us and ask, "What happened to the person that supplied the drug?" In July, the young man who allegedly gave the GHB, was arrested on school grounds with 1/2lb marijuana, pills and paraphernalia. Yet again, endangering the lives of his classmates. Did this young man learn nothing from his friends death? The guilty need to be made examples of.

We know you are all concerned about our youth. Our kids are begging for help, they often share with us that they are scared, telling us this with

tears rolling down their faces. This echoes in our minds! Thank you for asking us here today, lets unite and make our schools, communities and our nation safer and better for everyone.

Mr. MICA. Maybe I can start with some questions, if I may. You said in July of this year, the person who sold your son drugs was that this year—was selling them again a few years later?

Mrs. ALUMBAUGH. Yes, sir.

Mr. MICA. After your son was literally murdered?

Mrs. ALUMBAUGH. Yes.

Mr. MICA. No enforcement?

Mr. ALUMBAUGH. We were told by the detective, due to the fact that the drug was given without intent to harm our son, there was no harm committed.

Mr. MICA. Well, unfortunately, you know, I have heard this over and over. We heard it again yesterday. We had a picture of a beautiful young lady that her father brought to the subcommittee, and he described his daughter's horrible death on the same drug, except she lingered for 2 years.

Mrs. ALUMBAUGH. Oh, my.

Mr. MICA. And she ended up in a nursing home. She had convulsions that were beyond description. Her body temperature at some point—he said rose to 107. Her heartbeat was 170 and dropped at one point to 25, and their family went through hell for 2 years. She finally died.

One of the problems that we have is that we are being inundated with a supply, not only these designer drugs, but also they are very difficult to detect for enforcement. The only way they can tell on some of these drugs now is after death, through an autopsy, unfortunately. We have spent—you heard Mrs. Mink. We supported a $1 billion ad campaign, media campaign. We are reviewing the results of that. It has only been around for less than 2 years. What else can we do at the Federal level to address this problem?

Mrs. ALUMBAUGH. Newsletters.

Mr. ALUMBAUGH. We feel that there should be a special task force developed for clearing out our neighborhoods. You are going to have to be tough on crime and drug dealers.

Mr. MICA. Have you seen the ads that have been put out by the Office of National Drug Control Policy?

Mrs. ALUMBAUGH. Yes.

Mr. MICA. What is your evaluation? Are these effective? Unfortunately, the statistics are from 1998, the year your son died. I have not seen 1999, but I am sure that they have increased in 1999. The trends are just dramatic.

Mrs. ALUMBAUGH. I saw one of the ONDCP commercials. I have seen them on TV, but I witnessed one on the Internet that I would like to see more of on the TV, and by all means my son be a poster child for this. And it is the funeral director talking about bringing the body past the school yard one last time on its way to the cemetery.

I believe this is what our kids need. They need to know that they are going to die from these drugs, and more of that needs to be seen. They need to witness this. They need to hear this.

Again, I saw the commercial on the Internet. I have not seen it on TV yet. But those type of commercials, they need to know the reality of the drugs.

Mr. MICA. Mrs. Mink.

Mrs. MINK. Thank you, Mr. Chairman.

The comments you have made today are absolutely representative, I think, of the families who have suffered as you have with your son's involvement in this incident. I am not sure it was one incident or several, but it ended in this terrible tragedy. The point you make about young people not really comprehending the possibility of death from use of these drugs, I think, contributes to their general frivolous viewpoint about these drugs.

Now, in the school that your son attended, I am sure throughout the campus, throughout the school, there was knowledge and a shared grief about this incident. So as a consequence of that, is there any statistic that you can point to that in this particular school that your son attended that there is greater awareness and less incidents like this?

Mr. ALUMBAUGH. The school does seem to be a lot better school today than it was 2 years ago.

Mrs. ALUMBAUGH. Yes, we visited it just the beginning of this month. It is more stringent. The school resource officers is there and the whole atmosphere of the school is different.

Mrs. MINK. So when that young person who was your son's friend came back to the same campus——

Mrs. ALUMBAUGH. It was summer school.

Mrs. MINK [continuing]. To the same campus with the intent to distribute these drugs again, what did the school do to this individual?

Mrs. ALUMBAUGH. He was arrested on felony charges. He was released to his parents.

Mrs. MINK. How old is he?

Mrs. ALUMBAUGH. He is 17 now.

Mrs. MINK. And what charges have been brought against him?

Mrs. ALUMBAUGH. Possession to distribute, possession to sell, because he had baggies, scales, pills, money. So they arrested him with possession of narcotic, possession with intent to distribute and to sell.

Mrs. MINK. So why couldn't they levy the same charges in the incident that involved your son?

Mrs. ALUMBAUGH. Those are answers that I would like.

Mrs. MINK. Thank you, Mr. Chairman.

Mr. MICA. Mr. Ose.

Mr. OSE. I am most curious, when you meet with groups of kids, how is it that you communicate your message? It would seem to me that talking to adults about drugs is different than kids. Different words, different things that you visit with them about.

Mrs. ALUMBAUGH. Well, we have given Michael's message to students and to adults.

Mr. OSE. It is the same message, but is it delivered the same way?

Mrs. ALUMBAUGH. No.

To the parent we deliver it more on how to watch your child. I add in that I thought my child was safe in my own home.

Mr. OSE. For the benefit of those of us in Congress, some of the tell-tale signs of a child who is abusing drugs are?

Mrs. ALUMBAUGH. What you saw that night. I didn't have a clue myself that night.

Mr. ALUMBAUGH. When Michael came home that night and I confronted him and was talking to him, he had eye contact like we do now. But when he was sitting on the sofa and nobody was confronting him, he was comatose. He was in the ozone. He was sitting with his mouth hanging open, staring at the floor. I knew that there was something wrong with him that night. I could tell that he had taken something.

Mrs. ALUMBAUGH. Yet when he questioned the kids that he was with, they all denied it, one of which was my nephew. He asked point blank, Did Michael take something? No, Uncle Brad, honest, he just smoked some pot. Like that is not bad. Just smoked some pot.

Mr. ALUMBAUGH. A few months later, Michael's friends came by the house and they shared with me that they were—they were buddies, and they shared with me that they were going to smoke pot but they would do nothing else, and that day was different. That day they decided to take these pills. The old saying goes, you know, when they start smoking pot, that is the start of their drug activity.

Mrs. ALUMBAUGH. But the young boy who brought the drug didn't take it. He not only gave it to our son, he gave it to another child there also, but he didn't take this drug, but he is also the one who called our home the next morning to awaken Brad to tell him that Michael wasn't at the bus stop.

Mr. OSE. When you have meetings with young people, what are their questions? The phrase is "I don't want to rat somebody out." Obviously they have a fear of the consequence once the adults are out of the room kind of thing.

Mrs. ALUMBAUGH. A lot of them we have a book over there cry and they are worried. They are not worried so much about themselves. Some of them are worried about their parents and it is not just the young people that are doing these drugs. They are afraid. They don't know who to go to and they ask where can we go, you know.

Mr. ALUMBAUGH. They seem helpless and scared.

Mr. OSE. They are 12 to 17 and they don't have a lot of life experiences.

Mrs. ALUMBAUGH. True.

Mr. OSE. Thank you, Mr. Chairman.

Mr. MICA. Well, I appreciate so much your coming up from Florida. You testified before us in Orlando. When we learn these statistics, it confirms that we have drug-induced deaths exceeding homicides in this country. I thought it was important to have a human face on it. That is a 15-year-old kid; that is not a hardened drug dealer that died after a lifetime of abuse. And those individuals shouldn't die or be lost, and I appreciate your coming before the subcommittee today, trying to make something positive out of what has to be every parent's absolute worst nightmare.

Unfortunately, this death was repeated and this tragedy for 16,925 families the same year. So we appreciate again your coming and thank you for the message that you are giving to students and to communities and now to our country. Thank you so much, and I will excuse you at this time.

Mrs. ALUMBAUGH. Thank you.

Mr. ALUMBAUGH. Thank you.

Mr. MICA. Let me call our second panel. Our second panel consists of William Raub, who is the Deputy Assistant Secretary.

Mr. OSE. Could I interrupt? Could we have Mr. and Mrs. Alumbaugh stick around?

Mr. MICA. Dr. Raub is Senior Scientific Adviser to the Secretary for Science Policy, Department of HHS; Ms. Julie Samuels, Acting Director, National Institute of Justice, Department of Justice; Dr. Lloyd Johnston, Monitoring the Future Project, University of Michigan; and we have the Honorable Donald Vereen, who is the Deputy Director of the Office of National Drug Control Policy.

As I indicated before to our first panel, this is an investigations and oversight subcommittee. We do swear in our witnesses.

[Witnesses sworn.]

Mr. MICA. We actually have five witnesses at the table, if you can introduce yourself.

Mr. ZOBECK. I am Terry Zobeck. I am Chief of the Research Programs Branch at ONDCP.

Mr. MICA. Dr. Zobeck, thank you.

Let me first recognize Dr. William Raub who is with Scientific Research, HHS. Dr. Raub, welcome and you are recognized.

STATEMENTS OF WILLIAM RAUB, DEPUTY ASSISTANT SECRETARY, SCIENTIFIC RESEARCH, HEALTH AND HUMAN SERVICES; JULIE SAMUELS, ACTING DIRECTOR, NATIONAL INSTITUTE OF JUSTICE, DEPARTMENT OF JUSTICE; LLOYD JOHNSTON, MONITORING THE FUTURE PROJECT, UNIVERSITY OF MICHIGAN; DONALD VEREEN, M.D., DEPUTY DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY [ONDCP], ACCOMPANIED BY TERRY ZOBECK, CHIEF, RESEARCH PROGRAMS BRANCH, OFFICE OF NATIONAL DRUG CONTROL POLICY [ONDCP]

Mr. RAUB. Thank you, Mr. Chairman, and Representative Mink and Representative Ose. My name is William Raub, and I am the Science Advisor to the Secretary for Health and Human Services. I am pleased to come before the subcommittee today to highlight efforts undertaken by the Department of HHS during the past decade to monitor and track trends in youth drug use.

Mr. Chairman, with your permission I will submit my full statement for the record and make some brief statements.

Mr. MICA. Without objection, so ordered. Please proceed.

Mr. RAUB. Research methodology relevant to the study of complex social problems generally does not produce absolute results, nor are those results 100 percent precise. Thus, in seeking to understand the nature and scope of issues such as youth drug use, one is well advised not only to collect data from multiple sources but also to analyze such data from multiple perspectives. Although synthesizing and interpreting data gathered in different ways in different contexts is invariably challenging, such efforts often are essential to ensure confidence in the results. Moreover, assembling such a multifaceted knowledge base often is a prerequisite to developing effective prevention strategies.

With respect to the subject of this hearing, HHS conducts several surveys that provide estimates of the percentage of youth who use

illegal drugs, alcohol or tobacco. I will describe each of these surveys briefly and then discuss recent trends in youth substance use.

Since 1990, the CDC has operated the Youth Risk Behavior Surveillance System to provide information on specific behaviors that underlie the most important health problems among youth in the United States. The YRBSS reports on behavior in six risk areas: (1) tobacco use; (2) alcohol and other drug use; (3) behaviors resulting in unintentional injury and violence; (4) sexual behaviors contributing to unintended pregnancy and sexually transmitted diseases, including HIV infection; (5) unhealthy dietary behaviors; and (6) physical inactivity.

The national Youth Risk Behavior Survey is a national component of the YRBSS. This survey, conducted during the spring semester among national samples of high school students, provides data that are representative of all students in grades 9 through 12 in public and private schools in the 50 States and the District of Columbia. In 1999, 15,359 questionnaires were completed in 144 schools. Schools are selected using a scientifically based sampling process, and schools with a large percentage of African American and Hispanic students are oversampled to generate stable estimates each year for these subgroups of youth.

Since 1975, the National Institute of Drug Abuse has sponsored the Monitoring the Future Survey through a succession of grants to the University of Michigan's Survey Research Center. The purpose of the survey is to assess the attitudes and behaviors of high school youth in a variety of areas, including and most notably the areas of drug, alcohol, and tobacco use. The survey covers 45,000 to 50,000 students annually and provides unique data on both youth substance use and the attitudes and beliefs that may contribute to such behaviors. The survey has been conducted among high school seniors since its inception and, since 1991, has included 8th and 10th graders as well.

Since 1971, the Substance Abuse and Mental Health Services Administration has sponsored the National Household Survey on Drug Abuse. NHSDA is the primary source of statistical information on the use of illegal drugs by the U.S. population. Moreover, the Household Survey provides the only source of nationally representative data on adult substance use in this country.

The NHSDA is conducted with a nationally representative sample of the population through face-to-face interviews at the subjects' place of residence. The population covered by the survey is the civilian, noninstitutional population age 12 and older in the United States, including all 50 States and the District of Columbia. In 1999, the survey underwent a major redesign, moving from a paper questionnaire to computer-assisted administration and dramatically expanding the sample to almost 70,000 individuals, including approximately 25,000 youth between the ages of 12 and 17, to permit State-level as well as national-level prevalence estimates of substance use.

Taken together, these three surveys provide a rich array of information to monitor and attempt to understand trends in substance use and abuse. Each survey provides unique and important information that is useful to local, State and national decisionmakers attempting to address problems of substance use and abuse. All

three surveys recently were reviewed by a panel of outside experts, which concluded that each survey is methodologically strong, well designed for its intended purpose, and well administered.

I am pleased to report that these three surveys—individually and collectively—provide data that can help to resolve the central question posed in today's hearing: "Is drug abuse going up or down?" In particular, all three surveys indicate that use of illegal drug and tobacco among youth has leveled and, in some cases, declined over the last 3 years. However, the data also indicate that the success of the last 3 years hardly is cause for complacency, for youth use of illegal drugs and tobacco remains higher than that observed in 1991, the historical low point. In particular, all of the Department-sponsored surveys that track youth substance use show that the rates increased during the early to mid parts of the 1990's and then leveled off or declined somewhat since.

The data make clear that far too many of our Nation's young people and their families continue to experience the risks, and often fatal consequences, that attend the use of illegal drugs and other substances. Nevertheless, recent trends in youth use of illegal substances provide a basis for cautious optimism that the joint efforts of parents, teachers, counselors, and public officials to educate youth about the dangers of illegal drug, alcohol, and tobacco use are bearing fruit. The Nation must buildupon the momentum gained in recent years against this major public health and social problem.

The Department welcomes the continuing interest of the subcommittee. I will respond as best I can to whatever questions you may have.

Mr. MICA. We will get to you in a few minutes. I would dispute some of your testimony.

[The prepared statement of Mr. Raub follows:]

TESTIMONY OF
WILLIAM RAUB, Ph.D.
SENIOR SCIENTIFIC ADVISOR TO THE SECRETARY
FOR SCIENCE POLICY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
before the
U.S. HOUSE OF REPRESENTATIVES, COMMITTEE ON GOVERNMENT REFORM,
SUBCOMMITTEE ON CRIMINAL JUSTICE,
DRUG POLICY, AND HUMAN RESOURCES
on
"IS DRUG USE UP OR DOWN? WHAT ARE THE IMPLICATIONS?"
September 19, 2000

Thank you, Mr. Chairman. My name is Dr. William Raub, Ph.D., and I am the Senior Scientific Advisor to the Secretary for Science Policy at the U.S. Department of Health and Human Services (DHHS). I am pleased to come before the Subcommittee today to highlight efforts undertaken by DHHS and its agencies during the past decade to monitor and track trends in youth drug use. These efforts have proven vital to the Department's goal of developing appropriate and targeted interventions designed to reduce the numbers of our nation's youth who use illegal drugs, alcohol and tobacco.

Today's hearing examines trends in youth substance use, and attempts to assess the implications of this data for guiding prevention and treatment efforts. Complex issues of critical policy importance, such as youth substance use and abuse, often require examination and analysis from multiple perspectives. Because no survey methodology is absolute or 100% precise, it is critical to get input from multiple sources to guide decision-making. Although it is often challenging to synthesize and "make sense" of contrasting information, such processes are essential to fully understanding the nature, magnitude, and scope of complex social problems such as youth substance use. Moreover, assembling this type of informed knowledge-base is

often a prerequisite to developing effective prevention and intervention strategies.

It is from this perspective that the Department of Health and Human Services approaches its data collection and analysis efforts related to substance use. Specifically, DHHS conducts several surveys that provide estimates of the percentage of youth who use illegal drugs, alcohol, and tobacco. In the interest of time, I will briefly describe each of these surveys, before discussing recent trends in youth substance use.

The Centers for Disease Control and Prevention (CDC) developed the Youth Risk Behavior Surveillance System (YRBSS) to provide vital information on specific behaviors that cause the most important health problems among youth in the United States. The system has collected comparable data among national, state, and local samples of youth, beginning in 1990, and repeatedly every other year since 1991. The YRBSS reports on behavior in six risk areas; namely: 1) tobacco use; 2) alcohol and other drug use; 3) behaviors resulting in unintentional injury and violence; 4) sexual behaviors contributing to unintended pregnancy and sexually transmitted diseases, including HIV infection; 5) unhealthy dietary behaviors; and 6) physical inactivity.

YRBSS was developed with input from state and local health and education agency representatives and experts in each categorical area. The questionnaire underwent extensive focus group and field test work at CDC's Questionnaire Design Research Laboratory to further refine the wording of the questions and their appropriateness for youth. The YRBSS

questionnaire contains 87 multiple-choice questions, 30 of which focus on tobacco, alcohol, and other drug use (including marijuana, cocaine, inhalant, heroin, methamphetamine, steroid, and injected drug use and being offered or sold an illegal drug on school property). Most tobacco, alcohol, and other drug use questions have remained unchanged since 1991. In 1992 and 2000, methodological studies were conducted to measure the reliability of the questions. In both studies, the tobacco, alcohol, and other drug use questions were found to produce highly reliable data from high school students.

Survey procedures are designed to protect students' privacy by allowing for anonymous and voluntary participation. Students complete the questionnaire during a regular class period under the direction of specially trained field staff. A computer scannable questionnaire booklet is used to record responses. Local parental permission procedures are followed before survey administration. Survey administration procedures have remain unchanged since 1990.

The national Youth Risk Behavior Survey (YRBS) is a major component of the YRBSS. This survey, conducted during the spring semester among national samples of high school students, provides data that are representative of all students in grades 9 though 12 in public and private schools in the 50 states and the District of Columbia.. In 1999, 15,359 surveys were completed in 144 schools. Schools are selected using a scientifically-based sampling process, and schools with a large percentage of African American and Hispanic students are over sampled to generate stable estimates each year for these subgroups of youth.

The National Institute of Drug Abuse sponsors the Monitoring the Future (MTF) Survey through a grant to the University of Michigan's Survey Research Center. The purpose of the survey is to assess the attitudes and behaviors of high school youth in a variety of areas, including and most notably, the areas of drug, alcohol and tobacco use. The survey provides unique data on both youth substance use and the attitudes and beliefs that may contribute to such behaviors.. The survey has been conducted annually among high school seniors since 1975, and has included 8th and 10th grade samples annually as well since 1991.

The survey is fielded in approximately 435 schools across the country, reflecting a nationally representative sample of both public and private high schools. The MTF is administered to 50,000 8th, 10th, and 12th grade students annually, with slightly more students in lower grades participating in the sample. Students complete self-administered paper-and-pencil questionnaires given to them in their classrooms by survey personnel. Participation is entirely voluntary, and students can refuse to participate if they so wish. In general, students' responses are confidential, however, respondents do provide some identifying information on a tear-off card. Beginning in 1999, all 8th and 10th grade responses are anonymous with no identifying information requested.

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Household Survey on Drug Abuse (NHSDA). Conducted by the Federal Government periodically since 1971, and annually since 1990, the NHSDA is the primary source of statistical information on the use of illegal drugs by the United States population. Moreover,

the Household Survey provides the only source of nationally-representative data on adult substance use in this country.

The survey is conducted with a nationally representative sample of the population through face-to-face interviews at their place of residence. The population covered by the survey is the civilian, noninstitutional population age 12 and older in the U.S., including all 50 States and the District of Columbia. The survey incorporates procedures that are likely to increase respondents' cooperation and willingness to report honestly about their illicit drug use behavior. Confidentiality is emphasized in all written and verbal communications with potential respondents, respondents' names are not collected with the data, and computer-assisted interviewing, including audio computer-assisted self-interviewing, are used to provide a private and confidential setting to complete the interview.

In 1999, the NHSDA underwent a major redesign, moving from a paper questionnaire administration to computer-assisted administration, and dramatically expanding the sample to almost 70,000 individuals (including approximately 25,000 youth between the ages of 12 and 17) to permit state as well as national prevalence estimates of substance use. However, due to these differences in methodology and the impact of the new design on data collection, only limited comparisons can be made between data from the 1999 survey and data obtained from surveys prior to 1999. In order to permit some trend comparisons, SAMHSA included within the 1999 survey a supplemental national sample of over 13,000 individuals employing the pre-1999 survey administration methodology. This supplemental sample permits SAMHSA to assess

trends from 1979 to 1999 for a limited set of substance use measures for youth age 12 to 17 as well as for some other age groups.

Taken together, these three surveys provide an unparalleled source of information to monitor and more fully understand trends in substance use and abuse. Each survey provides unique and important information that is useful to local, state, and national decision-makers attempting to address problems of substance use. Moreover, all three surveys were recently reviewed by a panel of outside experts who concluded that each survey is methodologically strong, well-designed for its intended purpose, and well administered.

I am please to report to you that data from these three surveys can help to resolve the central question posed in today's hearing: namely, is drug use going up or down. Generally, the reality is that all three Department-sponsored surveys indicate that the use of illegal drugs and tobacco among youth has leveled, and in some cases, declined over the last three years. However, despite the success of the last three years, it is also true that the use of illegal drugs and tobacco among youth remains higher than at the historically low-point of youth use in 1991. In other words, all of the Department-sponsored surveys that track youth substance use have consistently shown that rates which increased during the early to mid part of the 1990's have leveled and begun to decline during the latter part of the decade.

It is understandable that the fluctuations in youth substance use during the past decade, and the subsequent efforts to accurately report these trends, might have been inadvertently

confusing to some. Nevertheless, as I noted earlier, information from multiple data sources are essential, and these sources are consistent in suggesting a leveling, and in some cases, declining use of illegal drugs and tobacco among youth during the past three years. While it is clear that far too many of our nation's young people and their families continue to experience the destructive and often fatal consequences of drug addiction, these recent trends also provide some cautious optimism that the joint efforts of parents, teachers, counselors, and public officials to educate youth about the dangers of illegal drug and tobacco use are beginning to bear fruit.

We must all continue to work together to build upon the momentum we have gained in reducing illegal drug use among youth in this country. Without sustained attention to prevention and treatment efforts, we will undoubtedly see these trends in youth substance use begin again to increase.

I thank the members of this Subcommittee for their interest in this important topic. I and my colleagues from the Department stand ready to address questions you may have.

Mr. MICA. Let me recognize now Julie Samuels, acting director, National Institute of Justice.

Ms. SAMUELS. Mr. Chairman, Congresswoman Mink, and Congressman Ose, I appreciate the opportunity to participate in the subcommittee's review of drug use trends in America. The National Institute of Justice operates the Arrestee Drug Abuse Monitoring the Future Program, known as ADAM. I would like my prepared statement to be accepted for the record.

Mr. MICA. Without objection, your entire statement will be made part of the record. Proceed.

Ms. SAMUELS. NIJ is the Department of Justice's independent research and development agency. Our mandate is to build knowledge to meet the challenges of crime and drug use. NIJ developed ADAM to build knowledge about drugs, crime, and related social issues and to support local and national policymakers. ADAM's primary purpose is to provide timely information about drugs and crime, patterns of drug use and treatment, emerging drug trends, the effect of law enforcement on drug use, treatment needs, and a wide range of related issues and it does this by focusing on people who are arrested and booked into local lockups.

ADAM's data are collected in 35 different U.S. Counties every quarter. Within 48 hours of arrest, local ADAM staff interview arrestees and collect urine samples for drug testing. Participation in this program is voluntary and anonymous.

Four things distinguish ADAM from other surveys as a source of information about drug use in America: One, ADAM focuses on communities. From ADAM, we develop detailed use of drug use among arrestees in specific areas.

Two, ADAM focuses on arrestees. ADAM focuses on people who have been arrested, so the program provides a firsthand look at the connection between drugs and crime. These arrestees also represent a group of great concern.

Three, ADAM includes a drug test. In addition to asking each respondent questions about his or her drug use and drug treatment experiences, respondents also provide a urine sample that is laboratory tested for a variety of drugs. The scientific testing supplements the interview responses.

Four, ADAM offers a research platform. Building on the core ADAM program, NIJ has established a cost-effective way to undertake specialized studies on a broad range of public safety and public health issues related to drug use in the arrestee population, such as domestic violence or the dynamics of drug markets.

Consistently, ADAM's data have shown that about two of every three arrestees who participate in the program test positive for at least one of five drugs: cocaine, opiates, methamphetamines, marijuana, or PCP. In recent years our data have shown little overall decline in the level of drug use among arrestees. Perhaps the most important thing we have learned is that the drug problem is different in different communities around the Nation. For example, methamphetamine use among arrestees remained low in most ADAM communities in 1999 but continued to vary by region, with use clearly higher in the ADAM communities in the western part of the Nation.

As I mentioned earlier, ADAM is primarily designed to provide data on drug use among arrestees on the local level. In that sense it helps communities nationwide to understand their particular problems of drugs and crime from a local perspective.

At present, ADAM data do not readily lend themselves to national estimates of drug use among arrestees. Nonetheless, in the same way that ADAM can help local communities shape local responses to drug and crime, it can help inform national policymakers about trends and patterns in various regions in the United States.

We hope to expand ADAM to 75 sites. As part of our expansion, we would routinely collect data on arrestees not only in urban metropolitan centers, but also in rural, suburban, and Indian country. In addition to extending the ADAM program and its benefits to other communities, this expansion and the improved methodology would enable us to make national estimates of drug use among the arrestee population. Our expanded plan would also allow us to increase the specialized studies that can inform both local and national concerns about the problem of drugs and crime in the United States.

Mr. Chairman, that concludes my opening remarks. I would be pleased to answer any questions.

Mr. MICA. Thank you. We will hold questions until we have heard from all of the panel witnesses.

[The prepared statement of Ms. Samuels follows:]

STATEMENT

OF

JULIE E. SAMUELS

ACTING DIRECTOR
NATIONAL INSTITUTE OF JUSTICE
OFFICE OF JUSTICE PROGRAMS

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

ON

SEPTEMBER 19, 2000

REGARDING

THE ARRESTEE DRUG ABUSE MONITORING (ADAM) PROGRAM

Good Morning, Chairman Mica and Members of the Subcommittee on Criminal Justice, Drug Policy and Human Resources. I very much appreciate this opportunity to participate in your Subcommittee's review of drug use trends in America. The National Institute of Justice (NIJ), the Justice Department's research and evaluation agency, has a long history of working to provide important information to assist our nation's policy makers in crafting strategies to respond to our nation's multi-faceted drug problems.

This morning I will discuss one important research program that NIJ operates – the Arrestee Drug Abuse Monitoring Program, known as ADAM. ADAM builds on the successes of the Drug Use Forecasting Program (DUF) by using more sophisticated methods and by involving more communities. For 14 years, through the collection and publication of these research data, NIJ has been helping communities nationwide to understand the problems of drugs and crime from the local perspective. With ADAM, local criminal justice policy makers and practitioners – from police to drug court judges, to drug treatment providers – are given a "window onto the world of offending" that no other crime data provide, making them better informed about the specific dimensions of drugs and crime in their community.

ADAM also has the potential to provide a national perspective of the link between drugs and crime. The ADAM data help us to understand regional patterns of drug use and how those patterns shift over time. At the present time, ADAM is not configured to provide a single national estimate of arrestee drug use. One of ADAM's goals is to be able to generate precise, statistically based, national estimates from data collected from a network of 75 ADAM sites.

The President's budget included a request that would allow us to continue toward this effort.

Before discussing the policy implications of what we have learned from ADAM, it is important to first explain how this unique data collection system works. Each quarter, in 35 communities nationwide, persons arrested and held in local lock-ups and jails for a wide range of crimes are interviewed and asked to provide a urine specimen to be tested for recent use of drugs. Through this local reporting, each year NIJ collects information on drug use, criminal activity, drug treatment, and a wide array of related information from over 40,000 male and female adult arrestees and 3,000 juveniles. Also, through special projects, ADAM periodically provides useful information about related issues, including drugs and firearms, drugs and HIV, domestic violence, and gambling.

More specifically, at each ADAM site, within 48 hours of arrest local ADAM staff interview and drug-test individuals held in lockups and booking centers for a wide variety of offenses. Respondents are identified by a scientific process and their participation in the program is voluntary and anonymous. Typically, about 8 of every 10 arrestees asked to participate will do so.

ADAM sites are managed by local site directors and coordinators who form partnerships with local law enforcement and corrections agencies. Interview data are forwarded to the national ADAM Data Center for analysis and urine samples from all sites are sent to the same laboratory for testing.

Unlike the other surveys being discussed here today, ADAM is designed to provide policy-relevant data from the community level. Rather than generating a single national estimate from which communities can only guess about their local drug problem, ADAM provides meaningful data at the local level that have relevance to the activities, policies, and programs of communities. All crime is local – including drug use. Local research data is necessary to fashion local solutions.

ADAM is the only national drug survey that routinely provides data on hard-core drug users. In addition, the ADAM juvenile samples routinely include a portion of youth who do not attend school regularly. Consistently, ADAM brings researchers into contact with persons who regularly use illicit drugs – and whose drug use can be readily linked to other illegal behavior. As a result, ADAM is uniquely positioned to provide a vivid picture of the consequences of illegal drug use in terms of crime and public safety in a way no other data system can.

Also, ADAM is the only national drug data system that includes a routine drug test as part of the data collection. In addition to an extensive interview, arrestees are asked to provide a urine specimen that is tested in a laboratory for evidence of recent drug use and type of drugs used. ADAM is the only national data system to do this. The urine testing provides reliable evidence of drug use that cannot always be obtained through an interview. In addition to the drug test, an extensive interview is used to collect information on public health issues, related criminal activity, drug purchasing and drug use behavior.

Understanding the drug use of arrestees is key to providing an effective criminal justice response to drugs and crime. Arrestees represent the "wide end of the criminal justice funnel," from which come all jail detainees, defendants, convicted offenders, and prison inmates. Understanding arrestees – and their drug use – is the first step in understanding how best to provide effective responses to drug use at every stage of the criminal justice process. And as offenders are being returned to our neighborhoods and communities in increasing numbers, understanding the link between drugs and crime among arrestees can help advance every aspect of public safety in our communities.

Arrestees in the ADAM sample have been arrested for a wide variety of offenses – not just drug offenses. As a result, ADAM provides crucial information about drug use among persons arrested for property crimes, for violent crimes such as domestic violence or assault, for prostitution, and for misdemeanor quality-of-life offenses.

Consistently, ADAM interviews and drug tests have revealed drug use levels among arrestees that are higher than any found in general population surveys. Drug use among arrestees carries the special significance of linking drug use with other criminal activity: drug users found by ADAM have already come to the attention of the criminal justice system, having been arrested and booked for a crime.

I have provided the Subcommittee with the 1999 ADAM Annual Report, and I would like that report to be made a part of the record. I would like to highlight just a few key policy-

relevant findings from that report. Notably, ADAM data continue to show that drug problems are different in different communities. In recent years through 1999, there has been little overall decline in the level of drug use among arrestees tested for the ADAM program. More specifically, in 1999 about 2 of every 3 arrestees in the ADAM sample tested positive for at least one of five drugs (cocaine, opiates, methamphetamine, marijuana, PCP). Also, in 1999 the drug most widely used by women in the ADAM sample was cocaine, and by men marijuana. Methamphetamine use among arrestees remained low in most ADAM communities in 1999, but continued to vary by region -- with use clearly higher in the ADAM sites in the western part of the nation.

Interestingly, data from ADAM urine testing of arrestees has demonstrated that the level of offender drug use is about twice as high as had previously been reported by offenders who were simply asked about their own drug use.

ADAM data have been useful for tracking drug epidemics. For example, ADAM data were used to track the increasing level of cocaine use among arrestees tested in ADAM communities during the late 1980s, and more recently tracked the aging of cocaine users in the ADAM samples. Also, ADAM data have been used to document the increasing use of marijuana among young offenders in the ADAM community samples during the 1990s. In response to media warnings about the coming of "ice" (a smokeable form of methamphetamine) to urban U.S. communities during the early 1990s, ADAM data were used to demonstrate that methamphetamine use remained a local, rather than a national phenomenon. ADAM data have

also shown that methamphetamine use has been more prevalent among female arrestees in the ADAM samples than male arrestees in the ADAM samples.

ADAM also permits us to conduct special studies. From these, for example, we have learned that the use and sale of methamphetamine was more prevalent among arrestees in some rural communities in Nebraska compared to the nearby urban area. Drug sellers/gang members own or have access to firearms at very high rates. And, used in conjunction with Drug Enforcement Administration STRIDE data, ADAM data have been used to demonstrate that higher prices for illicit drugs results in reduced demand for illicit drugs among arrestees. With its cutting-edge data collection techniques and through a redesigned sampling system, and with data "links" to other national drug data systems, like DAWN and NHSDA, ADAM has become a premiere information system for understanding the link between drugs and crime.

In our vision, one day ADAM will operate in 75 urban centers as the backbone of its data system. There will also be a special element targeted on rural data collection that will be able to examine and report on the level of drug use among arrestees outside of the central cities of the United States, in the mid-size, small communities, and rural areas of our states.

Since its inception as DUF, ADAM has continued to grow and meet new policy and practice needs through special data collection and analysis. As a "research platform," ADAM provides us with an unparalleled opportunity to study in-depth issues related to drug use and offending, like sexually transmitted diseases, the dynamics of drug markets, the need for use of

treatment among drug users, and broader issues of public safety and public health. At all times, we remain committed to our overall goal to make ADAM an important source of information about drugs and crime that will regularly inform local, regional, and national policy and practice. We are proud of our efforts to date to develop a sophisticated, scientific, fiscally sound, and practical program for collecting data about the drug involvement of arrestees, a population of hardcore drug users that we would otherwise know little about.

I have appended to my statement a list of the key publications that are drawn from ADAM data. These varied reports demonstrate how we can use the results of this research to inform policy and program development. All of these products are accessible from the ADAM Website at **http://www.adam-nij.net/report.htm** or from our clearinghouse.

Mr. Chairman, I appreciate the interest of the Subcommittee in the important challenges of understanding the many drug trend data available. I would be pleased to answer any questions that you or the Members of the Subcommittee may have.

Thank you.

Appendix to the Statement of Julie E. Samuels, Director, National Institute of Justice before the House Subcommittee on Criminal Justice, Drug Policy and Human Resources, September 19, 2000 regarding the Arrestee Drug Abuse Monitoring (ADAM) Program.

All of these key documents are accessible from the ADAM Website at **http://www.adam-nij.net/report.htm.**

Research Report, 1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees by the National Institute of Justice, July 2000
Summary, Full Text: Adobe Acrobat Files, Summary of Findings, Overview, and Methodology, Adult Program Findings, and Juvenile Program Findings

Research in Brief, Drugs in the Heartland: Methamphetamine Use in Rural Nebraska by Denise C. Herz, April 2000
Summary, Full Text: ASCII Text File and Adobe Acrobat File

Final Report, Methamphetamine Interagency Task Force by Jeremy Travis and Donald R. Vereen Jr., M.D., M.P.H., Cochair Designates, January 2000
Summary, Full Text: ASCII Text File and Adobe Acrobat File

1998 Annual Report on Drug Use Among Adult and Juvenile Arrestees, Research Report, by NIJ, April 1999
Summary, Full Text: ASCII Text File and Adobe Acrobat File, Adult Program Findings: Adobe Acrobat File, Juvenile Program Findings: Adobe Acrobat File

1998 Annual Report on Cocaine Use Among Arrestees, Research Report, by NIJ, April 1999
Summary, Full Text: ASCII Text File and Adobe Acrobat File

1998 Annual Report on Marijuana Use Among Arrestees, Research Report, by NIJ, April 1999
Summary, Full Text: ASCII Text File and Adobe Acrobat File

1998 Annual Report on Methampetamine Use Among Arrestees, Research Report, by NIJ, April 1999
Summary, Full Text: ASCII Text File and Adobe Acrobat File

1998 Annual Report on Opiate Use Among Arrestees, Research Report, by NIJ, April 1999

Summary, Full Text: ASCII Text File and Adobe Acrobat File

Comparing Drug Use Rates of Detained Arrestees in the United States and England, Research Report, by Bruce Taylor and Trevor Bennett, April 1999
Summary, Full Text: ASCII Text File and Adobe Acrobat File

Meth Matters: Report on Methamphetamine Users in Five Western Cities, Research Report, by Susan Pennell, Joe Ellett, Cynthia Rienick, and Jackie Grimes, April 1999
Summary, Full Text: ASCII Text File and Adobe Acrobat File

Crack, Powder Cocaine, and Heroin: Drug Purchase and Use Patterns in Six U.S. Cities - ASCII Text File and Adobe Acrobat File

Crack's Decline: Some Surprises Across U.S. Cities - ASCII Text File and Adobe Acrobat File

Mr. MICA. Next we will hear from Dr. Johnston who is with Monitoring the Future Project, the University of Michigan.

Mr. JOHNSTON. Thank you, Mr. Chairman and members of the committee. I appreciate this opportunity to testify. My name is Lloyd Johnston. I am a research scientist and principal investigator of the Monitoring the Future study at the University of Michigan. That study, as Mr. Raub mentioned, is now in its 25th year, and we have tracked American high school seniors for that entire period on an annual basis. In 1991, we added younger adolescents, 8th and 10th graders, fortunately at a point where it was helpful in interpreting what was going on.

This is an investigator-initiated research grant, which means that the scientists responsible came up with the idea, brought it before NIH for competitive review and must bring it back every 5 years for continued competitive review. The surveys involve in-school student-based samples as opposed to, for example, people in a household. They are large and nationally representative at each of the three grade levels. Each is a separate national survey independently selected; altogether we have close to 50,000 students per year located in some 430 secondary schools.

A less well known feature of the design is that we also follow some of each year's graduating high school class into adulthood by use of mail surveys, sent through the mail, and these give us a very nice national sample of American college students and eventually young adults of various ages who are high school graduates. We have people who are 40 years old whom we initially surveyed when they were high school seniors.

We have over the years given great priority to consistency of methods in this study so that we don't confuse methodological changes with real underlying changes in the phenomenon understudy.

As far as timeframe, our data are collected in the spring, primarily in March through May, and therefore we have a somewhat different time reference in the year than the National Household Survey which you will hear more about.

The content coverage is broad. We go into a great many substances, in excess of 30 categories and subcategories of substances, as well as many characteristics of the person and surrounding attitudes and beliefs that may help explain the use of these individual drugs.

As for recent trends, the most recent data are from the spring of 1999. The 2000 survey, while complete, is not ready for release and will not be until December. The results of the study are provided in a blue book of which I hope there are enough copies for all the committee members—called Overview of Key Findings, which gives a brief synopsis for each of the categories of drugs.

Several things to mention, one of which is that it is clear that the peak of the American epidemic was in the last third of the 20th century, the late seventies, beginning of the eighties. There was a long period of decline in use in all age groups, including the ones that we monitor, and that decline ended in the beginning of the 1990's. There then was a period of increase again, among adolescents only, a rather interesting development. Up to that point, almost all of the age groups were moving in parallel, and then sud-

denly adolescents began to show an increase in the 1990's that was not observed even among young adults.

You have alluded to the scale of that change, and what we saw was that by 1996, the 8th graders reached a peak level and there was an inflection point and use has been declining since then. The older adolescents reached an inflection point a year later in 1997, and the 12th graders thereafter have remained level in their use, and the 10th graders have shown some decline, although there was not much decline in any of these groups in 1999 specifically.

I might note that the eighth graders, the youngest of the students that we looked at, were the first to show the increase in the 1990's and also the first to show the decrease in the 1990's, which suggests to me that the younger children who really haven't established attitudes and patterns in this area yet are the most susceptible to the forces of change, whatever those forces might be—good or bad.

It also helps to explain why there are some differences in the results of the surveys, since our surveys cover somewhat different age bands. The Household Survey was down to age 12, and we start at 13 and 14.

Since those peaks, as I say, there has been some change, mostly in the younger children. And in 1999, only the eighth graders showed any further decline in overall illicit drug use. But nevertheless all groups showed some decline in some specific drugs. We saw some divergence of different classes of drugs. While heroin and marijuana and amphetamines remain fairly stable in 1999, a number did decline. Inhalants, crystal methamphetamine, crack cocaine, a very important drug, showed a decline for the first time among the eighth graders.

So there was some good news in that year, and there were two pieces of bad news. One was the increase of ecstacy, a sharp increase among the 10th and 12th graders. Ecstacy is also called MDMA, and we know from our surveys of young adults that ecstacy use has been climbing among those in the first half of the 20's through age 26. So we have clearly seen the emergence of an epidemic of use among those in the late teens, early 20's, of so-called club drugs.

Steroids also bumped up in 1999 among the younger children, 8th to 10th graders, perhaps for some very specific reasons. So in fact there has been a divergence, which I think helps to illustrate the point that different drugs to some degree march to their own drummers. As youngsters learn about the hazards of a drug, they are less likely to use. As peer disapproval emerges, they are less likely to use. With ecstasy or GHB and others which always are coming along, I think they enjoy a certain period of suspended judgment, as it were, what I call a "honeymoon period," where their alleged benefits are circulated among youngsters, but their effects are not yet well documented and convincingly communicated to youngsters. And I think that was the case with GHB related to the tragic story that we heard earlier from the first panel.

Another thing to note is that cohort effects have emerged, and the teens of the early 1990's are continuing to carry with them into young adulthood higher rates of drug use. The kids who were entering teenagehood in the late 1990's have lower rates of drug use,

which is the good news part of the story. We have not always seen these cohort effects in the past, but it clearly occurred, and I think it was because the kids who grew up in the late 1980's and the early 1990's saw so much less drug use around them, they saw much less of the consequences, the tragic consequences of use, and they came to see these drugs as less dangerous than their predecessors who had more direct observation of what happened.

Finally, you noted the increase in death rates, and that, of course, is a tragic fact. Death rates and some other consequences such as entering treatment do tend to occur on a lagged basis from when we actually see an increase in the prevalence of using the drugs. For example, cocaine use spread considerably in the late seventies, but it wasn't until the early eighties that we began to see a rise in deaths in people calling emergency hotlines and in people entering treatment and various other kinds of effects. So some of these indicators are what I call lagged indicators. And I think the spread of heroin earlier in the decade is probably one of the contributing factors to the death rates that are now rising because many of those people are still using heroin, and through a natural process of involvement, have become more involved and more susceptible to overdose.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Johnston follows:]

Testimony Submitted to

The Subcommittee on Criminal Justice, Drug Policy and Human Resources,
Government Reform Committee
United States House of Representatives

for hearings on
"Drug Use Trends in America"

September 19, 2000

By

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Thank you, Mr. Chairman, for this opportunity to testify at this hearing on "National Drug Use Trends in America." Since we have had extensive experience tracking, and trying to understand, the trends in licit and illicit drug use among young Americans over the last 30 years, I would like to share with you some of what we have learned which is of particular relevance to this hearing. The findings about which I will be speaking derive from the national study *Monitoring the Future*.

As to my background, I am a social psychologist by training and hold the title of Distinguished Research Scientist at the University of Michigan. I have been the principal investigator of the ongoing *Monitoring the Future (MTF)* study of American adolescents and young adults since it was launched 25 years ago. Prior to the launching of that study I authored the book *Drugs and American Youth* (Johnston, 1973), based on a prior national study, in which I reported the earliest national student survey data on adolescent drug use. I have also served as a member of the White House Conference for a Drug Free America; the National Commission for Drug Free Schools; the National Advisory Council on Drug Abuse; and various other national and international advisory bodies.

The Monitoring the Future Study

Under a series of investigator-initiated, competing research grants from the National Institute on Drug Abuse, which funds *Monitoring the Future*, my colleagues and I have conducted an annual national survey of 12th grade students in the coterminous United States each year since 1975. Starting in 1991 we have also surveyed nationally representative samples of 8th graders and 10th graders annually, with the result that some 45,000-50,000 students located in approximately 420 secondary schools now participate in the survey each year. (The results are published in an annual series of scientific monographs, e.g., Johnston, O'Malley, and Bachman, 1999a). The samples are drawn independently for each of the three grade levels (8, 10, & 12) and are drawn to be representative of all students attending that grade in both private or public schools in the spring of any given year.

I should also mention that we conduct follow-up surveys by mail of a randomly selected subsample of the participants in each year's graduating 12th grade class; we began doing this with the class of 1976. From these follow-up surveys we can now generate drug use estimates for adult high school graduates through age 40. These relatively low-cost data collections also provide annual estimates of substance use by American college students, and have done so since 1980. The results of these college-student and young-adult surveys are reported each year in a separate series of monographs (e.g., Johnston, et al., 1999b). These follow-up or "panel" studies can be used to address multiple scientific purposes, only one of which is prevalence and trend estimation for these segments in the population. Having data on the same individuals over time also permits us to examine the natural history of use, as well as the effects of a great many environmental and role transitions (leaving the parental home, going to college, becoming employed, serving in the military, becoming engaged, marrying, becoming a parent, divorcing, remarrying, etc.).

Design Features of *Monitoring the Future*

I understand that one of the purposes of this hearing is to compare results across surveys. Therefore, let me begin by noting some of the MTF design features which are important when comparing the results from this study with those from any of the other national scientific studies, such as the *National Household Survey on Drug Abuse (NHSDA)* and the *Youth Risk Behavior Study (YRBS).*

Timing. MTF is conducted in the spring of each year with data collection occurring from February through June, but with the majority of the fieldwork completed in March through May. The NHSDA collects data for a given year continuously from January through December, and thus they are finished with data collection roughly 6 months later in any given year. (In other words, their 1999 survey are collected in January through December of 1999 whereas our "1999" data are collected in February through June of

1999.) Their results for a given named year are, therefore, released some months after ours, but refer to a somewhat longer interval than ours.

Our findings on secondary school students are released through press releases and a press conference in early to mid-December of the year in which the data were collected. We then issue an *Overview of Key Findings* report a month or two later (e.g., Johnston, O'Malley, and Bachman, 2000), followed by a much larger monograph reporting the detailed results from secondary students about mid-year (Johnston, et al., 1999a). A second detailed monograph of results on the college students and adults (e.g., Johnston, et al., 1999b) follows a few months after that. (The results from the follow-up surveys are released later because the data collection itself runs later into the year.)

Samples. Our initial samples are taken in school, like those of YRBS but unlike those of NHSDA, which are taken in households. Because of dropping out, we miss from 15 to 20 percent of 12th graders who have left school, judging from Census estimates. However, the 8th and 10th grade estimates should be much less affected by this loss, since dropping out is much lower at *those* grade levels. (The college student estimates should be unaffected.) Even for the 12th graders, trend estimates should be little affected by the omission of dropouts, since dropout rates have not *changed* very much during the life of the study. (Our annual monograph devotes an entire appendix to a consideration of these issues. See Johnston, et al., 1999a.)

MTF generates grade-specific estimates based on large independent samples at each grade studied (8, 10, and 12), whereas YRBS draws its sample to represent a set of grades (9 through 12).

Field procedures. The MTF data are collected with self-administered questionnaires given to groups of students, usually right in their normal classrooms. This procedure is much like that used for the YRBS, but quite different from that used in the NHSDA, in which an interviewer individually administers an instrument in the home setting. The MTF questionnaires are comprised entirely of closed-ended questions (i.e., the answer

categories are all pre-specified) and the forms are designed for optical scanning of the answers. Thus no handwriting is contained. University of Michigan personnel conduct the administrations in the school and remove the questionnaires from the schools immediately after the administrations. Extensive procedures are used to protect respondent confidentiality.

Content coverage. MTF has an exceptionally broad coverage of (1) substances being studied; (2) attitudes, beliefs, and perceived availability directly related to those various substances; (3) behaviors and attitudes in other domains; and (4) other characteristics of individuals and their contemporary social environments. In the case of the follow-up respondents, we also have rich data on many transitions in life roles and social environments. There is also some information gathered about exposure to various programs and other interventions aimed at reducing substance abuse, such as the anti-drug media campaigns.

In addition to having data on tobacco, alcohol, and steroid use, we also gather information on a host of the illicit drugs. These range from marijuana, LSD, other hallucinogens, PCP specifically, cocaine, inhalants, amphetamines, sedatives, tranquilizers, heroin and other narcotics—to some of the more esoteric and recent drugs to come onto the scene such as crystal methamphetamine ("ice"), crack, Rohypnol, and "ecstasy" (MDMA). As the smorgasbord of available substances has proliferated over the years, we have tried to add to the list those that seemed to be the most important. For example, ketamine and GHB have now been added to the year 2000 questionnaires.

Methodological consistency. One of our major objectives in the MTF study has been to retain methodological consistency over the years, so that changes in methods do not give rise to artifactual changes in results. In other words, we want to avoid methodologically induced change which could be mistaken for real change in the underlying phenomena (e.g., levels of substance use). This has meant holding constant definitions of the universe, sampling methods, data collection procedures, instrument structure, question and answer wordings, question sequences (and thus question context), etc. Having the

same set of scientists making the hundreds of scientific judgments that must be made over the years in the conduct of such a study has gone a long way toward enabling us to fulfill this objective.

Some degree of change is necessary, of course, because reality changes. New drugs appear, a few fade into oblivion, new efforts are initiated to reduce substance abuse (i.e., the national parent movement and the anti-drug media campaigns, etc.) When there is compelling reason to make changes in response to these changing conditions (usually by adding question content), we have made every effort to minimize and/or quantify the impact of such changes on the other things already being measured. Overall, I think we have been quite successful at this.

Findings on Recent Trends in Drug Use

The most recent MTF data available on trends in substance use by young people are from the surveys conducted in the spring of 1999. Those from the year 2000 survey will not be available until this December.

An overview of the findings up to, and including, the 1999 survey of secondary school students is given for all classes of drugs in Johnston, et al., 2000. I would be glad to make copies of this report available to the Subcommittee. What it shows is that the recent peak in overall illicit substance use was reached in 1996 among 8th graders, and in 1997 among 10th and 12th graders. (It should be noted that 8th graders were not only the first to show the downturn in use, they were also the first to show the upturn in use at the beginning of the '90s.)

Having reached its recent peak, annual prevalence of using <u>any illicit drug</u> remained level for 12th graders from 1997 through 1999, but among the 8th and 10th graders it has shown some decline from the peak levels (in 1996 and 1997, respectively) through 1999. (See Figure 1 and Table 2, attached.) In 1999, specifically, the use of many drugs

appeared to remain fairly level among secondary school students, although some were in decline (such as inhalants, Rohypnol, crystal methamphetamine, and crack cocaine) and some showed important increases in use (ecstasy among 8th and 10th graders, and steroids among 10th and 12th graders). We know from our follow-up surveys that ecstasy use also rose substantially among 19- to 26-year-olds during the latter half of the '90s.

Not all substances move in parallel, because to some degree there are factors specifically influencing each one—such things as the degree of risk associated with using the drug, the extent of peer disapproval of its use, and the alleged benefits of use. New substances are now coming onto the scene with a certain numbing regularity, each with its own proponents and each with its initial set of supposed virtues. The advent of the Internet, with its chat rooms and many specialized sites, I believe, has made the diffusion process more rapid and perhaps more effective.

It takes some time for the adverse consequences of a drug to begin to show up, be clinically or scientifically documented, and then be convincingly communicated to the general population. (See Johnston, 1991, for a more detailed discussion of this process.) We have demonstrated that, once that happens, use tends to subside; but until that happens, use is likely to spread (as we have seen with ecstasy in recent years).

Interestingly, the resurgence of drug use in the early '90s was specific to adolescents—young adults and older adults did not show it until those adolescents grew older and *became* the young adults. (This reflects a pattern of change we call a "cohort change," which means that the change does not occur in parallel for different age groups but rather differentiates different birth cohorts from one another across time, controlling for age.) We have been reporting this emerging cohort-related change for a number of years now. (See Figure 2.) We have interpreted it to mean that a newer generation of young people, who grew up in the late '80s and early '90s, learned much less about the dangers of drugs than did their predecessors. We have used the term "generational forgetting" to

label this loss of knowledge by the country's youth of the dangers of drugs as generational replacement occurs.

We believe this generational forgetting of the dangers of drugs reflected the impact of a number of forces that roughly coincided. For one, young people were witnessing less use among their friends and among public figures than had their predecessors, since drug use rates had declined so much. Also, the media news coverage of the drug issue dropped precipitously around the buildup to the Gulf War, perhaps in part because the problem had subsided considerably. Thus, young people were being exposed to many fewer messages about the dangers of drugs in the news or, for that matter, through the airing of the anti-drug commercials, which also were in decline in that period. The federal budget for drug prevention programs in the schools declined appreciably in the early '90s; and I suspect that parents were communicating less with their children about drugs (though I am not aware of any empirical evidence documenting this). Finally, certain segments of the entertainment industry—in particular, the recording industry—began to glamorize drug use again in the '90s, as did the fashion industry with its "heroin chic" look.

The leveling and beginning of a correction in youth drug use, which seems to have occurred in the late '90s, may well reflect the reversal of many of these influences. For example, more young people and their public role models are using drugs and have begun to exhibit the consequences, thus providing an opportunity for vicarious learning by youth. The news media increased considerably their coverage of the drug issue, as studies like our own drew attention to the fact that the problem was getting worse. New anti-drug commercial campaigns were launched (against inhalants and heroin, for example), and the breadth and scale of the overall campaign have been boosted considerably with the addition of government funding. There is evidence to suggest that parents are talking more to their children about drugs, and federal support for drug abuse prevention in the schools has been increased. Even the recording and fashion industries have drawn in their horns considerably on the drug issue, partly in response to some drug-related tragedies among their own number.

But, even if overall drug use continues a downward pattern—and we do not know yet from our own study if it will—that does not mean that new drugs like ecstasy will not appear on the scene and show considerable popularity. My guess is that this new-drug phenomenon will continue to occur, and that it will make it difficult for us to feel that we ever have the "drug problem" quite under control. Indeed, we would be wise to never think that we have it under control, since that is precisely when we are most likely to forget one central fact. There is always a new generation of youngsters just around the corner who do not yet know anything about the dangers of drug use; and, if we do not have effective means for telling them, they are likely to find out for themselves the hard way.

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Figure 1
Trends in Illicit Drug Use

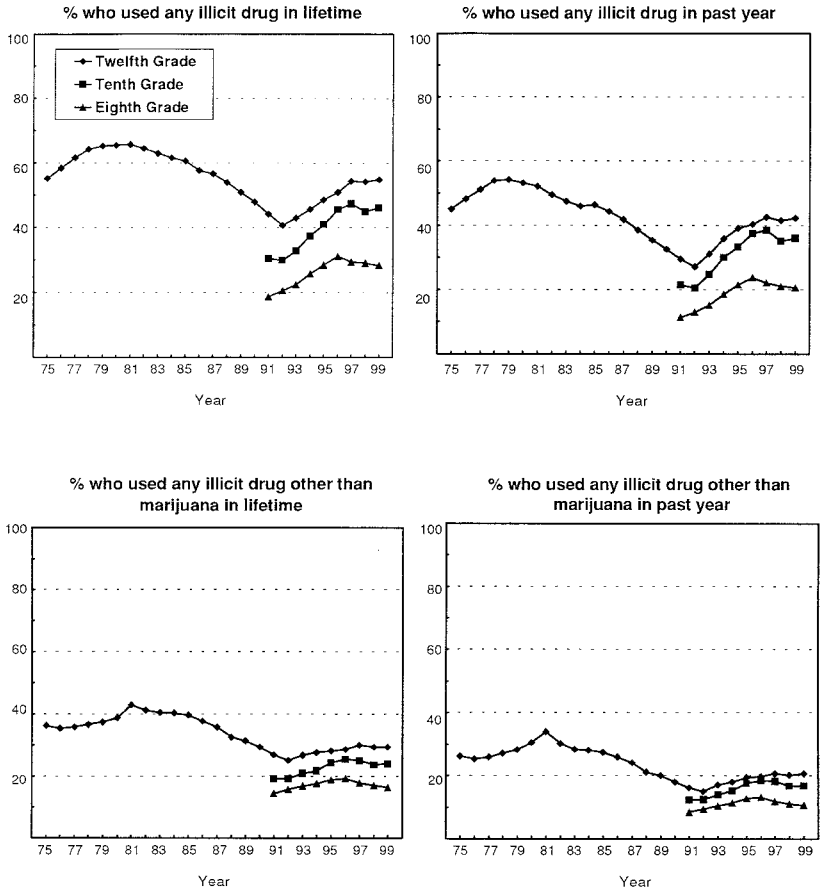
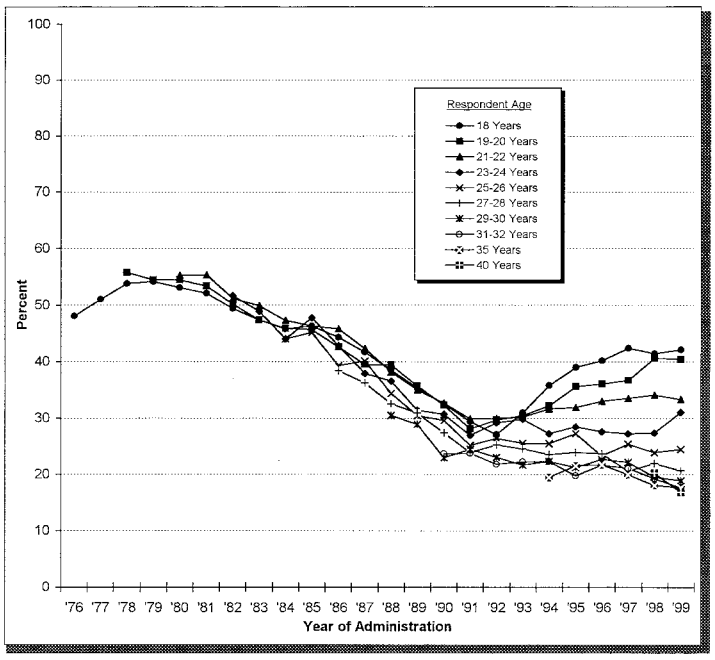


Figure 2
Any Illicit Drug Use: Trends in Annual Prevalence



Age of Respondent	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'98-'99 change
18 Years	48.1	51.1	53.8	54.2	53.1	52.1	49.4	47.4	45.8	46.3	44.3	41.7	38.5	35.4	32.5	29.4	27.1	31.0	35.8	39.0	40.2	42.4	41.4	42.1	+0.7
19-20 Years			55.8	54.5	54.5	53.4	50.2	47.4	45.9	45.7	42.6	39.5	39.4	35.7	32.3	28.1	29.7	30.5	32.2	35.6	36.1	36.7	40.6	40.4	-0.1
21-22 Years					55.3	55.4	51.2	49.9	47.3	46.3	45.8	42.3	38.2	35.0	32.7	29.9	30.0	30.2	31.6	31.9	33.0	33.5	34.1	33.3	-0.8
23-24 Years							51.7	48.9	44.0	47.8	42.8	37.9	36.6	31.4	30.7	27.0	29.2	29.8	27.3	28.5	27.6	27.3	27.4	31.1	+3.6s
25-26 Years									44.0	45.2	39.3	40.1	34.4	30.5	29.6	25.2	26.4	25.6	25.5	27.3	23.4	25.4	23.9	24.5	+0.7
27-28 Years											38.4	36.2	32.5	30.9	27.4	23.9	25.3	24.6	23.6	23.9	23.7	20.7	22.0	20.8	-1.3
29-30 Years													30.5	28.9	23.0	24.5	23.1	21.7	22.4	21.3	22.7	22.2	19.6	19.0	-0.6
31-32 Years															23.7	23.8	21.9	22.3	22.4	19.8	21.7	21.2	19.3	17.7	-1.5
35 Years																			19.5	21.6	21.8	20.0	18.1	17.7	-0.4
40 Years																							20.3	16.9	-3.5s

TABLE 1

Trends in Annual and 30-Day Prevalence of Use of Various Drugs for Eighth, Tenth, and Twelfth Graders

	Annual										30-Day									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	'98–'99 change	1991	1992	1993	1994	1995	1996	1997	1998	1999	'98–'99 change
Any Illicit Drug[a]																				
8th Grade	11.3	12.9	15.1	18.5	21.4	23.6	22.1	21.0	20.5	-0.5	5.7	6.8	8.4	10.9	12.4	14.6	12.9	12.1	12.2	+0.1
10th Grade	21.4	20.4	24.7	30.0	33.3	37.5	38.5	35.0	35.9	+0.9	11.6	11.0	14.0	18.5	20.2	23.2	23.0	21.5	22.1	+0.6
12th Grade	29.4	27.1	31.0	35.8	39.0	40.2	42.4	41.4	42.1	+0.7	16.4	14.4	18.3	21.9	23.8	24.6	26.2	25.6	25.9	+0.3
Any Illicit Drug Other Than Marijuana[a]																				
8th Grade	8.4	9.3	10.4	11.3	12.6	13.1	11.8	11.0	10.5	-0.5	3.8	4.7	5.3	5.6	6.5	6.9	6.0	5.5	5.5	0.0
10th Grade	12.2	12.3	13.9	15.2	17.5	18.4	18.2	16.6	16.7	+0.1	5.5	5.7	6.5	7.1	8.9	8.9	8.8	8.6	8.6	0.0
12th Grade	16.2	14.9	17.1	18.0	19.4	19.8	20.7	20.2	20.7	+0.5	7.1	6.3	7.9	8.8	10.0	9.5	10.7	10.7	10.4	-0.3
Any Illicit Drug Including Inhalants[a,b]																				
8th Grade	16.7	18.2	21.1	24.2	27.1	28.7	27.2	26.2	25.3	-0.9	8.8	10.0	12.0	14.3	16.1	17.5	16.0	14.9	15.1	+0.2
10th Grade	23.9	23.5	27.4	32.5	35.6	39.6	40.3	37.1	37.7	+0.6	13.1	12.6	15.5	20.0	21.6	24.5	24.1	22.5	23.1	+0.6
12th Grade	31.2	28.8	32.5	37.6	40.2	41.9	43.3	42.4	42.8	+0.4	17.8	15.5	19.3	23.0	24.8	25.5	26.9	26.6	26.4	-0.2
Marijuana/Hashish																				
8th Grade	6.2	7.2	9.2	13.0	15.8	18.3	17.7	16.9	16.5	-0.4	3.2	3.7	5.1	7.8	9.1	11.3	10.2	9.7	9.7	0.0
10th Grade	16.5	15.2	19.2	25.2	28.7	33.6	34.8	31.1	32.1	+1.0	8.7	8.1	10.9	15.8	17.2	20.4	20.5	18.7	19.4	+0.7
12th Grade	23.9	21.9	26.0	30.7	34.7	35.8	38.5	37.5	37.8	+0.3	13.8	11.9	15.5	19.0	21.2	21.9	23.7	22.8	23.1	+0.3
Inhalants[b,c]																				
8th Grade	9.0	9.5	11.0	11.7	12.8	12.2	11.8	11.1	10.3	-0.8	4.4	4.7	5.4	5.6	6.1	5.8	5.6	4.8	5.0	+0.2
10th Grade	7.1	7.5	8.4	9.1	9.6	9.5	8.7	8.0	7.2	-0.8	2.7	2.7	3.3	3.6	3.5	3.3	3.0	2.9	2.6	-0.3
12th Grade	6.6	6.2	7.0	7.7	8.0	7.6	6.7	6.2	5.6	-0.6	2.4	2.3	2.5	2.7	3.2	2.5	2.5	2.3	2.0	-0.3
Nitrites[d]																				
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	0.9	0.5	0.9	1.1	1.1	1.6	1.2	1.4	0.9	-0.5	0.4	0.3	0.6	0.4	0.4	0.7	0.7	1.0	0.4	-0.6[s]
Hallucinogens[e]																				
8th Grade	1.9	2.5	2.6	2.7	3.6	4.1	3.7	3.4	2.9	-0.5	0.8	1.1	1.2	1.3	1.7	1.9	1.8	1.4	1.3	-0.1
10th Grade	4.0	4.3	4.7	5.8	7.2	7.8	7.5	6.9	6.9	0.0	1.6	1.8	1.9	2.4	3.3	2.8	3.5	3.2	2.9	-0.3
12th Grade	5.8	5.9	7.4	7.6	9.3	10.1	9.8	9.0	9.4	+0.4	2.2	2.1	2.7	3.1	4.4	3.5	3.9	3.8	3.5	-0.3
LSD																				
8th Grade	1.7	2.1	2.3	2.4	3.2	3.5	3.2	2.8	2.4	-0.4	0.6	0.9	1.0	1.1	1.4	1.5	1.5	1.1	1.1	0.0
10th Grade	3.7	4.0	4.2	5.2	6.5	6.9	6.7	5.9	6.0	+0.1	1.5	1.6	1.6	2.0	3.0	2.4	2.8	2.7	2.3	-0.4
12th Grade	5.2	5.6	6.8	6.9	8.4	8.8	8.4	7.6	8.1	+0.5	1.9	2.0	2.4	2.6	4.0	2.5	3.1	3.2	2.7	-0.5
Hallucinogens Other Than LSD																				
8th Grade	0.7	1.1	1.0	1.3	1.7	2.0	1.8	1.6	1.5	-0.1	0.3	0.4	0.5	0.7	0.8	0.9	0.7	0.7	0.6	-0.1
10th Grade	1.3	1.4	1.9	2.4	2.8	3.3	3.3	3.4	3.2	-0.2	0.4	0.5	0.7	1.0	1.0	1.0	1.2	1.4	1.2	-0.2
12th Grade	2.0	1.7	2.2	3.1	3.8	4.4	4.6	4.6	4.3	-0.3	0.7	0.5	0.8	1.2	1.3	1.6	1.7	1.6	1.6	0.0

(Table continued on next page)

TABLE 1 (cont.)

Trends in Annual and 30-Day Prevalence of Use of Various Drugs for Eighth, Tenth, and Twelfth Graders

	Annual										30-Day									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	'98–'99 change	1991	1992	1993	1994	1995	1996	1997	1998	1999	'98–'99 change
PCP[d]																				
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	1.4	1.4	1.4	1.6	1.8	2.6	2.3	2.1	1.8	-0.3	0.5	0.6	1.0	0.7	0.6	1.3	0.7	1.0	0.8	-0.2
MDMA (Ecstasy)[d]																				
8th Grade	—	—	—	—	—	2.3	2.3	1.8	1.7	-0.1	—	—	—	—	—	1.0	1.0	0.9	0.8	-0.1
10th Grade	—	—	—	—	—	4.6	3.9	3.3	4.4	+1.1s	—	—	—	—	—	1.8	1.3	1.3	1.8	+0.5
12th Grade	—	—	—	—	—	4.6	4.0	3.6	5.6	+2.0ss	—	—	—	—	—	2.0	1.6	1.5	2.5	+1.0s
Cocaine																				
8th Grade	1.1	1.5	1.7	2.1	2.6	3.0	2.8	3.1	2.7	-0.4	0.5	0.7	0.7	1.0	1.2	1.3	1.1	1.4	1.3	-0.1
10th Grade	2.2	1.9	2.1	2.8	3.5	4.2	4.7	4.7	4.9	+0.2	0.7	0.7	0.9	1.2	1.7	1.7	2.0	2.1	1.8	-0.3
12th Grade	3.5	3.1	3.3	3.6	4.0	4.9	5.5	5.7	6.2	+0.5	1.4	1.3	1.3	1.5	1.8	2.0	2.3	2.4	2.6	+0.2
Crack																				
8th Grade	0.7	0.9	1.0	1.3	1.6	1.8	1.7	2.1	1.8	-0.4s	0.3	0.5	0.4	0.7	0.7	0.8	0.7	0.9	0.8	-0.1
10th Grade	0.9	0.9	1.1	1.4	1.8	2.1	2.2	2.5	2.4	-0.1	0.3	0.4	0.5	0.6	0.9	0.8	0.9	1.1	0.8	-0.3s
12th Grade	1.5	1.5	1.5	1.9	2.1	2.1	2.4	2.5	2.7	+0.2	0.7	0.6	0.7	0.8	1.0	1.0	0.9	1.0	1.1	+0.1
Other Cocaine[e]																				
8th Grade	1.0	1.2	1.3	1.7	2.1	2.5	2.2	2.4	2.3	-0.1	0.5	0.5	0.6	0.9	1.0	1.0	0.8	1.0	1.1	+0.1
10th Grade	2.1	1.7	1.8	2.4	3.0	3.5	4.1	4.0	4.4	+0.4	0.6	0.6	0.7	1.0	1.4	1.3	1.6	1.8	1.6	-0.2
12th Grade	3.2	2.6	2.9	3.0	3.4	4.2	5.0	4.9	5.8	+0.9	1.2	1.0	1.2	1.3	1.3	1.6	2.0	2.0	2.5	+0.5
Heroin[f]																				
8th Grade	0.7	0.7	0.7	1.2	1.4	1.6	1.3	1.3	1.4	+0.1	0.3	0.4	0.4	0.6	0.6	0.7	0.6	0.6	0.6	0.0
10th Grade	0.5	0.6	0.7	0.9	1.1	1.2	1.4	1.4	1.4	0.0	0.2	0.2	0.3	0.4	0.6	0.5	0.6	0.7	0.7	0.0
12th Grade	0.4	0.6	0.5	0.6	1.1	1.0	1.2	1.0	1.1	+0.1	0.2	0.3	0.2	0.3	0.6	0.5	0.5	0.5	0.5	0.0
Other Narcotics[g]																				
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	3.5	3.3	3.6	3.8	4.7	5.4	6.2	6.3	6.7	+0.4	1.1	1.2	1.3	1.5	1.8	2.0	2.3	2.4	2.6	+0.2
Amphetamines[g]																				
8th Grade	6.2	6.5	7.2	7.9	8.7	9.1	8.1	7.2	6.9	-0.3	2.6	3.3	3.6	3.6	4.2	4.6	3.8	3.3	3.4	+0.1
10th Grade	8.2	8.2	9.6	10.2	11.9	12.4	12.1	10.7	10.4	-0.3	3.3	3.6	4.3	4.5	5.3	5.5	5.1	5.1	5.0	-0.1
12th Grade	8.2	7.1	8.4	9.4	9.3	9.5	10.2	10.1	10.2	+0.1	3.2	2.8	3.7	4.0	4.0	4.1	4.8	4.6	4.5	-0.1
Ice[h]																				
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	1.4	1.3	1.7	1.8	2.4	2.8	2.3	3.0	1.9	-1.1ss	0.6	0.5	0.6	0.7	1.1	1.1	0.8	1.2	0.8	-0.4

(Table continued on next page)

TABLE 1 (cont.)

Trends in Annual and 30-Day Prevalence of Use of Various Drugs for Eighth, Tenth, and Twelfth Graders

	Annual										30-Day									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	'98–'99 change	1991	1992	1993	1994	1995	1996	1997	1998	1999	'98–'99 change
Barbiturates[g]																				
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	3.4	2.8	3.4	4.1	4.7	4.9	5.1	5.5	5.8	+0.3	1.4	1.1	1.3	1.7	2.2	2.1	2.1	2.6	2.6	0.0
Tranquilizers[g]																				
8th Grade	1.8	2.0	2.1	2.4	2.7	3.3	2.9	2.6	2.5	-0.1	0.8	0.8	0.9	1.1	1.2	1.5	1.2	1.2	1.1	-0.1
10th Grade	3.2	3.5	3.3	3.3	4.0	4.6	4.9	5.1	5.4	+0.3	1.2	1.5	1.1	1.5	1.7	1.7	2.2	2.2	2.2	0.0
12th Grade	3.6	2.8	3.5	3.7	4.4	4.6	4.7	5.5	5.8	+0.3	1.4	1.0	1.2	1.4	1.8	2.0	1.8	2.4	2.5	+0.1
Alcohol[i]																				
Any use																				
8th Grade	54.0	53.7	51.6	—	—	—	—	—	—	—	25.1	26.1	26.2	—	—	—	—	—	—	—
			45.4	46.8	45.3	46.5	45.5	43.7	43.5	-0.2			24.3	25.5	24.6	26.2	24.5	23.0	24.0	+1.0
10th Grade	72.3	70.2	69.3	—	—	—	—	—	—	—	42.8	39.9	41.5	—	—	—	—	—	—	—
			63.4	63.9	63.5	65.0	65.2	62.7	63.7	+1.0			38.2	39.2	38.8	40.4	40.1	38.8	40.0	+1.2
12th Grade	77.7	76.8	76.0	—	—	—	—	—	—	—	54.0	51.3	51.0	—	—	—	—	—	—	—
			72.7	73.0	73.7	72.5	74.8	74.3	73.8	-0.5			48.6	50.1	51.3	50.8	52.7	52.0	51.0	-1.0
Been Drunk[h]																				
8th Grade	17.5	18.3	18.2	18.2	18.4	19.8	18.4	17.9	18.5	+0.6	7.6	7.5	7.8	8.7	8.3	9.6	8.2	8.4	9.4	+1.0
10th Grade	40.1	37.0	37.8	38.0	38.5	40.1	40.7	38.3	40.9	+2.6s	20.5	18.1	19.8	20.3	20.8	21.3	22.4	21.1	22.5	+1.4
12th Grade	52.7	50.3	49.6	51.7	52.5	51.9	53.2	52.0	53.2	+1.2	31.6	29.9	28.9	30.8	33.2	31.3	34.2	32.9	32.9	0.0
Cigarettes																				
Any use																				
8th Grade	—	—	—	—	—	—	—	—	—	—	14.3	15.5	16.7	18.6	19.1	21.0	19.4	19.1	17.5	-1.6s
10th Grade	—	—	—	—	—	—	—	—	—	—	20.8	21.5	24.7	25.4	27.9	30.4	29.8	27.6	25.7	-1.9
12th Grade	—	—	—	—	—	—	—	—	—	—	28.3	27.8	29.9	31.2	33.5	34.0	36.5	35.1	34.6	-0.5
Smokeless Tobacco[d]																				
8th Grade	—	—	—	—	—	—	—	—	—	—	6.9	7.0	6.6	7.7	7.1	7.1	5.5	4.8	4.5	-0.3
10th Grade	—	—	—	—	—	—	—	—	—	—	10.0	9.6	10.4	10.5	9.7	8.6	8.9	7.5	6.5	-1.0
12th Grade	—	—	—	—	—	—	—	—	—	—	—	11.4	10.7	11.1	12.2	9.8	9.7	8.8	8.4	-0.4
Steroids[h]																				
8th Grade	1.0	1.1	0.9	1.2	1.0	0.9	1.0	1.2	1.7	+0.5sss	0.4	0.5	0.5	0.5	0.6	0.4	0.5	0.5	0.7	+0.2s
10th Grade	1.1	1.1	1.0	1.1	1.2	1.2	1.2	1.2	1.7	+0.5ss	0.6	0.6	0.5	0.6	0.6	0.5	0.7	0.6	0.9	+0.3s
12th Grade	1.4	1.1	1.2	1.3	1.5	1.4	1.4	1.7	1.8	+0.1	0.8	0.6	0.7	0.9	0.7	0.7	1.0	1.1	0.9	-0.2

Mr. MICA. We will now recognize Dr. Vereen, who is the Deputy Director of the Office of National Drug Control Policy.

Dr. VEREEN. Thank you, Mr. Chairman, Chairman Mica, Representative Mink, and Representative Ose and to the other members of the subcommittee.

The Office of National Drug Control Policy welcomes this opportunity to discuss illegal drug use trends in America. The annual report on the National Drug Control Strategy which is submitted to Congress every winter is a data-based comprehensive 10-year report that includes an assessment of Federal success in achieving the goals and objectives of the strategy. And the data presented in that 2000 report are valid, and they demonstrate that we are moving in the right direction to achieve the goals that we have identified for that strategy.

I would like to submit the full written testimony for the record and just give a brief oral statement.

Mr. MICA. Without objection, your entire statement will be made part of the record. Please proceed.

Dr. VEREEN. As my colleague from HHS has explained already, to assess trends in drug use, the government examines the results from a number of different surveys, three in particular, three nationally representative population studies. One is the HHS National Household Survey that has been presented. I will just add that is a study that is conducted through face-to-face interviews each year, using computer-assisted self interviews, and it covers a host of drugs that are used, including lifetime use, past-year use and past-month use.

You have just heard from Dr. Johnston on the Monitoring the Future study. This is a school-based study that surveys students in the 8th, 10th and 12th grades. These data are released every year in December, and the most recently available data are for 1999.

The third is the Center for Disease Control and Prevention's Youth Risk Behavior Study. That is also a school-based survey for students 9th through 12th grade. The data are released for that particular study every other year. That is important—an important point to make.

Let me refer you to a visual because it is very difficult to talk about data sometimes without getting some sense of what it looks like over time. Here is a slide that shows the trend lines from all three studies that have been presented to you, and what we have done here is to select out marijuana, the most commonly used drug by young people. The main point that we want to make from all of this data is that there is a remarkable consistency in the trends of the data. The actual numbers will change as a reflection of methodology and other factors, which we can go into if you would like, but the trends are consistent. So while the absolute prevalence rates may vary, the trends are consistent.

Of great concern to us is that even though recently we reported that there has been a 21 percent decline over the last 2 years in illicit drugs use in 12 to 17-year-olds, we are concerned as well about the increase, apparent increase in drug use in the 18 to 25-year-old group. The current use of any illicit drug among this group increased 28 percent from 1997 to 1999. This may capture some of the club drug use, as Dr. Johnston mentioned earlier, those in the

lower end of their 20's. Club drugs are becoming a drug of increasing use.

Past month use of marijuana in this group followed a similar trend, also increasing 28 percent. Overall drug use remains level, as you can see from these trend lines. According to the National Household Survey, the rate of illicit drug use in the population ages 12 and older is statistically unchanged over the past 2 years, if you look just at the statistics, and it is represented here visually. But as Dr. Johnston stated, the latest findings from the Monitoring the Future Study for the school year 1998 to 1999 indicate that we are holding the line against drug use; that we have turned a corner. He referred to it as—I am forgetting the word that he used before. But the data from the 1999 Monitoring the Future Study show that the use of illicit drugs among 8th, 10th and 12th graders remains pretty much unchanged from 1998 to 1999.

With regard to emerging drugs, there has been an increase in ecstacy or MDMA use among 10th and 12th graders which is of great concern. The documented increase in these drugs corroborates other recent indicators. As you have probably noted, these are huge studies with a 6-month to a 1-year lag time.

We have a couple of other mechanisms that allow us to get at local trends in a slightly faster fashion. ONDCP has a pulse check mechanism, and the Department of HHS, through the National Institute on Drug Abuse has a community epidemiology working group report that allows us to get a little closer to these local trends. And approximately a year ago, we were able to note the use in trends of club use drugs as that data was taken into account.

On the next slide I would like to briefly illustrate the methamphetamine problem. It has been of great concern to us, and we are going to illustrate the ADAM data here to give you a visual of that data set to show two main points. These are the blood tests or the drug test results of booked male arrestees, as was explained by my colleague earlier. But you will notice in the cities where methamphetamine was found, there are huge variations in the amount of methamphetamine use. We think of the drug problem in the country is a collection of local epidemics, as the past director of NIJ was wont to describe. Just so you get a picture of what the female arrestee rates look like, you will see a similar set of patterns, and I won't go into the specific changes from city to city.

The second point that I want to make about this data set is that you will notice that all of the cities are west of the Mississippi. This is a drug phenomenon that as it creeps across the country in its local fashion, has at this point stopped or hovered around the Mississippi River, and drug trends follow such patterns. So when you hear us announce national trends for methamphetamine, we are really talking about the western part of the country for the most part. In conclusion, Mr. Chairman, the trends among the 12 to 17-year-old age group are positive and encouraging. Adolescents increasingly disapprove of illegal drugs. But despite this good news, we face an increasingly difficult challenge to our abilities to detect, monitor and track emerging drug trends that pose a grave and dangerous threat to our children.

All of us at ONDCP are grateful to Congress for your efforts in this subcommittee. And now I would like to just say a couple of words about our performance measure system.

Our strategy, as you know, is attached to performance measures of effectiveness system. This system makes extensive use of many of the data sources that you have seen here for tracking our success or where we need areas of help in achieving our goals and objectives for the strategy. The system is complex. It involves an interagency effort, those of us sitting across this table as well as others. The performance measure community recognizes that such systems have to change and adjust, just like our national strategy. It is a 10-year plan based on data, but has flexibility built in to respond to new and local epidemics. This PME system has been favorably reviewed by the National Academy of Public Administration, the National Partnership for Reinventing Government, and the GAO.

At this point, I will end my comments.

Mr. MICA. Thank you.

[The prepared statement of Dr. Vereen follows:]

Statement by Donald R. Vereen, Jr., MD, MPH
Deputy Director, Office of National Drug Control Policy
Before the House Committee on Government Reform,
Subcommittee on Criminal Justice, Drug Policy, and Human Resources
September 19, 2000

INTRODUCTION

Chairman Mica, Representative Mink, distinguished members of the subcommittee, the Office of National Drug Control Policy (ONDCP) welcomes this opportunity to discuss illegal drug use trends in America. The *2000 Annual Report on the National Drug Control Strategy* transmitted by President Clinton to Congress in March 2000 includes a comprehensive assessment of drug use and availability trends in the United States. This annual report on progress in implementing the *Strategy* was submitted in accordance with Public Law 105-277. The report includes an assessment of federal success in achieving the *National Drug Control Strategy* goals and objectives using the Strategy's Performance Measures of Effectiveness system. It also features measurable data from the annual performance measures. The report's detailed discussion of drug use, availability, and social consequences is based on the most recent national, state, and local surveys, among other studies. A detailed list of the data sources used to prepare this annual report is provided in an appendix to this statement.

CURRENT DRUG USE TRENDS

To assess trends in drug use, the Government examines results from the following three nationally representative population surveys:

- The Department of Health and Human Services' National Household Survey on Drug Abuse (NHSDA). The NHSDA surveys the noninstitutionalized U.S. population aged 12 and over residing in households. The survey is conducted in face-to-face household surveys each year using computer-assisted self-interviews (this feature was added in 1999). The survey is conducted throughout the year. In 1999 the survey sample was increased to 66,700 respondents, enabling more precise estimates and, for the first time, state-level estimates. The survey covers the use (lifetime, past year, and past month) of specific drugs, including any illicit drug, marijuana, cocaine, heroin, hallucinogens (including ecstasy), inhalants, methamphetamine, nonmedical use of prescription drugs, alcohol, and tobacco; attitudes and perceptions toward drug use; measures of risk and protective factors; and estimates of abuse and dependence. The data are released each year in August. The most recent data available are for 1999.
- The University of Michigan's Monitoring the Future Study (MTF). The MTF is conducted each year through a grant from the National Institute on Drug Abuse. The MTF is school-based and surveys students in the 8th, 10th, and 12th grades. The 12th grade sample was initiated in 1975, the 8th and 10th grade samples were added in 1991. Sample sizes for 1999 were: 16,700 for 8th graders, 13,600 for 10th graders, and 13,600 for 12th graders. The survey collects data on specific drug use (lifetime, past year, and past month), including any illicit drug, marijuana, cocaine, heroin, inhalants, hallucinogens (including ecstasy), amphetamines

(including methamphetamine), steroids, nonmedical use of prescription drugs, alcohol, and tobacco; attitudes and beliefs toward drug use; and the social setting of drug use. The data are released each year in December. The most recently available data are for 1999.

- The Center for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey (YRBS). The YRBS was begun in 1990; starting in 1991 it has been administered every other year. The YRBS is school-based and surveys students in grades 9 through 12. In 1997, 15,349 students were surveyed. Unlike the NHSDA or the MTF, the YRBS is not focused primarily on substance abuse. Rather, substance abuse is one of several risk behaviors measured; others include seat belt use, motorcycle helmet use, bicycle helmet use, sport/physical activity-related injury, drinking and driving, carrying a weapon/gun, fighting, forced sexual intercourse, suicidal thought/behavior, sexual activity, diet, and physical activity. With respect to substance abuse, the YRBS collects data on the use (lifetime and past month) of specific drugs, including marijuana, cocaine, inhalants, heroin, methamphetamine, and steroids; use and trafficking on school property; and whether respondents had ever injected drugs. The data are released every other year in June. The most recently available data are for 1999.

According to the recently released 1999 NHSDA, an estimated 14.8 million Americans 12 years of age and older were current users of an illicit drug in 1999. Current use is defined as illicit drug use at least once during the 30 days prior to the interview. Current drug use rates were at the highest recorded level in 1979, when 14.1 percent of the population age 12 and over were current users. This rate declined to 5.8 percent in 1992 (the historical low point) and then increased to 6.1 percent in 1996. Since 1996 the rate of current use has remained steady, with no statistically significant changes occurring through 1999, when current use was estimated at 7.0 percent.[i] In 1999 an estimated 3.6 million people met the diagnostic criteria for dependence on illegal drugs in the past year, including 767,000 youths between the ages of twelve and seventeen.[ii]

Youth drug-use rates have declined or leveled-off. This year's good news is that the rate of past month use of **any illicit drug among 12-17 year olds declined significantly -- by 21 percent --** from 11.4 percent in 1997 to 9.0 percent in 1999. While the 1999 rate is not significantly different from 1998 (9.9%), this decline continues the downward trend from 1997 into the second year. Past month use of **Marijuana** among 12-17 year olds also is significantly down, by 26 percent, from 1997 (9.4%) to 1999 (7.0%).

For the **age group 18-25**, however, the trend is in the opposite direction. Current use of **any illicit drug** among this age group increased 28 percent between 1997 and 1999 (from 14.7% to 18.8% – a statistically significant change). Past month use of **Marijuana** followed a similar trend, also increasing 28 percent, from 12.8 percent to 16.4 percent. This 18-25 age cohort, which includes many of those who formed their attitudes about drug use and began to use in the early 1990s, can be expected to reflect relatively higher rates of drug use as they age.

Overall drug use remains level. According to the 1999 NHSDA, the rate of illicit drug use in the population aged 12 and older is statistically unchanged over the past two years (6.4% reported in 1997, 6.2% in 1998, and 7.0% in 1999).

Another major source of data about youth drug use is the *Monitoring the Future Survey* (MTF), funded by the National Institute on Drug Abuse (NIDA). The latest findings from the MTF, for school year 1998-1999, indicate that we are holding the line against drug use. Data from the 1999 MTF show that use of most illicit drugs among 8th, 10th, and 12th graders remained unchanged from 1998 to 1999. This is the third year in a row that drug use rates have leveled off or declined since their rapid rise in the early 1990s. The MTF also indicated a continued improvement in some key anti-drug attitudes among youth with significant increases in perceptions of the harmfulness of marijuana use among 8th graders.

The MTF provides some other good news. Among 8th graders, the rate of past year use of **crack cocaine** declined 14 percent (from 2.1% to 1.8%). This was the first such decline in the 1990s. Among 10th graders, the rate of past month use of **crack cocaine** also declined – by 27 percent (from 1.1% to 0.8%). Among 12th graders, the rate of past year use of **ice** (crystal meth) declined 37 percent (from 3.0% to 1.9%).

Attitudes about drug use, seen as key to later use, also showed some positive changes. Among 8th graders, **disapproval** of **trying marijuana once or twice** increased 2 percent (from 69.0% to 70.7%) and disapproval of **trying inhalants** increased 3 percent (from 83.0% to 85.2%). Among 10th graders, the perceived **harmfulness** (i.e., great risk) of trying **inhalants** once or twice increased 5 percent (from 45.8% to 48.2%), accompanied by an increased in perceived harmfulness of regular use of inhalants of 4 percent (from 73.3% to 76.3%). Disapproval of trying **inhalants** once or twice increased 3 percent (from 85.6% to 88.4%) and disapproval of regular use increased slightly (from 91.1% to 92.4%).
However, not all the findings from the 1999 MTF were positive. Use of drugs among our school children remains at unacceptably high levels. In 1999 approximately one in four 12th graders (25.9%), one in five 10th graders (22.1%), and about one in eight 8th graders (12.2%) used an illicit drug in the past 30-days. The most frequently used illicit drug among all three grades was marijuana (past 30-day use: 23.1% for 12th graders; 19.4% for 10th graders; and 9.7% for 8th graders). These rates are unchanged from 1998. However, there was an increase in use of the major "club drug," MDMA (Ecstasy) among both 10th and 12th graders and for steroids among 8th and 10th graders. The increase in MDMA (Ecstasy) use by 10th and 12th graders is of great concern. The documented increase in this so-called "club drug" corroborates other recent indicators, including ONDCP's *Pulse Check* and DHHS's Community Epidemiology Working Group Report, and underscores the importance of NIDA's new research and awareness initiatives on club drugs. Increases in the use of steroids highlights the need for the international sports community to serve as an example and educate youth about the dangers of steroids and other performance enhancing drugs.

The Youth Risk Behavior Survey (YRBS) [iii] provides a third data source on youth drug use. This study of high school students is conducted every other year and included 13 questions on drugs in 1999. Long-term results are consistent with NHSDA and MTF, reflecting an increase in the early 1990s and a relatively flat trend in recent years – current marijuana use remained statistically unchanged from 26.2 percent in 1997 to 26.7 in 1999[iv].

Statement by ONDCP Deputy Director, Donald R. Vereen, Jr., M.D., M.P.H.

THE NATIONAL DRUG CONTROL STRATEGY'S PERFORMANCE MEASURES OF EFFECTIVENESS SYSTEM

The *National Drug Control Strategy* is supported by a comprehensive Performance Measures of Effectiveness (PME) System. The stated intent of the *National Drug Control Strategy* is to reduce drug use and availability by 50 percent and decrease health and social consequences a minimum of 25 percent by 2007 (compared to 1996 baseline levels). The *Strategy* charts the course for accomplishing this end. Progress toward the *Strategy*'s five goals and thirty-one objectives must be continuously assessed in order to gauge success or failure and then adjust the *Strategy* accordingly. ONDCP has consulted with Congress, federal drug-control agencies, state and local officials, private citizens, and organizations with experience in demand and supply reduction to develop a Performance Measurement of Effectiveness (PME) system to gauge national drug-control efforts.

The PME system: (1) assesses the effectiveness of the *Strategy* and its supporting programs, (2) provides information to the entire drug-control community on what needs to be done to refine policy and programmatic directions, and (3) assists with drug-control budget management. The PME system fulfills congressional guidelines that the *National Drug Control Strategy* contain measurable objectives and specific targets to accomplish long-term quantifiable goals.

The nucleus of the PME system consists of twelve "impact targets" that define measurable results to be achieved by the *Strategy*'s five goals. There are five impact targets for demand reduction, five for supply reduction, and two for reducing the adverse health and criminal consequences associated with drug use and trafficking. Eighty-five additional targets further delineate mid- (2002) and long-term (2007) targets for the *Strategy*'s thirty-one objectives. They are "stretch targets" in that they require progress above that attained in previous years. This system is in accordance with recommendations from the National Academy of Public Administration (NAPA), the General Accounting Office (GAO), and other organizations advocating good government practices. For example, NAPA, in reviewing the PME system, noted:

> Congress, GAO, and OMB have all noted that inadequate coordination occurs among agencies that seek to achieve goals in the same area. **An exception is the national performance measurement system being established by the Office of National Drug Control Policy.** This office is engaged with 50 federal agencies and, indirectly, their state and local partners to identify performance indicators and targets for 5 goals and 32 objectives in the National Drug Control Strategy. Twenty-one interagency working groups have identified five-year (2002) and ten-year (2007) performance indicators and targets for each objective.[v]

Congress also strongly endorsed the PME system in the Office of National Drug Control Policy Reauthorization Act of 1998, noting that:

> "It is the sense of the Congress that – …

(D) the performance measurement system developed by the Director described in this subsection is central to the National Drug Control Program targets, programs, and budget;
(E) the Congress strongly endorses the performance measurement system for establishing clear outcomes for reducing drug use nationwide during the next five years, and the linkage of this system to all agency drug control programs and budgets receiving funds scored as drug control agency funding. 21USC 1705 (c)(1)

Progress toward each goal and objective is assessed using new and existing data sources. MTF and the NHSDA, for example, both estimate risk perception, rates of current use, age of initiation, and lifetime use for alcohol, tobacco, and most illegal drugs. The National Institute of Justice's Arrestee Drug Abuse Monitoring program and the Substance Abuse and Mental Health Service's Drug Abuse Warning Network surveys indirectly measure the consequences of drug abuse. The State Department's annual *International Narcotics Control Strategy Report* (INCSR) provides country-by-country assessments of initiatives and accomplishments. INCSR reviews statistics on drug cultivation, eradication, production, trafficking patterns, and seizure along with law-enforcement efforts including arrests and the destruction of drug laboratories. The Drug Control Research, Data, and Evaluation Committee (an advisory committee to the ONDCP Director), Subcommittee on Data, Research, and Interagency Coordination is developing additional instruments and measurement processes required to address the demographics of chronic users, domestic cannabis cultivation, drug availability, and other areas where data are lacking or not fully adequate to allow for the complete assessment of progress. These are referred to in the PME Report and the related data system as "data shortfalls."

- **ONDCP Is Also Tracking Progress Using Congressional Performance Targets**

While Congress endorsed the PME system, it also was the sense of Congress that targets should be achieved over a shorter period of time. In this regard it specified five targets in the areas of youth drug use, overall drug use, drug availability, drug purity, and drug-related crime to be achieved by 2003. Achieving these targets will allow for the annual restructuring of appropriations by the Appropriation Committees and authorizing committees of jurisdiction of Congress to meet the drug reduction goals, 21 USC (c) (1) (C). Progress toward achieving these targets will be assessed using many of the same data sources as those used by ONDCP's PME system. These targets are:

- ✓ Reduce illicit drug use to 3 percent of the U.S. population by December 31, 2003.
- ✓ Reduce adolescent drug use to 3 percent by 2003, and achieve at least 20 percent of this target between 1999 and 2003.
- ✓ Reduce cocaine, heroin, marijuana, and methamphetamine use in the U.S. by 80 percent by December 31, 2003.

- ✓ Reduce the purity of cocaine, heroin, marijuana, and methamphetamine by 60 percent by December 31, 2003.

- ✓ Reduce drug-related crime in the U.S. by 50 percent by December 31, 2003, with this reduction occurring in equal 20 percent increments between 1999 and 2003.

OVERVIEW OF DATA SOURCES

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;

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

(III) the number of metric tons of marijuana, heroin, cocaine, and methamphetamine seized;

(IV) the number of cocaine and methamphetamine processing laboratories destroyed domestically and in other countries;

(V) changes in the price and purity of heroin and cocaine, changes in the price of methamphetamine, and changes in tetrahydrocannabinol level of marijuana;

(VI) the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and

(VII) the effectiveness of Federal technology programs at improving drug detection capabilities in interdiction, and at United States ports of entry;

(iii) an assessment of the reduction of the consequences of drug use and availability, which shall include estimation of:

(I) the burden drug users placed on hospital emergency departments in the United States, such as the quantity of drug-related services provided;

(II) the annual national health care costs of drug use, including costs associated with people becoming infected with the human immunodeficiency virus and other infectious diseases as a result of drug use;

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

(II) 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.

- **Improving Federal Drug-Related Data Systems**

ONDCP is coordinating and financially supporting an initiative to develop a comprehensive data system to inform drug policy makers. It will support all ninety-seven targets that constitute the *Strategy's* Performance Measures of Effectiveness (PME) system. The ONDCP-coordinated Data Subcommittee is reviewing existing data systems to identify "data gaps" and determine what modifications can be made to enhance the system. SAMHSA, for example, has increased the sample size and scope of the NHSDA to provide state-by-state data and greater information about drug use among twelve to seventeen-year-olds. More frequent estimates of the social costs of drug abuse will be made. ONDCP is continuing the development of a "cocaine flows" estimate model.

This initiative is improving the policy relevance of federal drug-related data systems by bringing them into alignment with the PME system. The Data Subcommittee has supported the following innovations:

- ✓ The National Institute of Justice expanding and revising of the Drug Use Forecasting program into the Arrestee Drug Abuse Monitoring (ADAM) system. Plans call for the expansion of ADAM from the current 34 sites to 50 in FY 2001 and, ultimately 75 sites with a national model-based estimate. All these sites will use probability-based samples representative of their respective metropolitan areas, along with the new ADAM instrument that 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.

- ✓ SAMHSA enlarged the sample for the National Household Survey on Drug Abuse (NHSDA) – reaching nearly triple the size – permitting, for the first time, estimation of drug-use prevalence at the state level. The first wave of state-level data was included in the 1999 NHSDA survey released in August 2000.

- ✓ SAMHSA/CSAT is expected in FY 2001 to fund the implementation of the National Treatment Outcome Monitoring System (NTOMS). NTOMS will combine the work of two existing data systems currently 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 for the PME system on treatment, waiting time, and chronic users.

- ✓ SAMHSA/CSAP has several activities to promote state data systems. For example, twenty 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, consistent with ONDCP PMEs, in the pilot SAPT block grant application for FY2000.

ONDCP is currently leading an interagency effort to develop drug-flow models – from source countries through availability in the United States – for cocaine, heroin, marijuana, and methamphetamine. Results from this project are providing critical measures for the PME system, enabling assessment of the nation's supply-reduction programs.

CONCLUSION

All of us at ONDCP are grateful to the Congress for the bipartisan partnership we have forged on this difficult and important issue. Common commitment has been vital to our success, and we can all be proud of our achievements at home and abroad. The 1999 National Household Survey on Drug Abuse found that youth drug use declined by 9 percent between 1998 and 1999. This follows a 13 percent decline between 1997 and 1998. The 1999 Partnership Attitude Tracking Survey and 1999 Monitoring the Future Survey tell us that youth attitudes about drugs are changing. Adolescents increasingly disapprove of illegal drugs. An ever-growing number of young people are now using positive peer pressure to help friends stay drug-free. Our children get the message: "In America today you have a bright, drug-free future. Don't waste it with drugs."

We have made similar progress combating illegal drug organizations that traffic in these deadly poisons. We have cut drug-related murders to their lowest point in over a decade. We are reducing the supply of drugs on world markets. In Latin America, Bolivia reduced coca cultivation by 55 percent since 1995 and in Peru cultivation declined 66 percent over the same period. Bipartisan efforts to confront this threat are paying real dividends to the American people.

But we cannot rest on our success. Drugs continue to exact a tremendous toll on this country and internationally. Studies report an increase in steroid and MDMA (ecstasy) use among youth. One in four inmates in State prison and more than 60 percent of Federal inmates are drug offenders. Cocaine and heroin production have skyrocketed in Colombia. We need to focus our energies and expand initiatives needed to address pressing problems:

- **We need to empower America's young people to reject illegal drugs.**

- **We need to break the cycle of drugs and crime by dramatically increasing drug treatment programs within the criminal justice system.** These programs have been proven to reduce drug use and cut recidivism by up to 44 percent.

- **We need to close the gap between the number of people who have serious drug abuse problems and the treatment slots available on demand.** If drug-dependent individuals want to become drug-free, they deserve our help.

- **We must strengthen efforts to stop the flow of drugs into the United States across our southwest border and other points of entry.** Through new technologies and better

coordination, we can speed-up the flow of legitimate goods and services while turning off the tap for drugs.

- **We must help committed democracies resist the transnational threat posed by illegal drugs and the criminal organizations that traffic in them.**

These vital initiatives are key elements in our broad-based, balanced approach to combating drug abuse. Working together, the Congress and the Administration, teachers, coaches, clergy, researchers, mentors, health-care professionals, community activists, and others have made great progress in reducing drug abuse. By doing so, we have safeguarded the dreams of our children. We have increased the sense of security American families feel in their homes, streets, and communities. We have helped the international community combat a threat that respects no borders. We have much to be proud of, but we have much more to do. We look forward to working closely with the Congress in this effort.

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[i] The household survey methodology was changed to a computer-assisted format in 1999, which complicates assessment of trend data. This estimate of drug use rates was derived from a 1999 NHSDA supplemental national sample that parallels the method used to collect data from prior years, using a paper-and-pencil method

[ii] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Summary of Findings from the 1999 National Household Survey on Drug Abuse*, DHHS Publication No. (SMA) 00-3466, (Rockville: MD: U.S. Department of Health and Human Services, 1999). The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) National Household Survey on Drug Abuse (NHSDA) includes a series of questions based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) used to assess dependence on substances. NHSDA includes questions about health and emotional problems associated with substance abuse, attempts to cut down on use, tolerance, and other symptoms. Respondents are also asked to report whether they received treatment or counseling for a substance-abuse problem.

[iii] Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance – United States, 1999.* Morbidity and Mortality Weekly Report Vol. 49, No. SS-6, June 8, 2000.

[iv] YRBS does not permit calculation of a combined measure for "any illicit drug use" because of the limited number of drug questions in the study.

[v] *Effective Implementation of the Government Performance and Results Act*, National Academy of Public Administration, 1998, pg 16.

Appendix (Data Sources)
to Statement by Donald R. Vereen, Jr., MD, MPH
Deputy Director, Office of National Drug Control Policy
Before the House Committee on Government Reform,
Subcommittee on Criminal Justice, Drug Policy, and Human Resources
September 19, 2000

This appendix provides brief descriptions of the major data sources used by the Office of National Drug Control Policy to assess the success of national efforts to reduce drug use, drug availability, and the consequences of drug abuse in America.

PRIMARY SOURCES FOR DRUG PREVALENCE DATA

National Household Survey on Drug Abuse. The National Household Survey on Drug Abuse (NHSDA) measures the prevalence of drug and alcohol use among household members aged twelve and older. Topics include drug use, health, and demographics. In 1991, the NHSDA was expanded to include college students in dormitories, persons living in homeless shelters, and civilians living on military bases. In 1999, the NHSDA sample was nearly tripled to 66,700 respondents. Among other improvements, this increased sample size permits for the first time the production of state-level estimates of selected drug prevalence and attitude measures. The NHSDA was administered by the National Institute on Drug Abuse (NIDA) from 1974 through 1991; the Substance Abuse and Mental Health Services Administration (SAMHSA) has administered the survey since 1992.

Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth. Often referred to as the "High School Senior Survey," the *Monitoring the Future* (MTF) study provides information on drug use trends as well as changes in values, behaviors, and lifestyle orientations of American youth. The study examines drug-related issues, including recency of drug use, perceived harmfulness of drugs, disapproval of drug use, and perceived availability of drugs. Although the focus of the MTF study has been high school seniors and graduates who complete follow-up surveys, eighth and tenth 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. 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 ninth through twelfth graders from public and private schools. Schools with a large proportion of black and Hispanic students are over sampled to provide stable estimates for these subgroups. The 1992 Youth Risk Behavior Supplement was administered to one in-school youth and up to two out-of-school youths in each family selected for the National

Health Interview Survey. In 1992, 10,645 youth aged twelve to twenty-one 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.

OTHER RELEVANT DRUG DATA SOURCES

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program. The National Institute of Justice established the Drug Use Forecasting (DUF) program in 1987 to provide an objective assessment of the drug problem among those arrested and charged with crimes. In 1997 this program became the Arrestee Drug Abuse Monitoring (ADAM) program. The ADAM program collected data in thirty-five major metropolitan sites across the United States in 1998, up from twenty-three 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. The majority of sites each collect data from 300 to 700 adult male arrestees, 100 to 300 female arrestees (at thirty-two sites), and 150 to 300 juvenile male arrestees (at thirteen sites). Together, the 1998 data comprised 20,716 adult male arrestees, 6,700 adult female arrestees, and 3,134 juvenile male arrestees. The ADAM system is expanding to more cities in the coming years.

Community Epidemiology Work Group Report. Sponsored by the National Institute on Drug Abuse (NIDA), the CEWG is a network of epidemiologists and researchers in the United States that meets biannually to review current and emerging drug abuse indicator data, survey findings, and other quantitative information compiled from local, city, State, and Federal sources. To assess drug abuse patterns and trends, data from a variety of health and other drug abuse indicator sources are accessed and analyzed. The primary mission of the Work Group is to provide ongoing community-level surveillance of drug abuse through analysis of both quantitative and qualitative research data. Through this program the CEWG provides current descriptive and analytical information regarding the nature and patterns of drug abuse, emerging trends, characteristics of vulnerable populations, and social and health consequences.

Current Population Survey. 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 persons in a given area, their ages, educational background, and the characteristics of their housing enable government, business, and industry to plan more effectively.

Appendix (Data Sources) to Statement by Donald R. Vereen, Jr., M.D., M.P.H., Deputy Director, Office of National Drug Control Policy

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

The Economic Costs of Alcohol and Drug Abuse in the United States. The NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) commissioned this study to estimate the economic costs of alcohol and drug abuse in the United States. The study, which was released in 1998, is based on 1992 data and includes estimates for 1995. Before this report, the last complete cost estimate using detailed data were for 1985.

Estimating Cocaine Flow: The Sequential Transition and Reduction (STAR) Model, 1996-1998. ONDCP is developing a flow model for cocaine, called the Sequential Reduction and Transition (STAR) Model. The STAR model takes each of four point-estimates and uses transition matrices to estimate availability at all the other stages. These four independent measures are: (1) potential production estimate, an imagery-based estimate of the coca crop combined with and coca cultivation studies, (2) Interagency Cocaine Movement Assessment estimate, an event-based estimate of cocaine departing source areas, (3) an estimate of cocaine crossing the U.S. border based on the allocation of domestic resources and interdiction efficiency, and (4) a domestic consumption estimate. As a result, availability estimates at each stage of cocaine's movement, from source to consumer, are a composite of point-estimates. Abt Associates, Inc. prepared a report describing this model for ONDCP in 1999.

Federal-Wide Drug Seizure System . The Federal-Wide Drug Seizure System (FDSS) is an online computerized system that stores information about drug seizures made within the jurisdiction of the United States by the DEA, FBI, Customs Service, and Coast Guard. The FDSS database includes drug seizures by other Federal agencies (e.g., the Immigration and Naturalization Service) to the extent that custody of the drug evidence was transferred to one of the four agencies identified above. The database includes information from STRIDE, the Customs Law Enforcement Activity Report, and the U.S. Coast Guard's Law Enforcement Information System. The FDSS has been maintained by the DEA since 1988.

HIV/AIDS Surveillance Report. 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 semi-annually. 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.

Homelessness: Programs and the People They Serve. The National Survey of Homeless Assistance Providers and Clients provides a full picture of homeless service users in late 1996. It

provides updated information about the providers of homeless assistance services and the characteristics of homeless clients who use these services. Information from this survey was intended for use by federal agencies responsible for administering homeless assistance programs and other interested parties. The 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, provides the first opportunity since 1987 to update the national picture of homelessness in a comprehensive and reliable way.

International Narcotics Control Strategy Report. The International Narcotics Control Strategy Report (INCSR) provides the President with information on the steps taken by the main illicit drug-producing and transiting countries to prevent drug production, trafficking, and related money laundering during the previous year. The INCSR helps determine how cooperative a country has been in meeting legislative requirements in various geographic areas. Production estimates by source country also are provided. Since 1989, the U.S. Department of State has prepared the INCSR.

The Monetary Value of Saving a High-Risk Youth. 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.

National Drug Intelligence Center's National Threat Assessment. Each year the National Drug Intelligence Center (NDIC), funded through the U.S. Department of Justice, prepares an assessment of the domestic threat of drugs to the United States. This assessment is based upon a synthesis of available information from law enforcement, including intelligence data, and demand reduction sources, including the NHSDA.

National Drug Treatment Requirements. The U.S. Department of Health and Human Services (HHS) is mandated by Congress to report to the Office of Management and Budget on its goals for enrolling drug abusers in treatment facilities and the progress it has made in achieving those goals. HHS provides data on the estimated number of clients who receive treatment, as well as persons who need treatment but are not in treatment.

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

National Vital Statistics Report. Data on drug-induced deaths are based on information from all death certificates filed (2.3 million in 1997) in the fifty 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 biological, 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.

PRIDE USA Survey. The National Parent's Resource Institute for Drug Education (PRIDE) conducts an annual survey of drug use by middle school and high school students. The PRIDE survey collects data from students in sixth through twelfth 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 1998–99 school year involved approximately 135,000 students in 28 states.

Pulse Check: Trends in Drug Abuse. Developed and published by ONDCP, the Pulse Check provides a snapshot of local drug abuse situations throughout the country. The focus of Pulse Check is on trends in heroin, cocaine, marijuana, and methamphetamine within a six-month period. Pulse Check uses conversations with ethnographers and epidemiologists, law enforcement officials, and treatment providers working in the drug field to compose a snapshot of the current state of drug abuse, nationwide. As a qualitative measure of drug abuse, Pulse Check complements, rather than supplants, other methods of estimating the extent of drug abuse.

Reported Tuberculosis in the United States. 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, drug resistance, etc). 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.

Substance Abuse among Probationers and State and Federal Prisoners. Conducted by the Bureau of Justice Statistics, Office of Justice Programs, Department of Justice, the 1997 Survey on Inmates in State and Federal Correctional Facilities comprises 14,285 interviews for the state survey and 4,041 for the federal survey using computer assisted personal interviewing (published in December 1998). The survey is conducted every five to 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 over 2,000 adult probationers under active supervision (published in March 1998).

Summary of Notifiable Diseases. This publication contains summary tables of the official statistics for the reported occurrence of nationally notifiable diseases in the United States,

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

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

Survey of Inmates of Local Jails. The Survey of Inmates of Local Jails provides nationally representative data on inmates held in local jails, including those awaiting trials or transfers and those serving sentences. Survey topics include inmate characteristics, offense histories, drug use, and drug treatment. The Bureau of Justice Statistics (BJS) has conducted the survey every five to six years since 1972.

Uniform Crime Reports. 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.

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

System To Retrieve Information From Drug Evidence. The System To Retrieve Information From Drug Evidence (STRIDE) compiles data on illegal substances purchased, seized, or acquired in DEA investigations. Data are gathered on the type of drug seized or bought, drug purity, location of confiscation, street price of the drug, and other characteristics. Data on drug exhibits from the FBI; the Metropolitan Police Department of the District of Columbia; and some exhibits submitted by other federal, state, and local agencies also are included in STRIDE. STRIDE data have been compiled by DEA since 1971.

What America's Users Spend on Illegal Drugs: 1988–1998. This report estimates total U.S. expenditures on illicit drugs based on available drug supply and demand data. Data are provided on estimated numbers of users, yearly, and weekly expenditures for drugs, trends in drug supply, and retail prices of drugs. Abt Associates, Inc. first wrote the report for ONDCP in 1993. It was updated in 1995, 1997, and 1999.

Mr. MICA. Let me first turn to Julie Samuels of DOJ. You noted in your testimony, as a result of the urine testing of arrestees, it was revealed that the actual number of drug users was twice as high as the level that had been previously reported; is that correct?

Ms. SAMUELS. Yes, sir.

Mr. MICA. So some of the statistics we are looking at, unless there was drug testing, urine testing, may be even worse than what is being presented?

Ms. SAMUELS. It is unclear whether you can draw that conclusion. I think what we have learned with respect to doing both the interviews and the drug tests is there are times when what the arrestee tells us with respect to his drug use is not consistent with the confirmed drug test. I don't know whether you can necessarily generalize that to the rest of the population.

Mr. MICA. You said that the actual number of drug users was twice as high?

Ms. SAMUELS. Yes. Clearly for this population, they are not always admitting as much use as the drug tests indicated.

Mr. MICA. And that most of the testing that we have talked about is self-reported; is that correct, Dr. Johnston?

Mr. JOHNSTON. Yes. The national surveys are all self-reported. But I should note that the in-jail situation is a very extreme situation where people are there because of breaking the law and they are under charges.

Mr. MICA. Have you given any consideration in your reporting to finding a sample that would also look at some verification of the statistics that you are compiling, Dr. Johnston?

Mr. JOHNSTON. It is, unfortunately, the case that, short of doing actual hair or urine testing, there is no gold standard; and even those are not a gold standard.

Mr. MICA. Is there a comparison where they have conducted hair or urine testing and then compared it to the statistics?

Mr. JOHNSTON. Not in this country. I have seen it done in other countries, and the results were pretty good. But what we do is a number of what I call "triangulations" on validity and look at quite a host of things which should come out a particular way if the data are valid. We look for consistency among the answers that an individual gives about various drugs. And if it is a high rate of inconsistency, we throw the case out. And we look at their reports of friends' use about which there would be less motivation to conceal, presumably, since they are unnamed friends. We get both prevalence and trends, I might add, because sometimes it is asserted that maybe the willingness to be honest changes over time, but I think we have pretty good evidence to suggest that hasn't been the case, at least in the school surveys.

Mr. MICA. Dr. Vereen, we are trying to get measures of performance, and get some hard data on the success or failure that we have incurred in these programs. I guess you have a couple of targets, a 5-year target, 2002 or 2003, and that would be our closest target. What is the overall drug use percentage of the population that you are trying to achieve in 2003?

Dr. VEREEN. Overall, as we state in the national strategy, we want to cut past-month use in half. When you look at the whole population which the strategy deals with, there is approximately a

6.4 percent across the country drug use, and we want to cut that in half by 2004.

Mr. MICA. And you are trying to get to 3 percent; that is the goal?

Dr. VEREEN. Yes.

Mr. MICA. According to the report given to us in 1997, we were at 6.4 percent. In 1998 we have dropped slightly to 6.2 percent. However, this past year we are back at 7 percent. So instead of getting closer to the 3 percent of the population, we are now 4 full percentage points away. While we had 1 year where there was a slight decrease, it appears that the trend, in fact, for overall drug use remains increasing; is that correct?

Dr. VEREEN. That is 1 data point that——

Mr. MICA. From 6.4 to 7, and our goal is 3; 7 is higher than 3.

Dr. VEREEN. It is, but 1 point doesn't define a——

Mr. MICA. It doesn't appear that we are heading in the right direction. We use the chart here of marijuana. I don't know if you have charts of some of the other uses, but we have got ecstacy reaching cocaine and heroin proportions. Do we have a chart for ecstacy? I know that you testified that it is on the increase, and Dr. Johnston said that we are seeing a substitution. Rather than crack, rather than seeing other drugs we have seen in the past, that they are shifting use; is that correct?

Dr. VEREEN. That's correct.

Mr. MICA. The other problem is we are seeing death and also increase in hospital emergency admissions; is that correct?

Dr. VEREEN. Yes.

Mr. MICA. And I attribute this to two things: One, an incredible supply. There is an incredible supply of heroin coming in from Colombia. A 20 percent increase in production in black tar heroin from Mexico. And not only are we seeing a larger amount of heroin and cocaine coming into the country, we are also seeing the highest purity levels that we have ever confiscated or seized; is that correct?

Dr. VEREEN. Yes, but you are seeing exactly how the drug problem preys on the United States. It takes advantage of communities and——

Mr. MICA. We are seeing a regional problem. We see methamphetamines, and we held hearings in Mr. Ose's district up and down the West Coast. We were in Iowa, and they had captured something like 1,000 meth labs between local, State and Federal law enforcement sources. We were in Dallas, TX, Mr. Sessions' district, and the DEA that covers Oklahoma and Texas told us that there are almost 1,000 labs in that area producing meth; people, literally by the thousands, being addicted.

In Mr. Ose's district we had testimony from one social worker where several hundred children had been abandoned in one county of 100,000 population, and they could only get about 30 reunited with the family because the people were either incoherent or so damaged by meth. We are seeing a new phenomenon of death and destruction, I think unlike anything that we have experienced; would you agree?

Dr. VEREEN. Yes, and that occurs with each new drug. Each one has a new and different profile. The challenge is to react as quickly as possible to that new drug.

Mr. MICA. One of the things that we have is a gap in our survey. We had the people from the Center for Disease Control, and some of the drugs that are now in vogue are not even on the charts for bean counting.

Dr. VEREEN. The CDC study is an every-other-year study. The other two studies are starting to capture that. We have two other local mechanisms, the CEWG and our pulse check, that gave us information about these other phenomena within the last 2 years.

Mr. MICA. I have to dispute some of Dr. Raub's testimony, too; again, the leveling off. And I think if we look at long term, or we take some of these individual drugs, we can dispute that we have seen, as Dr. Johnston and Dr. Vereen have testified, that we are seeing, unfortunately, a continued use overall. We are seeing dramatic increases in adult population, we will say 18 to 25, in that range, because some of those are young adults, and we have seen still dramatic increases; even in drugs that are perceived as a lesser risk, like marijuana, only some minor leveling off.

Do you want to respond, Dr. Raub?

Mr. RAUB. Only that the thrust of my statement was not to declare victory; rather, to identify where there are some positive signals, but also to acknowledge that there are some disconcerting negative developments. This country cannot lower its guard, and I agree completely with your concerns.

Mr. JOHNSTON. We do have crystal methamphetamine for some years in the Monitoring the Future study, and for the first time in 1999 it showed a significant drop, roughly a 40 percent drop. So there was some good news on that front. I hope it holds.

Mr. MICA. Let me yield now to Mrs. Mink.

Mrs. MINK. Thank you, Mr. Chairman.

I am somewhat distressed by the tone of the testimony that all of you have presented, because I don't happen to agree that there is anything to celebrate. The trends that are developed by these individuals studies, I don't think relate to the real world that we have to face. While studies are very valuable to help people determine where the emphasis ought to be in law enforcement or treatment I think that the context in which they are sometimes read and presented turns people off guard into thinking, well, somebody must have a handle on all of this because such-and-such a report indicates that the trends are going down in consumption.

I happen to agree with the testimony and tone of the first panel where the witnesses said they had such extreme difficulty, even among family members, to get the teenagers to disclose the truth of what is happening in a school situation. And so I take a very jaundiced view about the studies that depend upon the teenagers themselves relating honestly their 30-day practices or 14-day practices or the year practices. And I think that our job really is to examine the veracity of this evidence that you have collected and test it to make sure that these are accurate phenomenon that are going on.

The first question I have is, while this chart, Dr. Vereen, is dismissed as indicating as the trends are similar, there is still a wide

range between the top line and the bottom line. How do you interpret that for a layperson like myself looking at this chart saying, why the differences?

Dr. VEREEN. That is an excellent question and I perhaps should invite you to some of our staff meetings.

Mrs. MINK. No, no, no.

Dr. VEREEN. I can partially explain the answer, and my colleagues can add what they would like.

The CDC study, the top line, has a slightly older population which we know has a higher drug rate use. The bottom line, the red line, is the National Household Survey which surveys people as young as 12 which have a——

Mrs. MINK. They have no business being on one chart.

Dr. VEREEN. Well, we made the judgment, since the studies were going to be presented and compared, we would show that. Yes, there are discrepancies in the prevalence rate, but we as scientists, we as policymakers, look at the trend. I can tell you as a physician, we do that as well. Sometimes when you get a series of blood tests, the absolute numbers are not as important as the trends sometimes.

So what we have here are multiple views of the drug problem to get as clear a picture as possible. That is what we attempt to do and that is why we have multiple studies. We don't just rely on one.

Mrs. MINK. The top line is what age group?

Dr. VEREEN. That is the 9th, 10th, 11th and 12th grades. The Monitoring the Future we have split out. That is 8th, 10th, and 12th.

Now, on the bottom line you have 12 and over, so you have young people who have a low rate of drug use, and then you have many older people who are not using drugs at all in a household, because that is where the study grabs it, and that is why it is important to understand what each of those lines mean.

Mrs. MINK. So they offer no conclusive evidence. They don't look at the chart and say, oh, I am a policymaker and now I know what to do.

Dr. VEREEN. The data tell us that the trends are consistent and move in the same direction.

Mrs. MINK. Do you have a similar chart for the 18 to 25, because in your testimony you point out in this age group there is a significant increase in users. Do you have a chart?

Dr. VEREEN. We have one that we can provide for you, certainly.

Mrs. MINK. So your testimony is corroborated by the other studies?

Dr. VEREEN. Yes. I can offer that we can take any of these numbers and any of the data that the U.S. taxpayer pays for and put it in any form. We have a copy of this here, if you would like a closer look at it.

Mrs. MINK. So if the rates of consumption, addiction, however you want to say, increase after age 18 up to 26 in the studies——

Dr. VEREEN. Not necessarily. What we may have is a cohort that had been using at a high rate before and are continuing to use at a high rate. When we select out that age group, it doesn't necessarily mean that they started at that age group.

Mrs. MINK. But they are continuing. Why the huge variance in use to the next group, Mr. Johnston?

Mr. JOHNSTON. We have very similar results and it is more detailed by age. What we see is the youngsters who were the teenagers in the early 1990's when drug use among teens was going up, as they enter the post-high school years, those same class cohorts or birth cohorts are showing higher rates than their predecessors in older ages as well. They are carrying with them the habits they established back in the early 1990's. That is an unusual pattern here. We see that all of the time with cigarettes. If a particular class cohort had a high rate of smoking, even in their early teens, they will carry with them those habits. We have not seen that with illicit drug use: this is the first occasion where we have actually seen a cohort effect, and that shows up in the later ages as those youngsters, become the people in their 20's and perhaps even into their 30's.

Dr. VEREEN. And as Dr. Johnston pointed out, the 20's are when many young people are using some of the club drugs for the first time.

Mrs. MINK. Who came up with the term "club drug?"

Dr. VEREEN. I am not sure.

Mrs. MINK. Your agency?

Dr. VEREEN. No.

Mrs. MINK. And "designer drug," who came up with that name?

Dr. VEREEN. One of the things that we try to do is speak to the American people. We try to get educated by them. So we try to keep tabs on all of the latest lingo on the drugs. If we want to get messages out to young people, we try to meet them halfway by speaking their lingo so that they know that we have listened to them and we can report back to them, reflect back to them: We are concerned; this thing that you think is not very harmful is.

We have been able to react very quickly to ecstacy, for example. We can now show with the latest technology that ecstacy, in fact, causes brain change, perhaps permanent brain change, and we are able to get that information back to young people who are engaging in the club drug scene.

A part of the initiative by the National Institute on Drug Abuse is to actually present those very clinical pictures and postcards distributed in batches of thousands to young people so they can see for themselves what this drug that they think won't harm them could actually do to their brains.

Mrs. MINK. Thank you, Mr. Chairman.

Mr. MICA. I thank the gentlelady.

I yield to the gentleman from California, Mr. Ose.

Mr. OSE. Thank you, Mr. Chairman. I want to go back to Dr. Raub. I want to make sure that I understand something. On page 5 of your written statement at the bottom paragraph, you indicate that there is a change in the methodology by which the data for the study was collected, and that there can only be limited comparisons made between the data from the 1999 survey and the data obtained from surveys prior to 1999; is that correct?

Mr. RAUB. Yes, that's correct.

Mr. OSE. If I also understand your testimony on page 4, the survey that we are referring to in that testimony I just cited is the

primary source of statistical information on the use of illegal drugs by the U.S. population? That is the bottom line there?

Mr. RAUB. Yes.

Mr. OSE. The question I have, I am up here trying to decide, as compared to Dr. Vereen, I am trying to decide as a policymaker what is the data that we are supposed to be using. If the methodology had not been changed, do you have any indication what the results of the survey would have been so we can tie apples to apples, for instance?

Mr. RAUB. In fact, your point is well taken, and the language here and the approach here was a cautionary one. This is a Household Survey based on direct interview, which is a very powerful type of method. Most surveys of this type over the last several years have been making the transition from pencil and paper questionnaire approaches to computer-assisted devices. These are generally more favorable in terms of both the accuracy and the efficiency of following up on the data, but there is also the risk of introducing a different methodology that may alter the reporting. Therefore, as a cautionary step, the people doing the Household Survey, while introducing the computer method for the first time, also maintained a parallel pencil-and-paper approach as a subset, as a way of testing that transition.

Mr. OSE. That is the 13,000 sample?

Mr. RAUB. That's correct. I don't think that the language here or from my colleagues from SAMHSA means to suggest that the new results are invalid, but rather it is a cautionary, upfront signal.

Mr. OSE. Is there a difference between the results in the 13,000 sample and the new modality sample?

Mr. RAUB. The analyses are underway. My understanding is that to date they seem to be consistent—that there does not seem to be a major quirk introduced by the change in the methodology. We will know better after another cycle.

Mr. OSE. When do you except the analysis on the current sample, the comparative analysis on the current two samples, to be finished?

Mr. RAUB. I don't know precisely, but I expect that to be in the near future.

Mr. OSE. I would appreciate having that information when you get it.

[The information referred to follows:]

FROM: CDC DASH FAX NO.: 7704883112 10-19-00 01:54P P.02

Fact Sheet:
Youth Risk Behavior Trends

From CDC's 1991, 1993, 1995, 1997 and 1999 Youth Risk Behavior Surveys

Risk Behaviors That Improved,[1] 1991-1999

	1991	1993	1995	1997	1999
Injury-related behaviors					
Never or rarely wore a seat belt	25.9	19.1	21.7	19.3	16.4
Never or rarely wore a bicycle helmet[2]	96.2	92.8	92.8	88.4	85.3
Rode with a drunk driver[3]	39.9	35.3	38.8	36.6	33.1
Carried a gun[4]	NA	7.9	7.6	5.9	4.9
Carried a weapon on school property[4]	NA	11.8	9.8	8.5	6.9
Involved in a physical fight[5]	42.5	41.8	38.7	36.6	35.7
Involved in a physical fight on school property[5]	NA	16.2	15.5	14.8	14.2
Seriously considered suicide[6]	29.0	24.1	24.1	20.5	19.3
Tobacco use					
Current smokeless tobacco use[4]	NA	NA	11.4	9.3	7.8
Sexual behaviors					
Ever had sexual intercourse	54.1	53.0	53.1	48.4	49.9
Had four or more sexual partners	18.7	18.7	17.8	16.0	16.2
Used a condom at last sexual intercourse[7]	46.2	52.8	54.4	56.8	58.0
Had been taught about HIV/AIDS in school	83.3	86.1	86.3	91.5	90.6
Physical activity					
Participated in strengthening exercises[3]	47.8	51.9	50.3	51.4	53.6

Risk Behaviors That Worsened,[1] 1991-1999

	1991	1993	1995	1997	1999
Tobacco use					
Frequent cigarette use[9]	12.7	13.8	16.1	16.7	16.8
Alcohol and other drug use					
Episodic heavy drinking[10]	31.3	30.0	32.6	33.4	31.5
Lifetime marijuana use	31.3	32.8	42.4	47.1	47.2
Current cocaine use[3]	1.7	1.9	3.1	3.3	4.0
Lifetime illegal steroid use	2.7	2.2	3.7	3.1	3.7
Sexual behaviors					
Used birth control pills at last sexual intercourse[7]	20.8	18.4	17.4	16.6	16.2
Physical activity					
Attended physical education class daily	41.6	34.3	25.4	27.4	29.1

[1] Significant linear change, $p < .05$.
[2] Among students who rode bicycles during the 12 months preceding the survey.
[3] ≥ 1 times during the 30 days preceding the survey.
[4] On ≥ 1 of the 30 days preceding the survey.
[5] ≥ 1 times during the 12 months preceding the survey.
[6] During the 12 months preceding the survey.
[7] Among currently sexually active students.
[8] On ≥ 3 of the 7 days preceding the survey.
[9] On ≥ 20 of the 30 days preceding the survey.
[10] Drank ≥ 5 drinks of alcohol on at least one occasion on ≥ 1 of the 30 days preceding the survey.
NA; data not collected

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC

Risk Behaviors That Did Not Change or Demonstrated Inconsistent Patterns of Change, 1991-1999

	1991	1993	1995	1997	1999
Injury-related behaviors					
Felt too unsafe to go to school[1]	NA	4.4	4.5	4.0	5.2
Threatened or injured with a weapon on school property[2]	NA	7.3	8.4	7.4	7.7
Attempted suicide[2]	7.3	8.6	8.7	7.7	8.3
Tobacco use					
Lifetime cigarette use[3]	70.1	69.5	71.3	70.2	70.4
Alcohol and other drug use					
Current alcohol use[1]	50.8	48.0	51.6	50.8	50.0
Alcohol use on school property[1]	NA	5.2	6.3	5.6	4.9
Marijuana use on school property[4]	NA	5.6	8.8	7.0	7.2
Sexual behaviors					
Currently sexually active[5]	37.5	37.5	37.9	34.8	36.3
Physical activity					
Participated in vigorous physical activity[6]	NA	65.8	63.7	63.8	64.7
Enrolled in physical education class	48.9	52.1	59.6	48.8	56.1

[1] On ≥ 1 of the 30 days preceding the survey.
[2] ≥ 1 times during the 12 months preceding the survey.
[3] Ever tried cigarette smoking, even 1 or 2 puffs.
[4] ≥ 1 times during the 30 days preceding the survey.
[5] Sexual intercourse during the 3 months preceding the survey.
[6] For at least 20 minutes on ≥ 3 of the 7 days preceding the survey.
NA: data not collected

About the Youth Risk Behavior Survey (YRBS)

The YRBS is a national school-based survey conducted biennially to assess the prevalence of health risk behaviors among high school students. Data from the 1991, 1993, 1995, 1997, and 1999 national YRBS were combined into one data set to examine trends in risk behaviors across time, controlling for grade, sex, and race/ethnicity.

For More Information

For additional information on the YRBS, contact the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, 4770 Buford Highway, NE, Mailstop K-33, Atlanta, GA 30341-3717; telephone 1-888-231-6405; Internet http://www.cdc.gov/nccdphp/dash.

Mr. RAUB. May I also add on the methodological front the question that came up before about the use of urine or regarding hair testing. As part of the continuing evolution of this survey, there is a subset of people in the 2000 Household Survey that will have urine and hair testing as well as a movement toward some further verification of this information, but this is just a natural part of the methodological evolution in these studies.

Mr. OSE. Ms. Samuels, how would you describe ADAM in terms of its value as a research tool?

Ms. SAMUELS. Well, I think that——

Mr. OSE. First, ADAM is the statistical process you use to——

Ms. SAMUELS. ADAM is the program by which we are working in these 35 communities across the country, conducting interviews and then collecting the drug test information. So from that we gain information about the picture of the drug problem in a particular community, and that information can then be the basis or analytic tool for folks living in that community so they understand exactly what the sorts of problems are that we are seeing, the types of drugs being used by this population, the age effects, the differences by gender.

Mr. OSE. So it is a pretty comprehensive look into a community's practices?

Ms. SAMUELS. Yes. With respect to research as well, we also have the opportunity because we are doing this periodically to go in and ask supplemental questions that might be of particular relevancy to communities that we can provide as part of the ADAM process, so that we can elicit this information from the arrestees in the lockups during part of our quarterly——

Mr. OSE. Is the quality of the information gleaned from ADAM high quality, low quality, medium quality? How would you characterize it?

Ms. SAMUELS. I hope it is high quality. I think we have put into place a number of checks to ensure that we are conducting the interviews using a consistent instrument across the country, to ensure that the drug tests that are taken are sent to a central laboratory so they are all analyzed under the same set of circumstances, and over time we are also working to improve the methodology to ensure that the information that we get from a particular county is in fact representative of that county.

Mr. OSE. The 35 communities in which ADAM is currently at work, were they statistically selected or did you just pull them out of a hat? Do they reflect the country at large?

Ms. SAMUELS. The 35 communities that are involved now evolved from an earlier part of this program. We had a program that was called the Drug Use Forecasting Program that goes back more than a decade. We were testing the question as to whether or not drug use testing could inform us about drug use among arrestees, and from there we have expanded to a number of other cities. Currently the program is not and cannot provide a national representative estimate of drug use among arrestees, but we do have a vision and a plan for expanding to 75 cities, and as part of that plan we would be able to provide representative and statistically valid data on the drug use in the arrestee population as a whole.

Mr. OSE. That is exactly where I want to focus my question, so I appreciate you getting to that. That was not set up, Mr. Chairman, but that just happened.

On page 3 of your testimony, you say ADAM is the only national drug survey that routinely provides data on hard-core drug users. Then in the last paragraph, you say ADAM is the only national drug data system that includes a routine drug test as part of the data collection. I presume by your inclusion of that specific statement you are trying to differentiate ADAM as a scientifically quantifiable survey as opposed to one that might just be verbal?

Ms. SAMUELS. I think what we are trying to show is that there are two parts of it. There is the interview that is supplemented by the drug test, so we will ask the arrestee, Are you using drugs? What types of drugs are you using? And by getting the results of the drug test, we can validate and look at the answers that they have provided to us.

Mr. OSE. Do you find a higher validity in the responses on the verbal side from those who know that they are going to have their urine or hair samples taken as opposed to those that don't? Dr. Johnston, you are kind of smiling.

Mr. JOHNSTON. That is a reasonable question. I was smiling because of what it says about human motivation. But the—I don't know whether ADAM has tested that. I know in the cigarette research literature, it has been found that if kids know that they are going to have saliva tests, they report higher rates of smoking, but it is not a consistent finding. It is depends on the situation that kids are presented with.

Mr. OSE. In California we have this Proposition 36 that purports to be something to address an inadequacy in our drug treatment and drug programs, but the actual initiative eliminates the opportunity to perform a urine or drug test. And it just seems to me that why would you put into law, in an actual referendum that is going to be the law of the State, why would you put into that position a preclusion, the inability to actually hold someone accountable for their actions so that you can get the truth? Our objective here is to provide treatment for people. Yet, we are going to put into law or at least control—what is the phrase, controlling legal authority—an inability to hold them accountable for what they tell us.

I was reading your testimony, and I can't say that it is in here explicitly, but implicitly at least in your testimony, that you have to have some means of verifying what you collect verbally, and that drug testing urine, blood, hair, is the most effective way of doing that.

I didn't set this up, Mr. Chairman, but it is absolutely so precisely targeted on the basic dilemma we face in California that I would have flown on three red-eyes, 3 days in a row, just to get that in the public record, and I appreciate Ms. Samuels doing that.

Who was it that testified on the Centers for Disease—Dr. Raub. You indicated that use levels had flattened or leveled and in some cases improved. I am a little bit confused about something. I have a copy of the basic data from the Center for Disease Control study, and it talks about risk behaviors that worsened; and it has got tobacco use frequently, alcohol and other drug use, episodic, current, sexual behaviors and the like, and it goes from 1991 to 1997 follow-

ing the 2-year implement pattern that Dr. Vereen mentioned. It indicates to me that over the five tests that would have been occurring in the 1990's, that being 1991, 1993, 1995, 1997, and 1999, lifetime marijuana use has gone from a risk factor of—I have to make sure that I understand this—31.3 to a comparative 47.2 in 1999. Is that percent? I can't tell if that is percent. It is a 50 percent increase over an 8 or 9-year period. Current cocaine use has gone from a risk behavior rating of 1.7 in 1991 to 4 in 1999, which is basically a 100 percent increase. Frequent cigarette use has gone from a risk behavior rating of 12.7 in 1991 to 16.8 in 1999.

If you look at trends, which I believe is what we are looking at here, either in that chart or most any others that we have seen here, the trend is not positive. The trend is showing an increase in the risk behaviors, at least as it relates to this chart, and I am wondering whether that corresponds to a decline in usage that is indicated in your testimony?

Mr. RAUB. On that specific line, sir, I would not characterize it as decline in usage. Compared to 1991, there is an increase. Compared to 1997, there is a leveling.

Mr. OSE. I would agree on a comparative basis.

Mr. RAUB. But we need additional years of evidence to determine whether we have turned a corner or whether that is just a momentary pause.

Mr. OSE. I am trying to deal with the trend. I am hoping that it is not a momentary pause and that it is the peak, so that it goes down. And that is as it relates to the marijuana use, the 47.1 to the 47.2 risk behavior rating; but in current cocaine use, it goes from 3.3 to 4, which is a 25 percent increase.

Mr. RAUB. Right.

Mr. OSE. Now, I am not here to argue about the other things, but whether you take it in segmented markets, depending on what designer drug of the day we are talking about, or otherwise, while there may be some indication from 1997 to 1999 as it relates to lifetime marijuana use that there is a leveling, I don't see the indication that there is a trend here that has been set of a leveling. And that is what I am trying to get at: whether or not these risk behaviors that are highlighted here indicate usage patterns.

If I understand your testimony correctly, it is that as it relates to lifetime marijuana use, as it relates to these numbers, there seems to be a leveling from 1997 to 1999; but that the trend from 1991 to 1999 indicates significant increases?

Mr. RAUB. That is the way that I interpret it, yes, sir. And it is a pattern that is consistent in the trend in the other two surveys.

Mr. OSE. The 1997 to 1999 change, or the 1991 to 1999?

Mr. RAUB. The recent year change. Depending when they do the measurement, the last few years have changed in the other surveys and are showing in general a leveling or a slight decline, but we are showing an increase compared to the early 1990's.

Mr. OSE. Can you explore with me a little bit, it is interesting to me that the difference between lifetime risk behavior reports and current risk behavior reports. For instance, in 1997, the risk behavior report here for lifetime marijuana use indicated a reporting level of 47.1, and in 1999 it indicated a reporting level of 47.2. That would suggest to me that the same people who had reported

a lifetime marijuana use in 1997 basically reported it also in 1999? I mean if they used it by the time they got to 1997, they would have used it by the time they got to 1999 on a lifetime basis. But if you go to the current report on cocaine use, which I guess would stand for one or more times during the 30 days preceding the survey, in 1997 you had a risk behavior rating of 3.3, and in 1999 you had a risk behavior rating of 4, which going back to my earlier comments indicates a 25 percent increase in the usage of one or more times during the 30 days preceding the survey.

So I am a little bit confused on the difference between lifetime and current usage and how it can get analyzed for those of us who are responsible for making policy so we can keep kids like this from, frankly, suffering what we don't want them to suffer.

Mr. RAUB. I think that is one that we might best submit for the record with detailed explanation of how the various terms are used.

Mr. OSE. I appreciate that. That would be helpful.

Mr. MICA. Just in conclusion, we have again what I consider the attempt to put a happy face on this situation. Both Mrs. Mink and I am dismayed by what we have heard today. The death statistics are frightening and that is 1998. We haven't seen 1999. I see no reason why there would be any change in the trend that we have seen at least from deaths. This chart that was brought in by ONDCP doesn't show the 18-to–25, which put another dramatic rise there. There is only one statistic that shows any possible trend and possible decline or leveling out of what is going on. All three of the top three measures include, and if we take the fourth measure, it also shows a scary little turn for the worse. So 1 year does not a trend make, and we are concerned with the overall picture, which again is pretty glum, combined with the new phenomenon of drug-induced deaths that we see reported here today. I guess that really isn't a question, it is more of a statement.

We would also appreciate if there is something the subcommittee could do in making certain that we properly address the evaluation and statistics-gathering to make these trends and this information more accurate. We would appreciate working with each of you in that regard, and we welcome your suggestions and recommendations in that vein.

Mr. Ose.

Mr. OSE. Thank you, Mr. Chairman. I have collected my thoughts. I want to go back to something. Dr. Vereen, I am a little bit confused on the statistical sample that was used to report the improvement in drug use over the last 3 years. I have in my possession here the 1998, 1999, and 2000 annual reports on the National Drug Control Strategy Performance Measures of Effectiveness. While I am looking for this article that I read which I seem to have misplaced, the question arises as to whether or not the sample on which the performance measurement or the performance metrics were based is 12th grade usage or 8th grade usage.

If I understand correctly, from the years leading up to 1999 and included in the 1999 annual report, the performance metric was the 12th grade usage, and in the current year the performance metrics is the 8th grade level usage. My question obviously arises, is that apples versus apples or apples versus oranges? And I would appreciate any input you might have on that.

Dr. VEREEN. It is apples and apples or apples versus oranges depending on the question that is being asked in general. I brought along the expert, Dr. Zobeck, to explain some of the technical reasons why that was changed. It depends on what age group you are looking at and what program we administer. So, for example, in our media campaign, we want to know what is happening with the youngest set. When we are talking about overall drug trends for the Nation, which we are required to report every year in February, we use the higher numbers. But I will let Dr. Zobeck run through the details.

Mr. ZOBECK. The article and the issue that you refer to relates to our Objective 2 under Goal 1 of the PME, which deals with implementing a media campaign as a prevention tool for youth.

About this time last year when we were beginning to prepare the report, we did our review of the various measures. I also worked closely with our media campaign people. I oversee the evaluation there. And I said, based on the refinements to the media campaign, where they decided that the primary focus of the campaign would be on what they call "tweens," 11 to 13-year-olds, I said that the better measure for seeing if that has any impact would be using the 8th grade sample rather than the 12th grade sample. If you are looking for the most immediate impact of the program, which would be the media campaign, that would be the most direct measure. So I made the recommendation that we switch it from 12th to 8th graders.

Mr. OSE. If it had stayed at 12th graders, what would have been the results?

Mr. ZOBECK. I think you would have had a similar picture. Let me go back. The issue that the article made was that by changing it to 8th graders, it made it look like we were accomplishing things. There was a misunderstanding in the article. The chart that came in question was our Progress at a Glance chart, if I can find it here.

This chart on page B–4 was designed to give the reader a quick idea based on a color-coding scheme as to whether we were making progress, not making progress, or had no data to assess it. That is on page B–4.

Mr. OSE. It looks like a health care plan to me.

Mr. ZOBECK. It is a very complicated system dealing with 100 measures. However, you notice up here it says, This progress is measured as of 1998 relative to 1996, and the increase or the change that the article focused on was the 1999 data which is relevant to this chart, the 1998 data.

The baseline for the media campaign was 1998 so we actually only had 1 year of data. So we coded this green because we had the data and it was right on target.

If you go back to page E–4, I believe it is—no, page E- 10, you have the chart for that specific measure. And you see 1998, the red line here is what we call our glide path, where we want to be by 2002 and 2007, our two targets. You can see that the 1999 data reported it because we had—it was at 73.3 percent, which is below the glide path. However, that red and green chart is not reflecting that data year, it is reflecting the 1998 one.

This coming report, we already know that is going to be a red color on there because we know we are low, below the glide path. If we had stayed with 12th graders, it would have been the same result. It would have been green for 1998 because that is the baseline year; but the 12th graders, also in 1999, would have been below the glide path. So for the next year's report, that is going to be red—either one.

Mr. OSE. Just to satisfy my curiosity as to whether or not we are getting the straight scoop, are you saying that the results on page E–10, whether you use 8th or 12th graders as the proxy, would have been the same?

Mr. ZOBECK. The 12th graders would have had a lower perception of risk, so they would have been—it would have been lower, so I guess it would have been a worse case.

Mr. OSE. That would have put them below the glide path?

Mr. ZOBECK. Below the glide path. You want to increase their perception of risk rather than decrease it.

Mr. OSE. So the 8th graders perceive a higher level of risk in marijuana use than 12th graders?

Mr. ZOBECK. A slightly higher.

Mr. OSE. So using the 8th grade cohort would have improved the results of the report?

Mr. ZOBECK. They still would have been below the glide path. They wouldn't have changed the color code.

Mr. OSE. If you project that out a couple, 3, 4 years to the dates on which the program is supposed to adhere to certain goals, do you get there using the 12th grade cohort or the 8th grade cohort, or both?

Mr. ZOBECK. We could get there using both. We have a separate evaluation of the media campaign to track this very closely, very specifically. This is really a very broad-brush way—indicator. It is just one specific variable perception of risk of using marijuana regularly. Our in-depth evaluation is looking at hundreds of different variables and the complex relationship between them. Risk itself is not the most—it doesn't explain all of the variations that you are going to get.

Mr. OSE. Prior to the decision to use the 8th grade cohort, was there a discussion amongst the people who had the responsibility for selecting which cohort to be used and as to what its ultimate appearance would be in these reports?

Mr. ZOBECK. At the time we had the discussion, we didn't have the 1999 data. We didn't know where it was going to go. It was based solely on my recommendation that 8th graders are a better source to track the effectiveness of the media campaign than 12th graders.

Mr. OSE. So if we change the media campaign, we may very well need to change the cohort that we look at in future years?

Mr. ZOBECK. If we change the media campaign to aim at older individuals, yes.

Mr. OSE. I will say that I can imagine our interest in this issue in terms of changing the cohort from the 12th to 8th grade sample without having been advised accordingly, because I can tell you that the members of this panel travel to a lot of different districts, for obvious reason.

My final question, Mr. Chairman, if I may: What steps are you taking so that in the future when the cohorts get changed, you advise the appropriate congressional committee of such changes?

Mr. ZOBECK. We are going to include a section in the PME report that says "Changes." For this one, we just viewed this as a technical change rather than a change to any of the goals, objective or targets. We changed a measure. We made a call thinking, well, this is a minor technical thing; we are not going to report it. We realize that we should have, and in the next report there will be a section of any changes to this report.

Mr. OSE. Thank you, Mr. Chairman.

Mr. MICA. I thank the gentleman. We do have a vote that has been called, and it looks like possibly a series of votes. I don't have any further questions of the panelists at this time. We may submit in writing some additional questions for you to respond to.

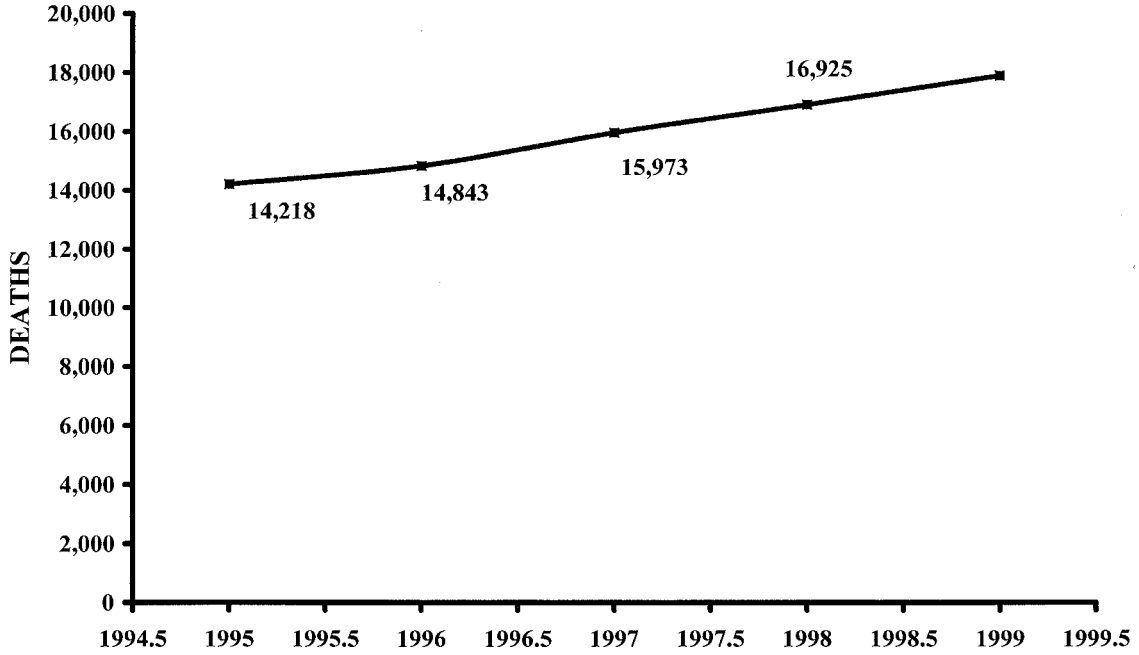
We appreciate your participation in our hearing today and your willingness to work with us to try to find some answers to some pretty difficult questions and bring what we see as a very serious situation under control.

There being no further business to come before the subcommittee at this time, this meeting is adjourned.

[Whereupon, at 12:21 p.m., the subcommittee was adjourned.]

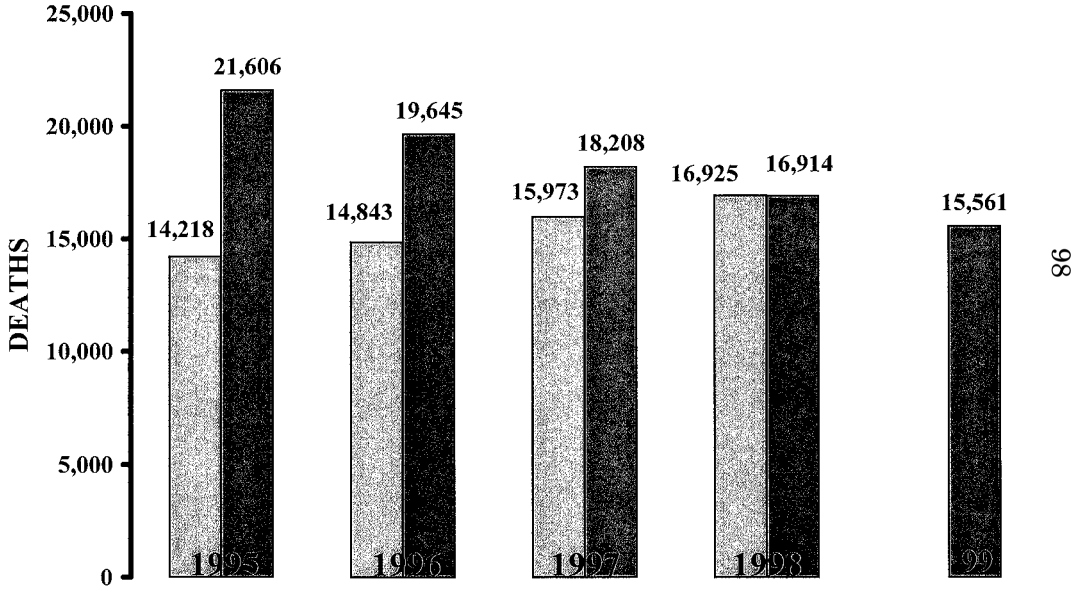
[Additional information submitted for the hearing record follows:]

DRUG-INDUCED DEATH RATE



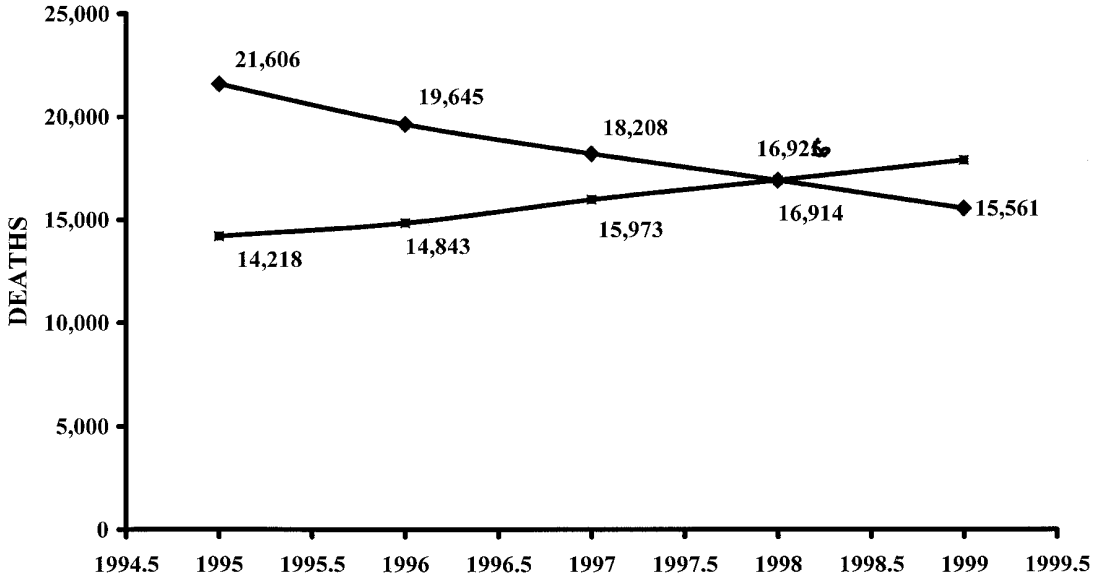
Source data: FBI Uniform Crime Statistics and the National Center for Health Statistics

DRUG-INDUCED DEATH RATE VS. MURDER RATE



Source data: FBI Uniform Crime Statistics and National Center for Health Statistics

MURDER RATE VS. DRUG-INDUCED DEATH RATE



Source data: FBI Uniform Crime Statistics and the National Center for Health Statistics