No Place to Hide:
Substance Abuse in Mid-Size Cities and Rural America

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Foreword and Accompanying Statement By Joseph A. Califano, Jr. Chairman and President

Growing up in the 1930s, 1940s and 1950s--whether it was in the Bedford Stuyvesant-Crown Heights section of Brooklyn where I spent my childhood or in Worcester and Cambridge, Massachusetts where I went to college and law school--illegal drugs were not on my radar screen or on those of my friends, relatives and classmates. Marijuana was something that jazz musicians, drummer/bandleader Gene Krupa and Hollywood actor Robert Mitchum smoked. Cocaine was a line in Cole Porter's memorable song, "I Get a Kick Out of You." Heroin was a horror used only by the most degenerate and despairing individuals.

In the 1960s, as I worked on President Lyndon Johnson's White House staff, we became conscious of a heroin problem simmering in urban ghettos. In 1965, LBJ asked Congress to enact the Drug Rehabilitation Act and asked for an annual appropriation of $15 million. In our wildest dreams, we never expected the need to exceed $50 million a year. We had difficulty mustering interest even in such modest amounts because most Americans tended to view drug addiction as an affliction of the urban poor, largely confined to black ghettos.

Our nation's failure to deal with the drug problem then--based in no small measure on the assumption that it was *their* problem, not *our* problem--allowed drugs time to seep into every neighborhood in every large city across America. Parents with the money and freedom fled to suburbs. But drugs did not respect geographic boundaries; they broke out of city limits and swarmed into Montgomery County, Grosse Point, Greenwich, Connecticut, Marin County and other suburbs. Even then, most of us saw mid-size cities and rural America as a drug-free oases. But marijuana, cocaine, heroin and hallucinogens like LSD soon found their

way into the heartland of mid-size cities, rural towns and farm communities.

The sores of drug abuse and addiction that we had allowed to fester in our urban ghettos today infect every hamlet in America.

Although no mid-size city or rural town is cloistered from the threat of drug abuse and addiction, most Americans persist in seeing drugs as an overwhelmingly urban problem. For many years, statistics reinforced that impressionistic view as drug use in smaller cities and towns lagged well behind such use in the nation's metropolises. But this picture began to change and our nation's Mayors were the first to suffer the consequences.

As we begin the 21st Century in America, there is *no place to hide* from the problem of substance abuse and addiction. The disturbing findings of this CASA White Paper, **No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America**, are that the rate of drug, alcohol and nicotine use among young teens in rural America is now higher than in the nation's large urban centers, and the rates of adult drug, alcohol and nicotine use are about the same in rural towns and mid-size cities as in large urban centers.

These troubling conclusions come from CASA's unique analysis of previously unreleased data from the 1999 Monitoring the Future Study conducted by the University of Michigan Institute for Social Research (ISR) for the National Institute on Drug Abuse and special runs of data from the National Household Survey on Drug Abuse, conducted for CASA by the Substance Abuse and Mental Health Service Administration (SAMHSA) Office of Applied Studies. CASA also analyzed data from the Treatment Episode Data Set (TEDS) and the Drug Abuse Warning Network (DAWN) of the U.S. Department of Health and Human Services and from the Arrestee Drug Abuse Monitoring Program (ADAM) of the National Institute of Justice in the Department of Justice. We examined statistics and studies from a number of states. CASA conducted numerous interviews with local law enforcement officers and other experienced experts in substance abuse. Finally, CASA reviewed more than 300 articles and publications. The result is the first comprehensive assessment and comparison of the incidence of substance abuse and addiction by population centers based on such a wide variety of data.

Bluntly put, meth has come to Main Street, along with other drugs and with magnum force aimed at our children. Eighth graders living in rural America--children usually 12- to 14-years old--are 104 percent more likely than those living in America's urban centers to use amphetamines, which include methamphetamine. This highly addictive substance, which sparks erratic, violent, paranoid and hyperactive behavior and can cause brain damage, has become a drug of choice for many children and teens in rural and mid-size city America.

Eighth graders in rural America are:

- Eighty-three percent likelier than those in urban centers to use crack cocaine;
- Fifty percent likelier to use cocaine;
- Thirty-four percent likelier to smoke marijuana;
- Twenty-nine percent likelier to drink alcohol and 70 percent likelier to get drunk;
- More than twice as likely to smoke cigarettes, and
- Nearly five times likelier to use smokeless tobacco.

Among tenth graders, use rates in rural areas exceed those in large urban areas for every drug, except Ecstasy (MDMA) and marijuana. Among twelfth graders, use rates in rural America exceed those in large urban areas for cocaine, crack, amphetamines, inhalants, alcohol, cigarettes and smokeless tobacco.

Drugs are now as available on Main Street as they are in Manhattan. The proportion of individuals surveyed in rural towns, small cities and large urban centers who find drugs "very easy" or "fairly easy" to obtain is essentially the same: for cocaine, 39.6 percent in rural areas, 41.8 percent in small cities and 39.8 percent in big cities; for crack, 38.0 in rural areas, 40.9 in small cities and 37.5 in big cities; for heroin, 29.9 in rural areas, 32.4 in small cities and 30.2 in big cities; for marijuana, 59.9 in rural areas, 61.1 in small cities and 59.3 in big cities.

From 1990 to 1998, the smaller the city, the larger the increase in drug law violations. Over that period, the average annual increase in per capita drug law violations in cities with populations of 50,000 to 100,000 was more than double that of larger cities of 250,000 or more; in cities with 25,000 to 50,000 people, almost triple that of such larger cities; in cities with 10,000 to 25,000 people, four times that of such larger cities; in cities with fewer than 10,000, more than six times that of such larger cities.

In 1988, the White House Office of National Drug Control Policy (ONDCP) began identifying High Intensity Drug Trafficking Areas (HIDTA). These are areas identified as centers "of illegal drug production, manufacture, importation or distribution" that need a significant increase in Federal resources to fight the problem. The HIDTA designation was originally used by the Federal government solely to mark giant urban centers such as New York, Los Angeles and Miami. In 1996, it was applied to Iowa, Kansas, Nebraska and South Dakota and in 1998 to Kentucky, Tennessee and West Virginia.

According to the U.S. Centers for Disease Control and Prevention, from 1994 to June of 1999, AIDS cases in rural areas increased by 82 percent compared to a 59 percent increase in metropolitan areas with populations above 500,000, a rise due largely to intravenous drug use. A 1998 report from the SmithKline Beecham Drug Testing Index, based on drug tests of about five million employees in various regions of the eastern United States, revealed that eight to 14 percent of workers in rural areas of Tennessee, Indiana and Florida tested positive for drugs, compared to four to six percent of workers in the three largest metropolitan areas.

To appreciate how drugs have come to Main Street, consider the spread of meth. From 1994 to 1998, Drug Enforcement Administration seizures of meth labs jumped from 263 to 1,627--a sixfold increase concentrated largely in less populated areas of the West and Midwest. In 1998, state and local police seized another 4,132 illegal drug labs, almost all of them producing meth, largely centered in rural and mid-size city America. Meth labs are like daggers stabbing the heartland of America--from California across the middle of the nation to Illinois. In addition to California and Illinois, states in which at least 50 meth labs were seized in 1998 include Arizona, New Mexico, Utah, Colorado, Oklahoma, Missouri and Arkansas. Anecdotal evidence now suggests that meth may be making its way to the East Coast. From January to November 1999, police in the Shenandoah Valley of Virginia seized approximately $1 million of the drug, raising concern that the area may be an East Coast hub for meth trafficking.

Substance abuse and addiction is public enemy number one in America. Its threat to teens and children is aggravated in small and mid-size towns, cities and counties that lack the resources and experience available to large metropolitan concentrations to combat this problem.

Smaller communities have greater difficulty in providing accessible drug treatment programs and attracting trained substance abuse professionals, school nurses and counselors. They do not have a large enough tax base to hire and train a sufficient number of law enforcement officers. We have a common obligation to provide these communities the resources they need. Just as drugs recognize no boundaries as they spread across our land, so we must accept no boundaries in our efforts to combat substance abuse. At a time of enormous federal budget surpluses, the national government should provide resources to our rural communities and mid-size cities in order to increase treatment and local law enforcement capacity and to enhance the ability of the Drug Enforcement

Administration to assist and help train local police and sheriff's departments.

The Administration is asking Congress to appropriate, on an emergency basis, $1.6 billion for military operations and equipment for the government of Colombia to battle drug lords and stamp out production centers there. But drugs come to America by invitation, not simply by invasion and drugs are produced within our borders as well as in foreign countries. If we can afford to provide such extraordinary resources for anti-drug military operations in Colombia, then surely we can provide similar resources to assure that every individual in America who seeks treatment can obtain it; give rural and small and mid-size city citizens the ability to reduce the demand for drugs in their communities through expanded prevention and treatment services; increase the capabilities of local law enforcement agencies to cut the availability of drugs in smaller communities, and provide the law enforcement and technical support to stamp out illegal drug production such as the meth labs in rural America.

The Clinton Administration and the Congress should match, dollar for dollar, aid to Colombia with aid to the rural communities and small and mid-size cities to battle substance abuse on our own soil.

The need is particularly urgent with respect to methamphetamine. Meth addiction is one of the greatest threats to families in the West and Midwest, stealing parents from their children and children from their parents. The proliferation of meth labs, which bring together a volatile and explosive mix of chemicals, endangers the public safety.

We Americans must understand that when any of us is savaged by drug abuse and addiction, we all bleed. We face this problem whether we live on Park Avenue or near a National Park, in central Harlem or a rural hamlet, in Beverly Hills or Boise, Idaho. Battling drugs only in one place is like pushing down on a pillow: they will just pop up somewhere else. We can no more deal with the scourge of drugs in one city or section of the nation than we can cure leukemia in only one part of the bone marrow. We must increase our efforts in rural areas and mid-size cities while maintaining our efforts in large urban centers.

The mayors of our nation are on the front line in the battle against drug abuse and addiction. They recognize that prevention, education and treatment are as central to their efforts as law enforcement. To this end, many Mayors and other local leaders have adopted imaginative and effective ways to attack the problem. Mayor Brent Coles of Boise, Idaho, is the driving force behind *Enough is Enough*, a large-scale drug prevention program that has mobilized Idaho communities. The *Regional Drug Initiative* works to keep drugs out of Portland, Oregon and its surrounding communities. Michigan's *Upper Peninsula Teen Leadership Program* brings together community residents to work with teens and children in drug prevention, education and early intervention. *Promise of a New Day* in Franklin County, Ohio, is a comprehensive community-wide prevention effort that addresses a wide range of substance abuse-related problems.

The Drug Enforcement Administration has been fighting drugs in the heartland with its *Mobile Enforcement Team Program (MET).* The MET program provides local police and sheriffs with skilled personnel and other expertise that help attack violent drug organizations in their communities. Between October 1995 and October 1998, METs went into 214 communities to help reduce assaults, robberies and murders in each by more than 10 percent. We need to provide DEA with additional revenues to expand this effort.

Mayors and other local officials can learn from each other's innovative programs, but federal and state governments must also step up to the plate. A coordinated effort to reduce both demand and supply is needed to turn the tide against drugs in mid-size cities and rural towns.

The Mayors of America know this problem and their communities well enough to understand that the most important battles are fought at home. What happens across the kitchen table

and in the living room, classroom and church pew has the greatest influence on whether American teens smoke pot, snort cocaine, take meth or binge drink. We cannot let the availability of drugs undermine the efforts of parents, teachers and churches to help our children.

In June of 1996, then Conference of Mayors President Mayor Richard M. Daley of Chicago appointed Mayors H. Brent Coles of Boise, Idaho and Scott King of Gary, Indiana to serve as Co-Chairs of the Drug Control Task Force. Under the leadership of Mayors Coles and King, the Conference held a Mayors National Forum on Drug Control in May of 1997, at which "A National Action Plan to Control Drugs" was released. One of the major focuses of that plan was the need for greater attention to the issue of methamphetamine.

In February 1999, the U.S. Drug Enforcement Administration (DEA) hosted *Crisis in Middle America: A National Conference on Drugs, Crime, and Violence in Mid-Sized Communities*, a conference on the spread of drugs and drug-related violence to America's mid-size cities and rural areas. At this meeting, The United States Conference of Mayors (USCOM) and the DEA formed an Interagency Working Group to further explore these issues.

The Conference of Mayors Task Force on Drug Control next convened a working session on the substance abuse and methamphetamine crisis in rural America in May, 1999 in Boise, Idaho, which was attended by representatives of the law enforcement, prevention and education, treatment and research communities. Following that meeting, The United States Conference of Mayors and the Drug Enforcement Agency asked CASA to assess the extent of the drug problem in mid-size cities and rural America.

Many individuals worked hard to produce this report: Susan E. Foster, CASA Vice President and Director of Policy Research and Analysis is responsible for preparing the report. Jordan Matsudaira, Research Associate, Michael Paul, Research Assistant and John Muffler, Senior Research Associate, helped. Justin Bernbach did the editing. Jane Carlson handled the administrative details.

We greatly appreciate the assistance of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, which provided complex special runs of the National Household Survey on Drug Abuse, and the University of Michigan which made available previously unreleased data from its 1999 Monitoring the Future Study.

We are especially grateful to the Drug Enforcement Administration for the support that helped make this project possible, and to the National Institute on Drug Abuse for their assistance. The United States Conference of Mayors deserves special commendation for their commitment to dealing with this problem. Their commissioning of this report and having it presented at their annual meeting is evidence of their determination to stamp out drug abuse and addiction in their communities.

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I. Right Here in River City

America's substance abuse epidemic has come to rural America. Substance abuse is no longer a phenomenon limited to large cities. Adults in small metropolitan and rural areas are just as likely as those in urban America to use and abuse illegal drugs, alcohol and tobacco. Young teens in small metropolitan and rural areas are even more likely to abuse substances than those in large metropolitan areas. Today in River City, drugs are just as easy to obtain as they are in Metropolis.

In preparing this paper, CASA conducted a unique analysis of previously unreleased data from the 1999 Monitoring the Future Study, conducted by the University of Michigan Institute for Social Research (ISR) for the National Institute on Drug Abuse, and special runs of data from the National Household Survey on Drug Abuse, conducted for CASA by the Substance Abuse and Mental Health Service Administration (SAMHSA) Office of Applied Studies. CASA also analyzed data from the Treatment Episode Data Set (TEDS) and the Drug Abuse Warning Network (DAWN) of the U.S. Department of Health and Human Services, and from the Arrestee Drug Abuse Monitoring Program (ADAM), of the National Institute of Justice in the Department of Justice. CASA examined statistics and studies from a number of states. CASA conducted numerous interviews with local law enforcement officers and other experienced experts in substance abuse. Finally, CASA reviewed more than 300 articles and publications. The result is the first comprehensive assessment and comparison of the incidence of substance abuse and addiction by population centers based on such a wide variety of data.

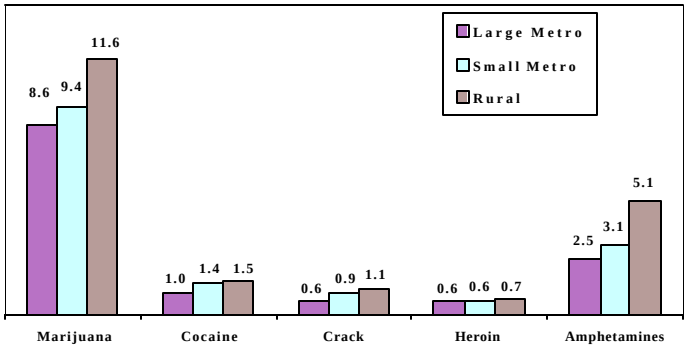
Substance Use in Smaller Cities and Rural Communities

Youth

CASA conducted a unique analysis of 1999 data from the Monitoring the Future Study on illicit drug, alcohol and nicotine use[*] of eighth, tenth and twelfth graders in order to determine differences among large metropolitan, small metropolitan and rural areas.[1] The CASA analysis reveals that eighth graders in rural areas were more likely to have smoked marijuana, snorted cocaine and used inhalants, crack, amphetamines, tranquilizers, alcohol, cigarettes and smokeless tobacco in the past year than eighth graders in the largest metropolitan areas.[†]

Figure 1.A

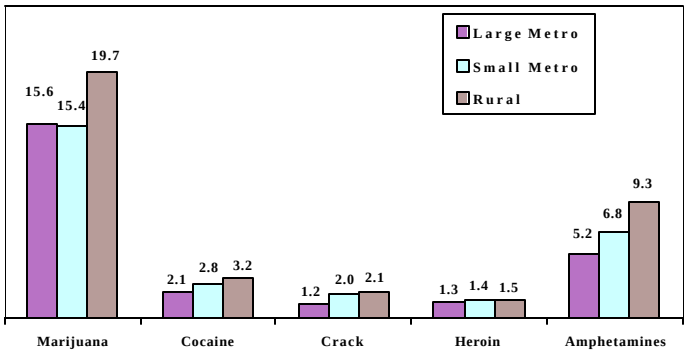
Past Month Use of Illicit Drugs by Eighth Graders: 1999



Source: The Monitoring the Future Study, University of Michigan

Figure 1.B

Annual Use of Illicit Drugs by Eighth Graders: 1999



Source: The Monitoring the Future Study, University of Michigan

Illicit drugs. Eighth graders in rural America are 34 percent more likely to have used marijuana in the past month than their peers in large metropolitan areas (11.6 percent vs. 8.6 percent) and 26 percent more likely to have used it in the past year (19.7 percent vs. 15.6 percent).[‡] (Figures 1.A and 1.B) They are 52 percent likelier to have used cocaine (3.2 percent vs. 2.1 percent) and 75 percent likelier to have used crack cocaine (2.1 percent vs. 1.2 percent) in the past year than their large city counterparts. Eighth graders in small metropolitan areas are also more likely to have used crack cocaine in the last year than eighth graders in large metropolitan areas. (Figure 1.B)

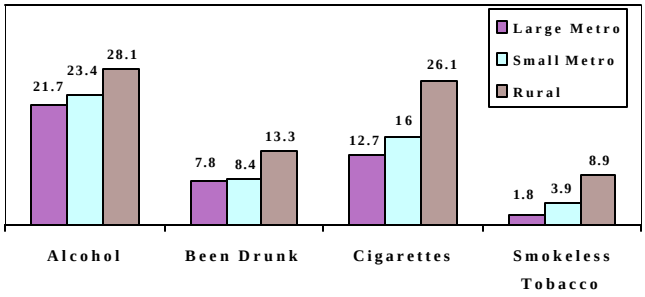
[*] At CASA's request, the University of Michigan provided unreleased data from the 1999 Monitoring the Future Study for the purpose of this report. CASA analyzed this data to test for significant differences in drug use by population density.

[†] In this paper, large metropolitan areas, also referred to in the text as 'large urban' areas or 'big cities,' are areas over one million in population. Small metropolitan areas have populations between 50,000 and one million. Metropolitan areas refer to counties or groups of economically integrated counties containing a central city with a population over 50,000. Rural areas are counties with no city of over 50,000. See Appendix A for details.

[‡] Unless otherwise noted, all differences described in this report are statistically significant at the 0.05 level. Where small sample size makes it impossible to determine whether differences are statistically significant, they are noted with an [*].

For amphetamines, including methamphetamine, the difference is even more striking. Rural eighth graders are 104 percent likelier to have used amphetamines in the past month (5.1 percent vs. 2.5 percent) and 79 percent likelier to have used amphetamines in the past year (9.3 percent vs. 5.2 percent) than their peers in large metropolitan areas. While use rates were lower for eighth graders in small metropolitan areas than for those in rural areas, they were still 31 percent more likely to use amphetamines in the past year than eighth graders in larger cities (6.8 percent vs. 5.2 percent).

Figure 1.C
Past Month Use of Alcohol and Tobacco by Eighth Graders: 1999



Source: The Monitoring the Future Study, University of Michigan

Eighth graders in rural areas are more likely to have used inhalants in the past month and in the past year than eighth graders in large cities. Heroin use among eighth graders in rural areas matched use rates in the large cities. (Figure 1.B)

For tenth graders current use rates in rural areas exceed those in large urban areas for cocaine, amphetamines, crack,* barbiturates,* inhalants,* hallucinogens,* LSD,* heroin,* steroids* and tranquilizers*--every drug except MDMA (Ecstasy) and marijuana.*

Among twelfth graders, current use rates in rural areas exceed those in large urban areas for cocaine, amphetamines, barbiturates, inhalants,* crack* and tranquilizers.* Current use of marijuana,* hallucinogens,*, LSD,* MDMA* and steroids* is higher in urban areas than in rural areas among twelfth graders. Heroin use is the same in rural and large urban areas.

* Small sample size makes it impossible to determine whether this difference is statistically significant.

Marijuana use in the past year is higher among twelfth graders in urban areas than in rural areas (38.7 percent vs. 34.7 percent).

Alcohol. Eighth graders in rural areas are 29 percent more likely to have used alcohol in the past month (28.1 percent vs. 21.7 percent) and 70 percent more likely to have been drunk in the past month (13.3 percent vs. 7.8 percent) than eighth graders in large metropolitan areas. (Figure 1.C) Past month alcohol use by high school seniors was higher in small metropolitan areas than in large cities (52.8 vs. 48.9) and tenth graders in rural areas were more likely to have been drunk in the past year than their big city counterparts (43.4 vs. 39.4).

Tobacco. Rural eighth graders were more than twice as likely to have smoked cigarettes in the past month than those in large metropolitan areas (26.1 percent vs. 12.7 percent) and almost five times more likely to have used smokeless tobacco (8.9 percent vs. 1.8 percent). (Figure 1.C) For eighth, tenth and twelfth graders, the smaller the community, the greater the rates of use of tobacco products.

Gateway drugs. Higher rates of use of illicit drugs, alcohol and tobacco among eighth graders may have particular significance for teens in rural areas because of the role of marijuana, alcohol and tobacco as gateway drugs. In 1997, CASA established the statistical relationship between use of tobacco, alcohol and marijuana--in and of themselves--and use of drugs such as cocaine, heroin and acid.[2] Examining data from the U.S. Centers for Disease Control and Prevention's 1995 Youth Risk Behavior Survey of 11,000 students in grades nine through

twelve, CASA isolated teen use of these gateway drugs from other problem behaviors, such as fighting, drunk driving, truancy, promiscuous sexual activity, carrying a weapon and attempting suicide. Among teens who report no other problem behaviors, those who drank and smoked cigarettes at least once in the past month are 30 times likelier to smoke marijuana than those who did not; those who used cigarettes, alcohol and marijuana at least once in the past month are almost 17 times likelier to use another drug like cocaine, heroin or LSD. By way of comparison, in 1964 the first Surgeon General's Report on smoking and health found a nine to 10 times greater risk of lung cancer among smokers,[3] and the early results of the Framingham heart study found that individuals with high cholesterol were two to four times likelier to suffer heart disease.[4]

Although most youth who use marijuana will not move on to heroin and cocaine, teens who use marijuana are far more likely to get into harder drugs than teens who do not. Biomedical and scientific studies are beginning to unearth the reason for this strong relationship between the use of marijuana, alcohol, tobacco and other drugs. Recent studies at universities in California, Italy and Spain reveal that these drugs all affect dopamine (the substance that gives pleasure) in the brain in a manner similar to heroin and cocaine.[5]

Table 1.1
Past Month Use of Various Drugs by Adults: Annual Averages 1997-1998

	Age Group	Large Metro	Small Metro	Rural
Any illicit drug	18-25	14.9	18.0	11.8
	26-34	8.2	6.5	6.0
Marijuana	18-25	13.0	15.8*	9.5*
	26-34	6.6	5.1	4.4
Cocaine	18-25	1.4	1.9	1.3
	26-34	1.2	0.8	1.1
Hallucinogens	18-25	2.2	3.2	2.1
	26-34	0.3	0.5	0.6
Heroin	18-25	0.1	0.2	0.0
	26-34	0.1	0.1	0.1
Stimulants	18-25	0.6	0.8	0.4
	26-34	0.1	0.4	0.2
Sedatives	18-25	0.1	0.3	0.1
	26-34	0.0	0.1	0.1
Analgesics	18-25	1.5	1.7	1.2
	26-34	0.9	0.5	0.7

* Note: This is the only statistically significant difference in this table.
Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse.

Table 1.2
Past Month Use of Licit Drugs by Adults: Annual Averages 1997-1998

	Age Group	Large Metro	Small Metro	Rural
Alcohol[a]	18-25	58.3	61.0	57.7
	26-34	61.8	61.9	55.0
Binge alcohol	18-25	27.1	33.3	28.9
	26-34	22.3	22.8	22.8
Heavy alcohol	18-25	10.2	14.7	12.8
	26-34	6.9	7.5	8.1
Cigarettes	18-25	36.7	42.1	47.7
	26-34	32.3	31.8	37.3
Smokeless tobacco	18-25	2.5	5.3	9.1
	26-34	2.5	4.1	8.8

Note: None of the differences for alcohol, binge or heavy alcohol use are statistically significant. For cigarettes, the difference between rural and large metropolitan areas is significant. For smokeless tobacco, all differences are significant except between small and large metropolitan use rates for 26- to 34-year olds.
Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse.

Adults

Illicit drugs. CASA's analysis reveals that, for illicit drugs other than marijuana, there is no statistically significant difference in drug use in the past month among adults age 18 and older between large cities, mid-size cities and rural areas. (Table 1.1)

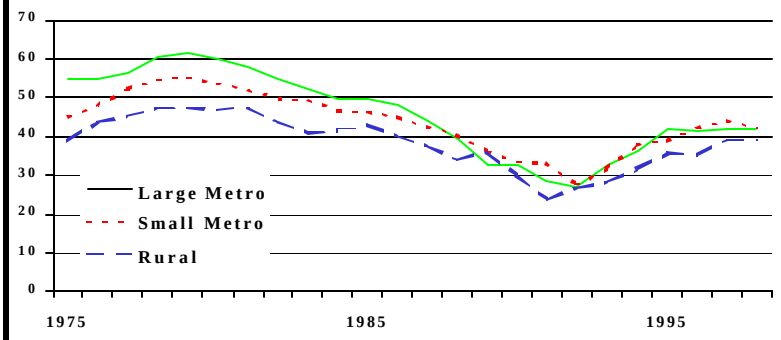
Alcohol. Adult use of alcohol does not differ significantly by community size, regardless of the amount consumed or age. (Table 1.2) This is true whether we look at any use in the past month or at more specific categories such as heavy drinking or binge drinking.

Tobacco. Use of tobacco products is greater in smaller metropolitan and rural areas than in

large metropolitan areas. (Table 1.2) Young adults aged 18 to 25 in rural areas are 30 percent likelier than adults in large metropolitan areas to have smoked a cigarette in the last month (47.7 percent vs. 36.7 percent). Rural 18- to 25-year olds are more than 3.5 times likelier to use smokeless tobacco than adults in large metropolitan areas (9.1 vs. 2.5 percent).

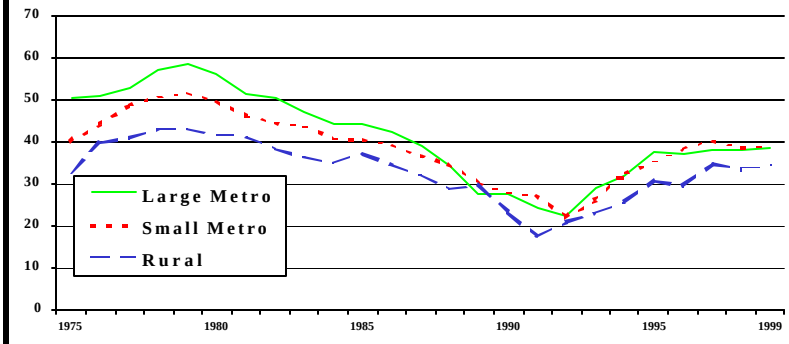
Trends

Figure 1.D
Annual Use of Any Illicit Drug by Twelfth Graders: 1975-1998



Source: The Monitoring the Future Study, University of Michigan

Figure 1.E
Annual Use of Marijuana by Twelfth Graders: 1975-1999



Source: The Monitoring the Future Study, University of Michigan

A lack of data prevents us from examining drug use patterns before the latter half of the 1970s, but in that decade and into the early 1980s, the proportion of twelfth graders reporting any kind of illicit drug use was about 10 percentage points higher in large metropolitan areas than in rural areas.[6] Thereafter, the gap began to close, with rural use eclipsing use in large cities in 1989 and again in 1992. (Figure 1.D) The differences among large and small metropolitan and rural areas were not statistically significant in 1998.

A closer look at the data reveals interesting differences among drugs. Marijuana has regularly been used more by twelfth graders in large cities, though the difference has fallen from around 10 to 15 percentage points in the late 1970s, to five to eight percentage points in the late 1980s and 1990s (Figure 1.E) Hallucinogens displayed a similar pattern.

The largest change has occurred with cocaine. Twelfth graders' cocaine use was eight to nine percentage points higher in large metropolitan areas in the mid-1980s than in rural areas. In 1999, the use in large cities dropped to nearly two percentage points lower than in rural areas. (Figure 1.F)

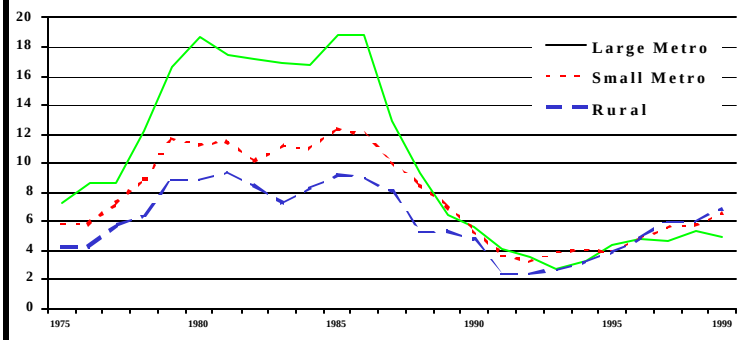
Twelfth graders' use of heroin has not displayed any consistent pattern over time, with the lead in use alternating randomly between large metropolitan and rural areas throughout the period. (Figure 1.G) The levels of use of other drugs, such as barbiturates, inhalants and tranquilizers--which have also alternated between being more prevalent in large cities and rural areas--have been higher in rural areas in recent years.

Adult illicit drug use, driven in large part by marijuana, has dropped over the past 20 years. In 1979, 54 percent of young adults aged 18- to 25-years old used illicit drugs in the past year in large metropolitan areas, compared to 51

percent in small metropolitan areas and 43 percent in rural areas. (Figure 1.H) As with youth, throughout the 1980s this gap narrowed, and in 1993, rates of use were actually higher in rural communities than in large metropolitan areas. In both 1997 and 1998, the differences in use between rural communities and small and large metropolitan areas were not statistically significant.

Figure 1.F

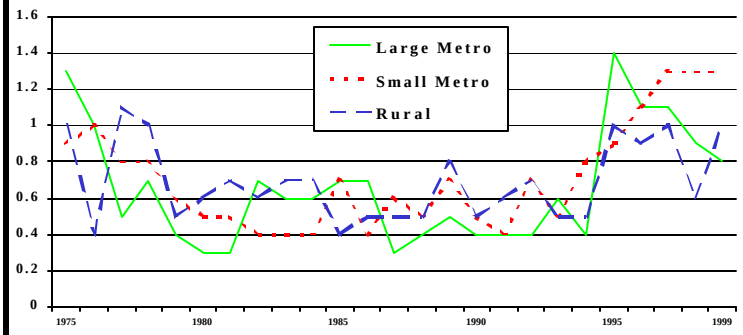
Annual Use of Cocaine by Twelfth Graders: 1975-1999



Source: The Monitoring the Future Study, University of Michigan

Figure 1.G

Annual Use of Heroin by Twelfth Graders: 1975-1999



Source: The Monitoring the Future Study, University of Michigan

Diversity of Drug Problems in Smaller Cities and Rural Areas

National prevalence data can mask a great deal of diversity among smaller cities and rural areas. The drug problem may vary among communities that are grouped under the categories of small metropolitan and rural. It is difficult to assess the extent to which drug use in a farming community differs from that in a town of 40,000 residents, since most studies do not sample these subgroups in sufficient numbers.* To provide more detailed analysis, the Substance Abuse and Mental Health Administration (SAMHSA) averaged, at CASA's request, 1997 and 1998 data from the National Household Survey on Drug Abuse. Small metropolitan areas were subdivided into areas with population between 250,000 and one million, and 50,000 and 250,000; and rural areas were subdivided into areas with population between 2,500 and 50,000, and less than 2,500.

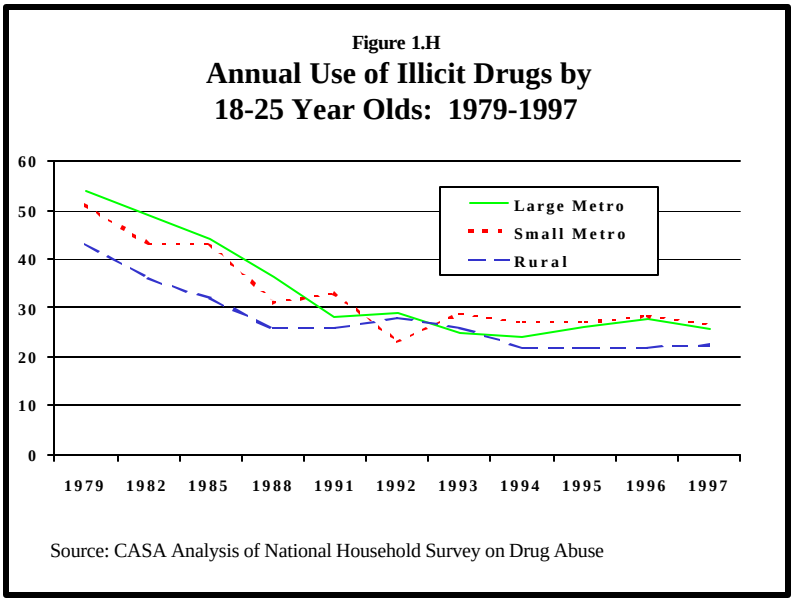
Among adults the use of drugs is generally highest in areas between 50,000 and 250,000 residents, and is incrementally lower in both larger and smaller sized communities. Past month use of cocaine and amphetamines are identical in rural areas with populations less than 2,500 and large metropolitan areas.† (Figure 1.I)

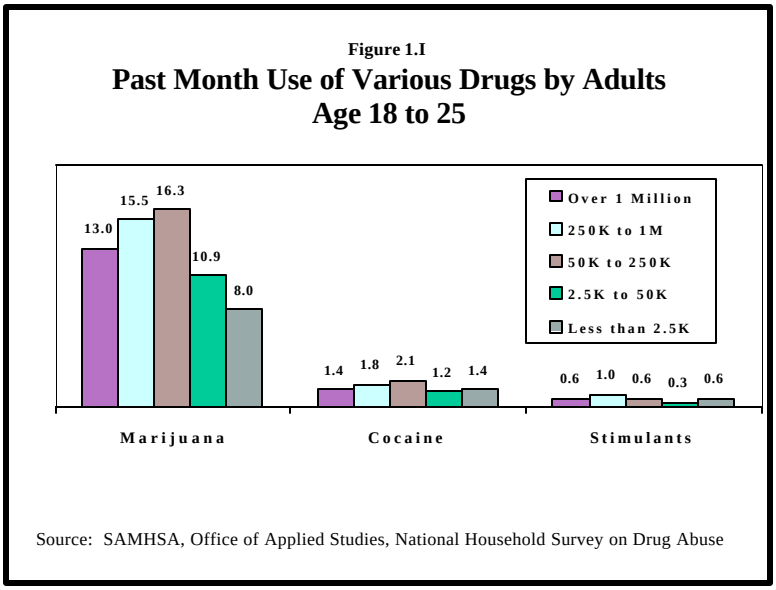
Tobacco use continues to display a consistent relationship to community size when further broken down by population density: the smaller the area the higher the rates of use of both

* The 1980 and 1994 NHSDA studies are exceptions. Both oversampled 'rural' areas to allow for drug use prevalence estimates that are nationally representative of rural America.

† Because of small sample size it is impossible to determine whether these differences are statistically significant.

cigarettes and smokeless tobacco. (Figure 1.J)





There is significant variation in the scale and scope of drug problems among geographic regions of the country. For example in Indiana in 1997, 20 percent of eighth graders reported using any illicit drugs in the past month compared to 13 percent nationwide,[7] and in Washington in 1998, 24 percent of twelfth graders reported ever using hallucinogens compared to 14 percent nationwide.[8] Anecdotal evidence reveals some of the ways in which sharp regional differences can be masked by national data. Plano, Texas, an affluent suburban town of about 200,000 residents was rocked by the death of 18 youths between 1996 and 1998 due to heroin abuse.[9] In Palmer, Tennessee--a town of only 1,000 residents--officials detained more than a 100 suspects in 1998 for methamphetamine-related charges and the drug was related to more than 97 percent of arrests.[10]

Demographics

Gender, ethnic and racial differences in the use of alcohol and other drugs are similar in urban and rural areas.[11] There is, however, one population that warrants special consideration in the rural context for their particular vulnerability to the ravages of alcohol, tobacco and illicit drugs--Native Americans.

In 1992, the alcohol-related death rate among Native Americans was 5.2 times higher than in the general U.S. population.[13] Rates of other illicit drug use among Native American teens have been found to be much higher for nearly all drugs than in studies of youths nationwide.[*] Youth on the reservation were 3.5 times likelier to have tried marijuana, 5.8 times more likely to have tried stimulants and 8.3 times more likely to have tried heroin than were youths in a nationwide

> *We do not just have a national drug problem. What we really have is a series of local drug epidemics.*
>
> *--General Barry McCaffrey*[12]
> *Office of National Drug Control Policy Chief*

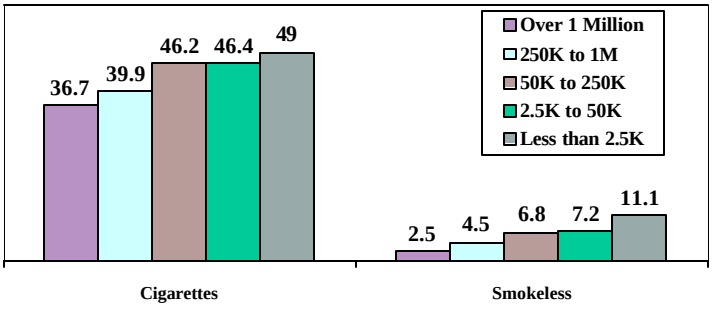
[*] The Native American sample refers to 1988-1989 statistics compiled by the Tri-Ethnic Center for Prevention Research at Colorado State Univiersity on lifetime prevalence for youth grades 7 to 12. Data for the National Sample are from the 1988 National Household Survey on Drug Abuse for youth ages 12 to 17.

sample.[14] (Table 1.3)

The Demand

Figure 1.J

Past Month Use of Tobacco by Adults Age 18-25
Expanded Population Category: 1997-1998 Averages



Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse

Though most of the studies identifying factors that help predict the likelihood of involvement with drugs have focused on populations in large urban areas, research suggests that people in smaller communities appear to use drugs, alcohol or tobacco for essentially the same reasons as their urban counterparts.[16] Factors associated with increased drug use, particularly for youth, include perceptions of low risk of the consequences associated with drug use and a host of other factors including problem behaviors (i.e., juvenile arrests, low school achievement) and family history of substance abuse.[17] On the supply side, drug availability is obviously a prerequisite, if not an explanation, for use.

Table 1.3

Lifetime Drug Use by Native American Youth
Age 12 to 17: 1988

Substance	Native Americans	National Sample
Alcohol	80.5	50.2
Marijuana	61.1	17.4
Inhalants	23.8	8.8
Cocaine	7.9	3.4
Stimulants	24.7	4.2
Depressants	10.5	2.3
Heroin	5.0	0.6
Hallucinogens	9.8	3.5
Tranquilizers	7.4	2.0
Cigarettes	78.4	42.3
Smokess tobacco	58.3	---

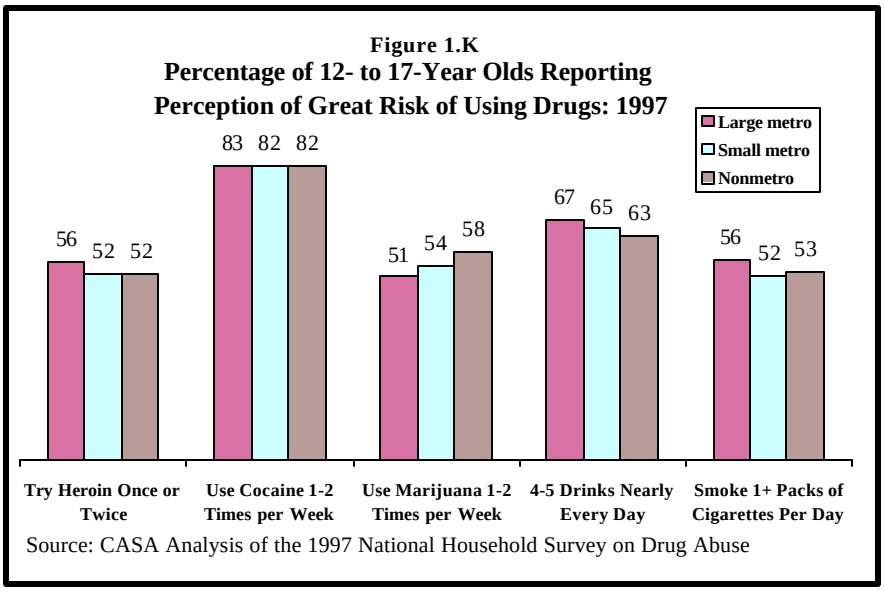
Source: Beauvais, F., & Segal, B. (1992). Drug use patterns among American Indian and Alaskan native youth: Special rural populations. In R. Edeards (Ed.), *Drug use in rural American communities* (pp. 77-95). New York: Hawthorne Press.

Crank [methamphetamine] will do to the reservations what Custer couldn't.

--Bonnie Pipe[15]
Clinical director of a tribal recovery center in Lame Deer, MO

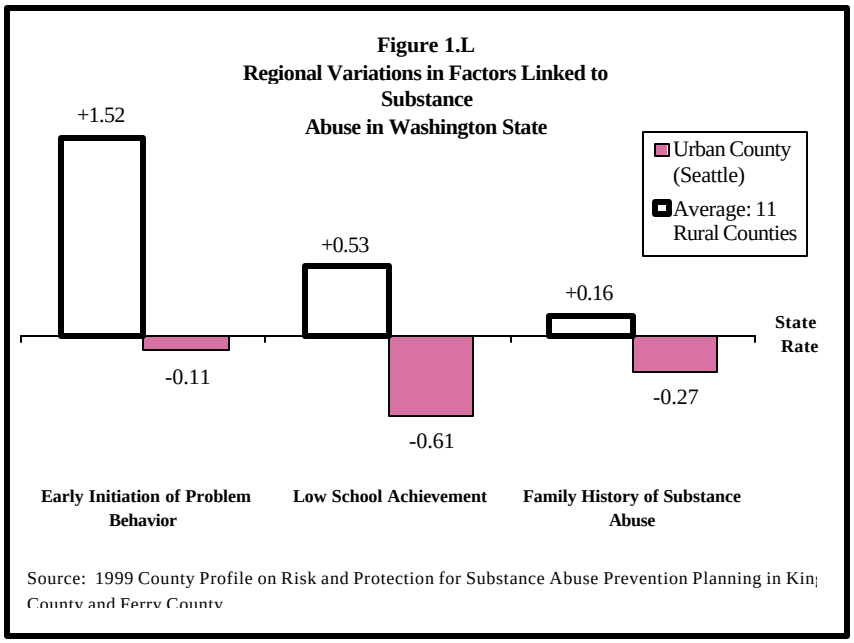
Perceived Risk

The perceived risk of using drugs is not notably different between large and small metropolitan and rural areas. (Figure 1.K) There is no statistically significant difference in perceptions of risk for heroin or cocaine use.



Other Social Factors

Washington state provides an example that illustrates regional diversity in social factors linked to drug use. The Washington State Division of Alcohol and Substance Abuse of the Department of Health and Social Services generates yearly profiles of risk and protective factors at the county level. Data for 1999 compared King County, a large metropolitan area including Seattle, with a population of 1.67 million, to 11 rural counties in the eastern part of the state.[18] (Figure 1.L) Although not the case for every indicator, some of the same factors linked to alcohol, tobacco and other drug use are present to a greater degree in the rural areas. For example, early initiation of problem behavior, measured by juvenile arrest rates, is significantly higher than the state rate for the average of the rural counties, but below the state average for Seattle, the largest urban area in the state. Low school achievement, and family history of substance abuse, both factors that increase the likelihood of drug involvement, were more prevalent in the group of rural counties.



Availability

Drug availability is a key prerequisite of use. CASA's analysis shows that people over the age of 12 report essentially no differences in the availability of drugs from large urban cities to smaller cities and rural communities (Table 1.4)

The Supply of Drugs

National data and testimony from the Drug Enforcement Administration (DEA) suggest a recent increase in drug trafficking in smaller cities and rural communities, helping to explain why levels of drug availability are now comparable to those in large urban areas. Although the absolute number of violations remains lower in less populated areas, the percentage increase in the number of drug law violations* per capita has been larger in smaller cities in the 1990s.[19] (Figure 1.M)

Table 1.4

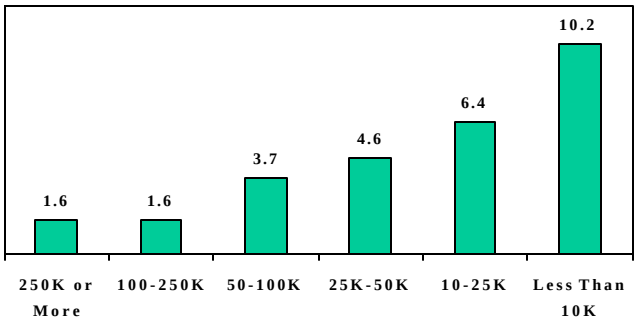
Percentage of Persons Over Age 12 Reporting Various Drugs are Fairly or Very Easy to Obtain: 1997

Substance	Large Metro	Small Metro	Rural
Cocaine	39.8	41.8	39.6
Crack	37.5	40.9	38.0
Heroin	30.2	32.4	29.9
Marijuana	59.3	61.1	59.9

Source: CASA analysis of 1997 NHSDA.

Figure 1.M

Drug Law Violations by City Population: Average Annual Percent Change: 1990-1998



Source: Crime in the United States, 1998

Many drugs, like cocaine, heroin and certain synthetic drugs, have traditionally been imported into the country by criminal organizations in large urban cities and, as a result, were more available in these areas.[21] Cocaine and heroin are imported into the U.S. and distributed throughout the country from major cities like New York, Philadelphia, Miami, Chicago, Houston and Los Angeles.[22] Trade in both drugs is dominated by Colombian and Mexican trafficking organizations that oversee smuggling operations into the U.S. as well as wholesale distribution.[23] Retail distribution in the major cities is frequently controlled by major gangs and the DEA believes that the movement of these gangs or individual gang members to smaller cities plays a major role in introducing the drug there.[24]

International trafficking organizations, especially from Mexico, appear to be growing more involved in all aspects of the distribution of illicit drugs in small metropolitan and rural areas. In a survey of some 200 law enforcement officials, mainly from smaller cities around the country, 69 percent of respondents indicated that groups from outside of the U.S. dominated the retail market in their communities.[25] For example, Mexican drug dealers have been implicated in the heroin market in Plano, Texas,[26] and in the methamphetamine trade in places as diverse as Billings, Montana[27] and Tulsa, Oklahoma.[28] Explanations for the increased attention to smaller communities by drug traffickers include intensifying competition among sellers, increased law enforcement in large urban areas and search for new and lucrative markets.[29]

> *Our greatest problem is illegal aliens and drugs.... The vast majority of this is being transported up from Mexico, and we're getting our butts kicked over it.*
>
> --Tom Pagel
> Director of the State Division of Criminal Investigation in Cheyenne, WY[20]

* Refers to 'drug abuse violations,' defined in the *Uniform Crime Reports* as arrests for state and/or local offenses relating to the unlawful possession, sale, use, growing and manufacturing of narcotic drugs.

Marijuana, though imported in large quantities through Mexico, is also grown extensively within the United States.[30] Growers of the drug generally favor suburban and rural areas to elude law enforcement, with major outdoor cultivation occurring in Tennessee, California, Hawaii, Kentucky and Idaho.[31] According to the Office of National Drug Control Policy (ONDCP), marijuana has become the number one cash crop in poor areas of many of these states.[32] In 1997, authorities seized more than 76,000 marijuana plants in Boise, Idaho.[33]

In 1997, Ferry County, WA-- rural area of seven thousand-- had twice the number of alcohol and tobacco retail licenses per capita as Kings County-- an urban area including Seattle of 1.67 million.[34]

Alcohol and tobacco are easily obtained in less populated areas. In Washington state, for example, rural counties have significantly higher rates of liquor and tobacco sales licenses per capita than do urban counties, including Seattle.[35]

CHAPTER I

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II. Meth Comes to Main Street

In recent years, the attention of the media, law enforcement and policymakers has been captured by the increased use, trafficking and production of the drug methamphetamine. Part of the reason 'meth' has garnered so much attention is the degree to which it appears to have penetrated rural America.

The Drug and Its Effects

Methamphetamine is far from new. The stimulant was synthesized in the 1930s and used by soldiers during World War II,[1] fueling what was perhaps the first meth epidemic in post-war Japan when wartime stockpiles were released on the open market.[2] In the United States, Methedrine--an early oral form of methamphetamine--was popular among ex-servicemen in the 1950s, and was even prescribed by some doctors as a remedy for heroin and alcohol dependency.[3] Reflecting a backlash against growing evidence of abuse, meth was one of the drugs banned in the Controlled Substances Act of 1970,[4] and is now included in Schedule II of the Act along with drugs like morphine, PCP and cocaine.[5] Although the drug remains available in prescription form to treat health problems such as obesity, most of the drug "involved in substance abuse is homemade, resembling a fine, coarse powder, crystal, or chunks."[6] Crystal methamphetamine, or 'ice', is a potent variation of the drug that derives its name from its appearance.

Though the long term effects of methamphetamine are not yet fully understood, its apparent effects on the mind and body are pernicious. Like cocaine, meth's short term effects include increased heart rate; elevated blood pressure and body temperature, inducing a heightened sense of euphoria; increased alertness and vigor, decreased appetite and reduced need for sleep.[7] Chronic users may

become violent, paranoid, confused and unable to sleep with psychotic symptoms lasting for months or years after use has ceased.[8] Compared to cocaine, however, the drug metabolizes more slowly in the body.[9] A single dose of meth may produce effects lasting eight to 12 hours, compared to one to two hours for cocaine.[10]

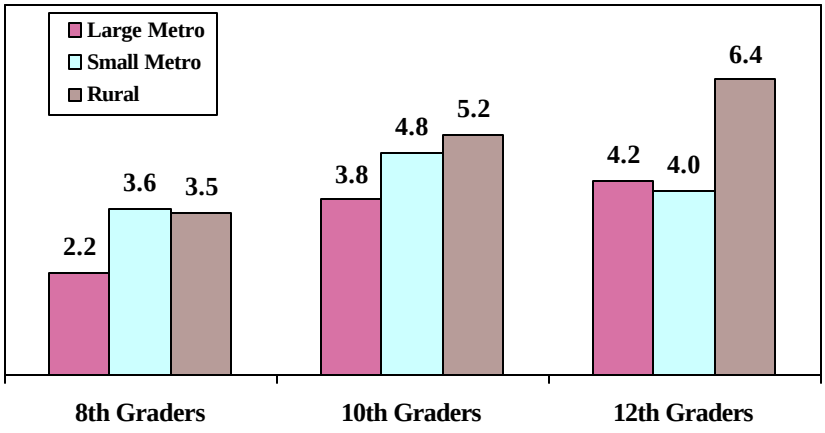
Sensational accounts of the effects of the drug on the user's mind are common. In Fargo, North Dakota a man who claimed to be hallucinating while on meth burned his house down, killing his mother.[11] An Arizona man high on meth for 24-hours stabbed his 14-year old son 29 times and then cut off his head, telling police he thought the boy was possessed.[12] Against this backdrop, meth has been called "the poor man's cocaine,"[13] "the crack of the '90s"[14] and "the worst drug ever to hit America."[15]

Use Among Youths

The data presented here provide the first comprehensive look at youth methamphetamine use in the United States.[16] Nationwide, 3.2 percent of eighth graders, 4.6 percent of tenth graders and 4.7 percent of twelfth graders used meth in the previous 12 months.[17] In the past month, 1.1 percent of eighth graders, 1.8 percent of tenth graders and 1.7 percent of twelfth graders used the drug.

Like amphetamines, methamphetamine use rates among teens are higher in smaller communities. (Figure 2.A) Eighth graders are 59 percent likelier in rural areas than in large cities (3.5 percent vs. 2.2 percent) and 64 percent likelier in small metropolitan areas than in large cities (3.6 percent vs. 2.2 percent) to have used methamphetamine in the past year. Among tenth graders, use rates are 37 percent higher in rural and 26 percent higher in small metropolitan areas compared to large metropolitan areas. Twelfth graders in rural areas were 60 percent likelier to have used meth in the past year than their peers in small metropolitan areas, and 52 percent likelier than twelfth graders in large metropolitan areas. Lifetime use rates of crystal methamphetamine among high school seniors are not significantly different in different sized communities.

Figure 2.A
Annual Use of Methamphetamine by Youth: 1999



Source: The Monitoring the Future Study, University of Michigan

Use Among Adults

No significant differences in the percentage of adults who have ever used methamphetamine appear among large and small metropolitan areas and rural communities. (Table 2.1) While reported rates in 1997-1998 were highest in small metropolitan areas for all three age categories, the differences are not statistically significant.

Table 2.1
Lifetime Methamphetamine Use by Adults, 1997-1998

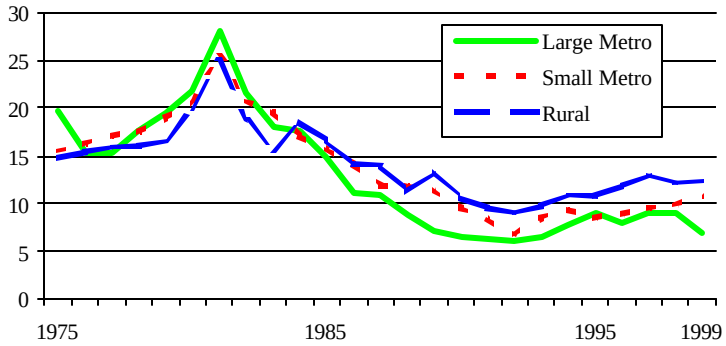
Age	Large Metro	Small Metro	Rural
18-25	2.2	3	1.9
26-34	2.5	3.1	2.2
35 or older	2.2	3.2	1.6

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse.

Trends

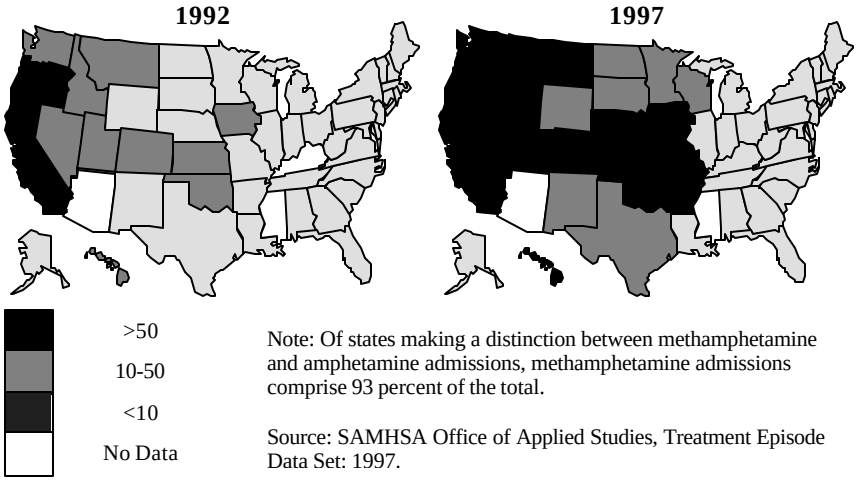
Methamphetamine appears to have first been widely used in the San Francisco Bay Area in the 1950s and 1960s, and largely involved diversion and abuse of the legal drug Methedrine.[18] Use did not remain confined to the West coast, however, and before long crystal methamphetamine was in vogue in eastern cities such as New York.[19] In 1979, the Drug Enforcement Administration (DEA) documented 137 seizures of methamphetamine laboratories nationwide, up from 11 in 1975--an increase of more than 1,100 percent.[20] And in 1980, a DEA official testified that "the abuse of clandestinely manufactured illicit drugs is a problem of national proportions. The problem is, perhaps more pervasive in [the Philadelphia] area than in any other."[21]

Figure 2.B
Annual Amphetamine Use
Among 12th Graders: 1975 to 1999



Source: The Monitoring the Future Study, University of Michigan

Figure 2.C
Primary Meth/Amphetamine Admission Rates by State:
(per 100,000 population aged 12 and over)



Note: Of states making a distinction between methamphetamine and amphetamine admissions, methamphetamine admissions comprise 93 percent of the total.

Source: SAMHSA Office of Applied Studies, Treatment Episode Data Set: 1997.

Trends in meth use by population density are not available, but the trend in overall amphetamine use may be suggestive. Amphetamine use peaked in 1981, with rates of use being highest in large metropolitan areas.[22] (Figure 2.B) While use rates plummeted in large metropolitan areas, however, the decline was more gradual in rural areas. As a result, rates of use among high school seniors in rural areas have been consistently higher than in large metropolitan areas since 1984, usually exceeding those of their urban peers by three to four percentage points.

Regional Differences

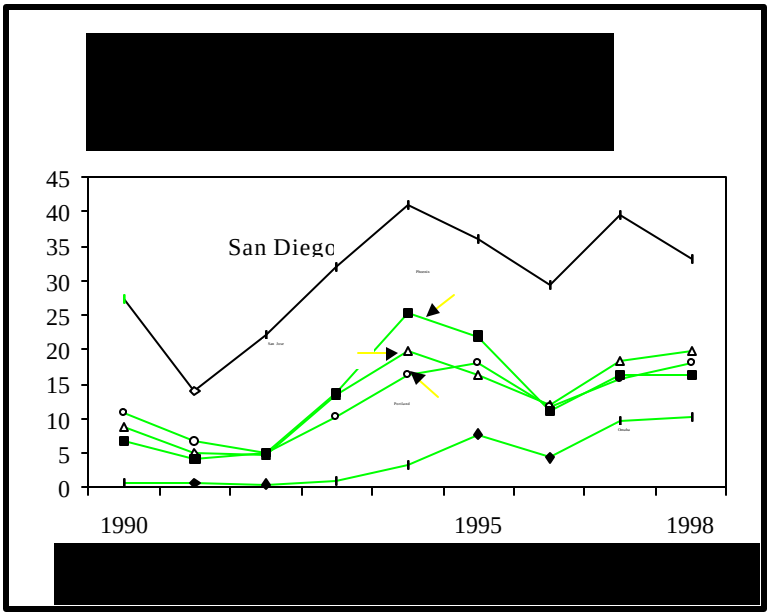
National data masks a great deal of diversity among regions and communities. Sufficiently detailed data on meth use do not exist, but CASA has examined available information on treatment admissions, arrestee drug use, drug related emergency department episodes, and drug abuse deaths in an effort to assess the impact of meth on different communities. In 1992 the number of methamphetamine admissions to treatment facilities per 100,000 exceeded 50 in only two states: California and Oregon.[*] [23] (Figure 2.C) Over the next five

[*] Only admissions to facilities that report to individual State administrative data systems are included. Differences in reporting practices may account for some of the difference in admissions among states.

years, the total number of such admissions jumped by 265 percent nationwide, with the increase concentrated in the West and Midwest.[*] (Figure 2.C)

The scope of the methamphetamine problem relative to other drugs also differs greatly by region. In 1997 amphetamine (including methamphetamine) was the primary substance of abuse for 4.5 percent of all admissions nationwide, and accounted for less than one percent in 24 states.[†] During the same period, meth accounted for up to 22 percent of admissions in Hawaii, and was the reason for more admissions than heroin in 16 states[‡] and more than cocaine in 13.[§] Even in the 15 states with more meth admissions per capita than the national average, however, alcohol dominated treatment admissions, ranging from 34 percent of admissions in Texas to 68 percent in Wyoming.

The Arrestee Drug Abuse Monitoring (ADAM) program reveals similar patterns.[24] Out of the 35 predominantly large metropolitan areas monitored, more than 10 percent of male arrestees tested positive for meth in 10 cities in 1998: San Diego (33.2 percent), Sacramento (24.6 percent), Salt Lake City (20.3 percent), San Jose (19.7 percent), Portland (18.1 percent), Phoenix (16.4 percent), Spokane (15.8 percent), Las Vegas (13.8 percent), Des Moines (10.2 percent) and Omaha (10.2 percent). On the other hand, meth has never been found in more than one percent of arrestees in Atlanta, Chicago, Cleveland, Detroit, Indianapolis, Miami, New Orleans, New York City and Washington, D.C.[25] (Figure 2.D)



Trends in arrestee data, drug abuse deaths[26] and emergency department[27] drug mentions suggest that methamphetamine use has risen over the 1990s, but the rate of increase may be leveling off in major cities in the West and Midwest. In San Diego, for example, the 33.2 percent of male arrestees that tested positive for meth in 1998 was much higher than the 14.1 percent recorded in 1991, but down from nearly 40 percent a year before. Similarly, in the 21 large metropolitan areas tracked by the Drug Abuse Warning Network (DAWN), the number of methamphetamine or amphetamine mentions in all emergency department episodes decreased by 33 percent from 1997 to 1998, increasing only in Dallas, Texas.

Though no national data exist, there is anecdotal evidence suggesting that the use of meth may be continuing to increase in some rural communities and extending to the East. For example, in Washington State, the Department of Ecology cleaned up more than 450 labs through the first nine months of 1999, condemning 240 houses due to chemical contamination, up from 349 labs and 105 houses in all of 1998.[28] In 1998, 434 methamphetamine

[*] The states with over 50 admissions per 100,000 population in 1992 were California and Oregon; in 1997, they were Arkansas, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, Oklahoma, Oregon, Utah and Washington.

[†] Nationwide, 93 percent of amphetamine/methamphetamine admissions were for methamphetamine.

[‡] Georgia, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Utah and Wyoming.

[§] California, Hawaii, Idaho, Iowa, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Utah and Wyoming.

laboratories were found in Arkansas, up from just 24 in 1995.[29] From January to November of 1999, police in the Shenandoah Valley of Virginia seized 22 pounds of methamphetamine worth an estimated one million dollars, leading to suspicion that the area was becoming a major hub in East coast trafficking of the drug.[30]

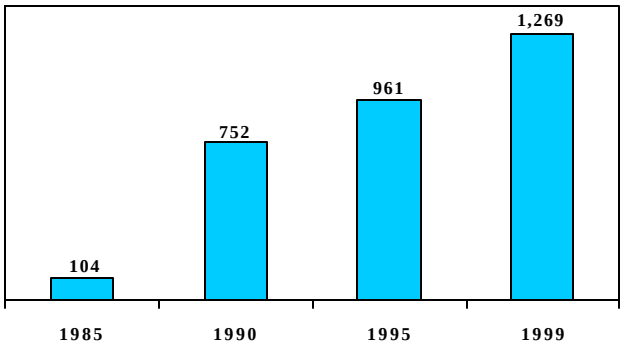
Supply Characteristics

After the first clandestine methamphetamine laboratories appeared in the San Francisco Bay Area in the early 1960s,[31] sale and production of the drug was believed to be controlled largely by outlaw motorcycle gangs in all parts of the U.S.[32] According to the DEA, however, the mid-90s witnessed the entry of large Mexican polydrug organizations into the market, precipitating the recent increase in the drug's production.[33] The quantity of the drug that the DEA seized soared 624 percent from 1985 to 1990, 28 percent from 1990 to 1995, and 32 percent from 1995 to the 11 months through November in 1999--a twelve-fold increase over the entire period.[34] (Figure 2.E) Over the same period, marijuana seizures decreased 83 percent (1985-1990), then increased 55 percent (1990-1995) and 44 percent (1995-1999), and cocaine seizures increased 204 percent (1985-1990), then decreased 29 (1990-1995) and 35 percent (1995-1999).[35]

Mexican criminal organizations have developed new production processes for methamphetamine, allowing chemicals imported through Mexico in bulk quantities to be turned into unprecedented amounts of the drug in super labs capable of producing more than 10 pounds per production cycle.[36] To avoid discovery due to the noxious smell and occasional explosion produced by chemical reactions in cooking the drug, these labs are located primarily in sparsely populated areas in the western United States. In 1998, of 71 such labs seized by the DEA, 57 were located in California, with the next closest state being Colorado with four labs. The DEA estimates that these super labs produce more than 80 percent of the methamphetamine available in the country.[37]

The entry of Mexican drug cartels, that had already established distribution channels for heroin, cocaine and marijuana throughout the West and Southwest, into the methamphetamine trade has produced a dramatic surge in the flow of meth into the heartland of America.[38] According to the DEA, drug organizations frequently install their operatives in rural communities among laborers working in the meatpacking, fruit picking, farming and other industries.[39] Under this cover, drug traffickers import meth by the carload along the interstate highways[40] to be sold for prices several times what they might receive in major metropolitan areas.[41]

Figure 2.E
DEA Domestic Methamphetamine Seizures
(in kilos.)



Source: DEA

Local Impact of Meth Production

Although over 80 percent of all of the methamphetamine abused by U.S. citizens is supplied by major Mexican drug organizations,[42] the remaining 10 to 20 percent of meth production imposes disproportionately large costs on society. Methamphetamine is extraordinarily easy to make: little formal chemistry training is required and the recipe to manufacture the drug can be obtained over the Internet.[*] Further, despite governmental efforts to restrict access to the needed ingredients,[43]

[*] See, for example, www.overthrow.com. In fact, a recipe book for the drug will be shipped within 24 hours of an order from Amazon.com.

these chemicals remain easily obtained in small amounts. Accordingly, there has been an explosion in entrepreneurs setting up small labs to produce methamphetamine for personal use and limited local distribution.[44]

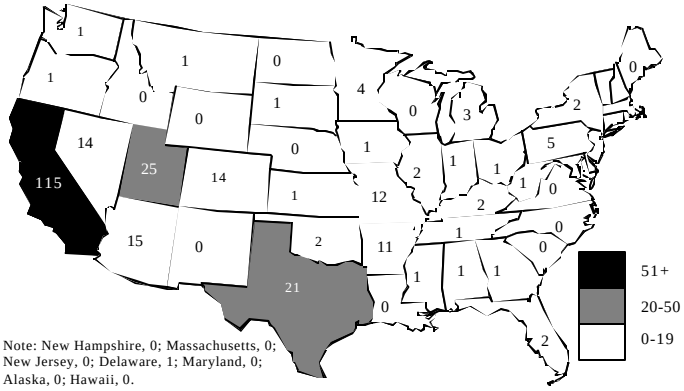
DEA seizures of meth labs have increased nearly sixfold, from 263 labs in 1994 to 1,627 labs in 1998. Mirroring trends in treatment admissions, the location of labs seized by the DEA also reveal a clear trend eastward over time. Although only California had more than 50 clandestine lab seizures in 1994, eight states spread throughout the Midwest topped that mark in 1998.[*] (Figure 2.F and 2.G)

In 1998 local and state police seized an additional 4,132 clandestine labs,[†] nearly all of which produced meth. California had the most total lab seizures by far, but relatively rural states such as Missouri, Arkansas and Oklahoma also had extremely high numbers of seizures. Though traditionally small labs were found mainly in rural areas, increasingly 'cookers'--as those who make the drug are called--used hotel rooms, rented storage lockers and other makeshift labs in more urban settings. In 1997, 58 percent of the labs that the DEA seized were in urban and suburban sites compared to 32 percent in rural areas.[45]

Aside from the health risks involved in using the drug, many individuals die from its dangerous manufacturing process. The production process for meth can be very dangerous and violent explosions are not uncommon. According to one account, "as many as one of every four labs seized [in Western states] had signs of explosions and fires."[46] Manufacture also represents an environmental threat, as production leaves behind five to six pounds of toxic waste per pound of methamphetamine produced.[47] This waste is often discarded carelessly into the soil or into rivers, where it can mix with local drinking water supplies, creating public health disasters.[48] The cost of cleaning up these labs costs around $3,000 per site, but large labs can cost upwards of $100,000 per site.[49]

Figure 2.F

DEA Clandestine Laboratory Seizures: 1994

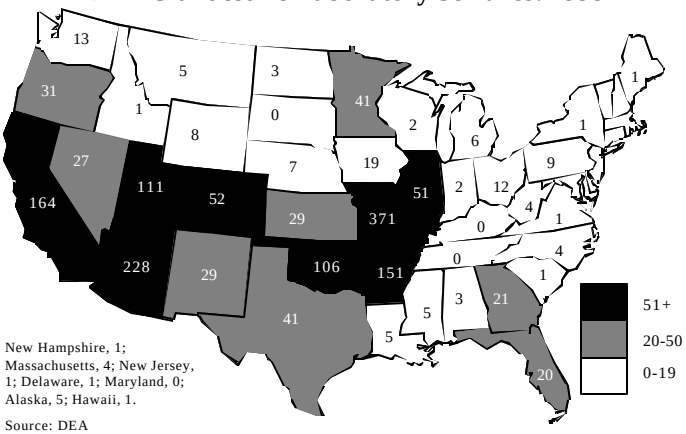


Note: New Hampshire, 0; Massachusetts, 0; New Jersey, 0; Delaware, 1; Maryland, 0; Alaska, 0; Hawaii, 0.

Source: DEA

Figure 2.G

DEA Clandestine Laboratory Seizures: 1998



New Hampshire, 1; Massachusetts, 4; New Jersey, 1; Delaware, 1; Maryland, 0; Alaska, 5; Hawaii, 1.

Source: DEA

[*] Arizona, Arkansas, California, Colorado, Illinois, Missouri, Oklahoma and Utah.

[†] There may be some double counting of labs in cases where seizures are reported by both the DEA and state or local authorities.

CHAPTER II

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III. Barriers Faced by Small Cities and Rural Areas

Although small metropolitan and rural communities have similar problems of illicit drug, alcohol and tobacco use as urban America, the consequences are not the same. The limited capacity of smaller communities to cope with the problem can increase the threat substance abuse poses to individuals and institutions. The lack of a critical mass of resources to deal with the consequences of substance abuse creates enormous challenges for local leaders.

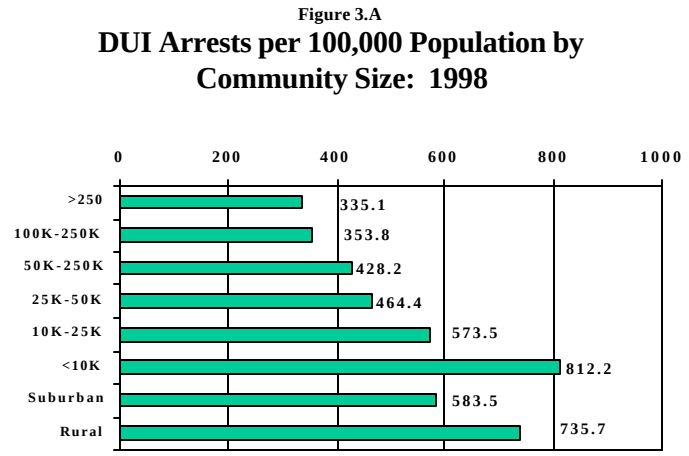
Consequences of Substance Abuse

Crime

All cities, large or small, suffer from crime related to drug and alcohol abuse. In 1998, 30 percent of the 14.5 million arrests in the United States were for drug abuse violations (including the illegal manufacture, sale, purchase or possession of illicit substances) or alcohol related events (including DUI, liquor law violations, drunkenness, disorderly conduct and vagrancy).[2] Seventy-seven percent of the half million individuals incarcerated in America's local jails in 1996 either committed a crime to get money to buy drugs (13 percent); violated drug laws (21 percent); were driving under the influence (eight percent); have a history of regular illegal drug use (59 percent); have a

> *Narcotics investigations don't have any boundaries anymore. Now it's more than a citywide problem. It's something you have in the county, across the tri-state, around the country and even worldwide.*[1]
>
> --Police Sgt. Mike Lauderdale
> Evansville, Indiana

history of alcohol abuse (15 percent); or share some combination of these characteristics.[*] [3]

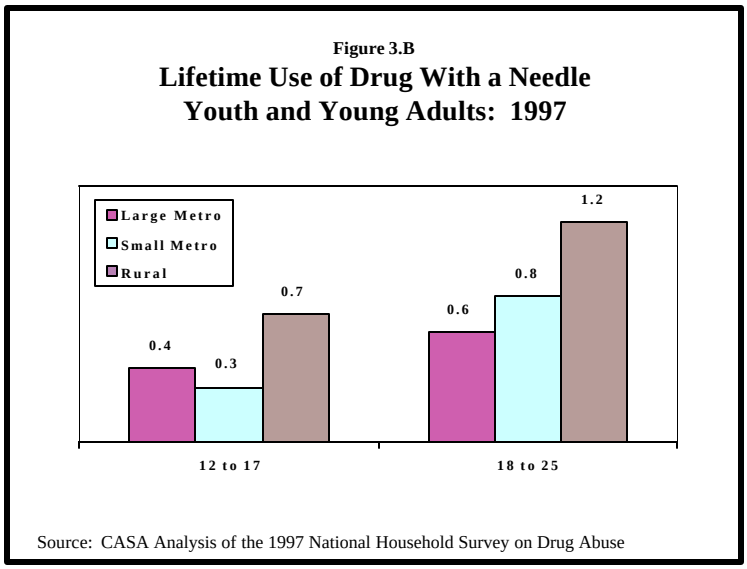


Drug abuse violations increased in the 1990s at a faster rate the smaller the size of the community. Drug trafficking gangs traditionally located in large cities have spread into small towns, and the operations of large, international drug trafficking organizations or syndicates have been discovered recently in places such as Tulsa, Oklahoma and Glenwood Springs, Colorado.[4] Increases in violent crime have accompanied this shift. For example, in Prince George's County, Maryland, a suburban area outside of Washington, DC, drug trafficking and drug-related crime have been increasing in recent years.[5] In 1998, there were 82 drug-related murders in Prince George's County compared to 51 in 1995.[6] Driving under the influence (DUI) arrest rates in small metropolitan or rural areas are more than double those of large metropolitan areas.[7] (Figure 3.A)

Health

The adverse health consequences of substance abuse are enormous. More deaths, illnesses and disabilities can be attributed to substance abuse than to any other preventable condition.[8] CASA's report on the cost of substance abuse to America's healthcare system determined that over 70 different medical diseases and conditions, including AIDS, tuberculosis and hepatitis B and C, are at least partially attributable to substance abuse.[9]

According to the U.S. Centers for Disease Control and Prevention, from 1994 to June of 1999, AIDS cases nationwide increased by 82 percent in rural areas (from 22,866 to 41,517) as compared to a 59 percent increase (from 374,533 to 596,592) in metropolitan areas with populations of 500,000 or more.[10] The connection between intravenous drug use and AIDS is a concern in rural communities since the proportions of teens and young adults that have used drugs intravenously are even larger there than in metropolitan areas.[11] (Figure 3.B)



[*] Percentages cannot be added to 77 percent due to overlap.

Worker Productivity

A 1998 report from the SmithKline Beecham Drug Testing Index, based on drug tests of about five million employees in various regions of the U.S., revealed that in rural areas of Tennessee, Indiana and Florida, between eight and 14 percent of the workers tested positive for drugs, compared to a positive rate of four to six percent in the three largest metropolitan areas.[12] Substance abuse makes it difficult to obtain and keep a stable job, with addicts often moving from one part-time job to another,[13] and is associated with higher absenteeism rates and higher job-related accident and injury rates.[14] The most serious substance abusers may not be capable of working and may become institutionalized, homeless or engage in criminal behavior in order to support their drug habits.[15]

Families

Little data are available on the effects of substance abuse on families in rural communities compared to metropolitan areas. However, CASA's research has shown that substance abuse and addiction severely compromise or destroy the ability of parents to provide a safe and nurturing home. The number of abused and neglected children increased from 1.4 million in 1986 to about three million in 1997.[17] Over 70 percent of child welfare professionals included in a CASA survey cited substance abuse as one of the top three causes for the dramatic increase in child abuse and neglect cases since 1986.[18] Many counties in the State of Oregon estimate that "child protective workers spend 75 to 90 percent of their time working with families torn by meth."[19] Substance abuse is also connected with increased family conflict and domestic violence against women,[20] problems that know no geographic bounds.

> *In the past few years, meth has shown up in a growing number of grisly child abuse cases and deaths, none as well known as the 1997 torture-murder of 3-year old Tesslynn O'Cull of Springfield. The toddler's mother, Stella Kiser, and Kiser's boyfriend, Jesse Caleb Compton-both meth addicts-were convicted of aggravated murder.*[16]

Impact on Governmental Systems

State and local governments incur costs of providing treatment and prevention programs, as well as enforcing regulatory compliance programs for alcohol and tobacco. This spending is minimal, however, in comparison to the financial strain caused by the consequences of substance abuse. While no data show the relative costs of prevention and treatment versus the consequences to local governments by population density, other research suggests a dramatic difference. For example, in 1995 for every dollar spent by federal health entitlement programs on treatment and prevention, $11.00 were spent on the health consequences of substance abuse.[21] Costs linked to the consequences of substance abuse, for example, show up in local budgets for law enforcement, for drug-related crime, jail and court costs, government services for child welfare, social and health services, clean-up costs for meth labs and added school costs. CASA has found that 77 percent of local jail costs and 70 percent of local child welfare costs are substance abuse-related.[22]

Barriers to Combating Substance Abuse in Small Metropolitan Areas and Rural Communities

The Myth of Rural Communities

Substance abuse problems in large cities such as New York, Los Angeles, Houston or Miami have been the primary focus of public, academic and government attention for the past several decades.[23] Rural areas are largely seen as "isolated, and therefore, protected from this uniquely urban problem."[24] Though recently more attention has been given to smaller communities because of methamphetamine, the general problem of substance abuse frequently goes unnoticed. The lack of research and data examining substance abuse problems for smaller communities[25] has made it too easy for the public to ignore the problem.

Availability of Treatment

The low population density of rural communities often makes it difficult for substance abuse or other mental health services providers to achieve the economies of scale needed to provide effective treatment services.[26] Overhead costs cannot be spread out over a large number of clients and the per capita cost of providing medical services becomes prohibitive.[27] In 1990, only 79.5 percent of rural counties had any mental health services available, as opposed to 95.7 percent of all metropolitan areas.[28] Seventy-six percent of the 518 areas designated as having a significant shortage of mental health professionals in 1997 were rural communities.[29] In 1993, 55 percent of the 3,075 counties in the U.S. had "no practicing psychologist, psychiatrists, and social workers, and all of these counties [were] rural."[30]

Table 3.1

Alcohol and Other Drug Abuse Treatment Beds* per 100,000 Population: Metro and Rural, 1995

Region	Metro		Rural	
	Number of beds	Rate per 100,000	Number of beds	Rate per 100,000
United States	16,050	7.5	3,909	7.4
New England	714	5.9	68	5.4
Mid-Atlantic	3,184	9.1	156	4.6
East North Central	2,863	8.3	671	7.5
West North Central	1,098	10.0	1,013	13.5
South Atlantic	2,935	7.8	699	7.0
East South Central	1,383	14.8	445	6.5
West South Central	1,959	8.7	392	5.8
Mountain	669	5.7	345	7.9
Pacific	1,245	3.2	120	3.3

* Data are missing for 17 percent of hospitals.
Source: American Hospital Association Annual Survey of Hospitals. In *Rural Health in the United States*, p. 167.

Because of this shortage of providers, the responsibility of the delivery of substance abuse treatment in rural areas often falls to local hospitals. In 1986, 40 percent of substance abuse personnel and mental health services in rural areas were based in hospitals, as opposed to 18 percent for the rest of the country.[31] The number of beds available for substance abuse treatment in metropolitan vs. rural areas in 1995 were virtually the same: 7.5 beds per 100,000 in metropolitan[*] areas vs. 7.4 in rural areas.[32] (See Table 3.1) Disparities do exist in certain geographic areas, in particular the East South Central and Mid-Atlantic regions, in which the number of beds is significantly lower in rural areas.

Hospital-based outpatient services are clearly lacking in rural areas. (Table 3.2) In 1995 only 10.7 percent of hospitals in rural areas provided outpatient alcohol and drug abuse treatment services, compared to 26.5 percent of hospitals in metropolitan areas.[33] The shortage was more pronounced in the two South Central Regions and the Mountain region, where hospitals in metropolitan areas were at least three times more likely to provide outpatient treatment services than hospitals in rural areas.

Rural areas have less specialized substance abuse treatment services than metropolitan areas.[34] The overall lack of personnel forces health professionals to perform a wider variety of tasks.[35] A mental health counselor, for example, must act as a generalist in rural areas, and "may need to function in the roles of case manager, grant writer, crisis worker, administrator, public relations person and therapist."[36] In fact, a recent survey indicated that only 6.6 percent of substance abuse treatment providers serving youth in rural areas indicated a specialization in the areas of drug or alcohol abuse, as opposed to 17.8 percent of providers based in urban areas.[37] Most professional schools for mental health and substance abuse counselors focus on an urban model of service delivery, and workers are trained in a specialty field.[38] This training is often inadequate to prepare professionals for the generalist role that they must play in smaller communities.[39]

[*] Here, 'metropolitan' refers to both small and large metropolitan areas.

Table 3.2

Hospital-based[a] Outpatient Alcohol and Other Drug Abuse Treatment Services by Region and Urbanicity, 1995

Region	Metro (n=3,993)		Rural (n=2,451)	
	Percent of hospitals	Percent no response	Percent of hospitals	Percent no response
United States	26.5	19.0	10.7	12.7
New England	32.7	19.7	31.0	6.9
Mid-Atlantic	27.7	19.5	16.7	12.2
East North Central	35.2	13.1	16.0	8.6
West North Central	35.6	8.9	11.3	7.4
South Atlantic	24.9	21.6	10.2	15.4
East South Central	26.8	17.2	9.5	17.3
West South Central	19.0	14.3	4.3	11.2
Mountain	28.8	22.8	9.2	15.9
Pacific	17.6	29.4	7.7	26.9

[a] Including state and county mental hospitals, private psychiatric hospitals, VA medical centers and nonfederal general hospitals with psychiatric services.

Source: American Hospital Association Annual Survey of Hospitals. In *Rural Health in the United States*, p. 168.

In rural communities, poverty rates are generally higher than in metropolitan areas.[49] Bleak economic conditions often lead individuals in rural areas to delay seeking preventive health care services, only to require more costly treatment later.[50] A recent survey showed that between 10 and 12 percent of residents in rural communities delayed receiving care because of cost compared to eight percent in metropolitan counties.[51]

While specialized youth-oriented treatment programs are in short supply nationally, the shortage is even more pronounced in rural areas.[40] Eleven percent of treatment providers in rural areas are oriented toward providing services for youth, as opposed to 15 percent of providers in metropolitan areas.[41] One-quarter (25.2 percent) of adolescents in need of substance abuse treatment in rural areas participate in youth oriented treatment programs, compared to more than one-third (34.8 percent) of the youth in metropolitan areas.[42] Rural areas also have fewer treatment programs tailored to substance abusing women with children.[43]

Access to Treatment

The geographic dispersion of people in rural areas often forces clients to travel long distances to receive treatment.[44] One program in Cedar Falls, Iowa, for example, required that some participants travel for as long as three hours each way to get to the facility.[45] Many rural areas lack adequate public transportation systems.[46] Only 12 percent of communities with less than 2,500 people have public transportation.[47] Not only must clients travel greater distances to receive treatment, but staff members also have to travel greater distances to reach clients.[48]

In smaller communities, access to treatment is limited because people are less likely to have medical insurance. In 1997, 18.7 percent of people living outside metropolitan areas lacked insurance, compared to 16.3 percent within metropolitan areas.[52] Reasons for this include higher rates of poverty and the difficulty of getting group insurance rates in the smaller companies common to rural areas.[53] Moreover, jobs such as farming, logging and mining, typical of rural areas, are considered higher risk employment and therefore have higher premium rates.[54]

Smaller communities also depend more upon public insurance programs such as Medicare and Medicaid. In 1997, 18 percent of people living outside metropolitan areas had public insurance, as opposed to 14.7 percent within metropolitan areas.[55] These programs often have complex reimbursement policies and regulations that limit access in rural communities. For example, in order to receive reimbursement for mental health services under Medicaid, care needs to be provided by, or under the supervision of, a physician.[56] In rural areas, there may not be doctors to fulfill this role.[57] These circumstances often result in delays in receiving approval for mental health or substance abuse services provided under Medicaid.[58] Managed care

companies have initiated other policies that serve as barriers, such as reimbursing only certain individual providers and reducing the number of specific types of mental health professionals that are considered approved providers.[59]

Acceptability of Services

Certain values common to rural communities and small towns may interfere with the provision of substance abuse treatment. Self-reliance is traditionally valued in smaller communities, and receiving treatment may be seen as a sign of weakness.[60] In rural areas, many individuals may have limited knowledge about mental health and substance abuse services,[61] and question the value of receiving treatment.[62] Ensuring confidentiality is extremely difficult in rural communities where everyone is well known.[63] Substance abuse service professionals in rural areas may have difficulty understanding cultural values of local communities, creating a further barrier to treatment. Service professionals' lack of awareness of local values and customs may lead to conflict with residents and a reluctance to trust treatment providers.[64]

Law Enforcement

Smaller cities and rural areas suffer from a lack of personnel, financial resources and expertise to stop drug trafficking. In less densely populated communities, police departments are smaller and individual officers need to provide a greater variety of services than those in more urban communities.[65] They do not have the manpower to deal with drug trafficking organizations operating in their communities. For example, most departments in smaller cities have no more than 10 to 15 individuals in their narcotics unit. However, it would "take this many officers to conduct a single technical surveillance investigation on only one phone location" of a drug trafficking organization.[66]

Rural areas and smaller cities have fewer available financial resources to support enforcement than urban communities.[67] The Bureau of Justice Statistics of the U.S. Department of Justice estimated that in areas with a population of less than 2,500 people, per officer operating expenditures[*] are $31,500, while in metropolitan areas they are nearly double, at $62,600.[68] Most small cities and rural areas also “lack the resources and manpower to provide specialized, drug enforcement training to their officers."[69] This lack of capacity is more alarming when we recognize that drugs such as marijuana and methamphetamine are often produced in rural areas.[70] Rural police forces are unlikely to have the expertise to close down methamphetamine labs--a job comparable to “storming a toxic waste dump that could blow up at the slightest provocation.”[71]

Funding

A decrease in the value of farm lands and the out-migration of residents have reduced the property tax base of rural communities.[72] Consequently, smaller communities must depend more heavily on state and federal funding to respond to the formidable challenges caused by substance abuse. A University of North Carolina study examined the financing of substance abuse treatment providers for adolescents. It found that in 1994, state and federal government funds accounted for 60.6 percent of the financing for services in rural areas, as opposed to 46.3 percent of the financing for services in metropolitan areas.[73]

Federal funding for substance abuse in rural states is limited by the urban bias built into the allotment formula for the Substance Abuse Services block grant.[74] Under the current allocation formula, the number of 18- to 24-year olds in urban areas is double weighted because of the perceived increased need for substance abuse treatment services in cities.[75] A study by the RAND Corporation concluded that 22 percent of the funding should shift from more urban to rural states to achieve parity.[76]

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[*] Operating expenditures include all direct costs a police officer incurs, such as gross salary and officer training costs. Excludes capital expenditures, such as buildings and equipment.

CHAPTER III

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IV. Stepping Up to the Challenge

As mayors and other local officials in small metropolitan and rural areas across the country struggle with the impact of substance abuse, they are challenged to use existing resources in strategically creative ways. CASA has identified several examples of programs that are helping to raise public awareness, make better use of prevention, education, intervention and law enforcement resources and change the way services are delivered. This is not meant as a comprehensive review of interventions or an evaluation of programs but as a sampling of promising innovations.

Raising Public Awareness

Challenging the myth that mid-sized cities and rural areas are immune from drug problems is a necessary first step for elected leaders. Innovations in Boise, Idaho, Portland, Oregon and California provide three examples of very different ways this problem can be addressed.

Idaho's Enough is Enough

Fashioned by the Mayor of Boise, Brent Coles, along with the President and General Manager of KTVB Television, *Enough Is Enough* is the largest drug prevention campaign in the history of Idaho. It is designed to motivate, mobilize and unite Idaho's communities in the fight against substance abuse and was adopted by the Association of Idaho Cities as a prime initiative. Over a three-year period, annual seminars were convened and attended by 15,000 adults and 25,000 students in grades seven through twelve. These seminars were televised, some during prime time, and attracted audiences measured at 350,000--representing one third of the state's population. The media coalition that is part of *Enough is Enough* also includes a statewide radio network, Idaho Public Television and statewide cable operators. As a result of this initiative, the Idaho Legislature passed, and the

governor signed, *Enough Is Enough* sponsored bills allowing easier prosecution for methamphetamine production, workers' compensation incentives for businesses with drug free workplace policies and mandatory minimum sentencing for methamphetamine production.[1]

Portland's Regional Drug Initiative

In 1987, citizens and leaders in Portland, Oregon and four surrounding counties created the Regional Drug Initiative (RDI), a broad-based coalition committed to making the area drug free. A critical element of the RDI effort is the *Drug Impact Index*--12 county and statewide indicators of the severity of substance abuse problems in the region. The *Drug Impact Index* is used to raise public awareness, demonstrate that prevention and treatment work and make the case for more effective policies and programs. The current *Index* reports a 74 percent reduction in drug-related births in Multnomah County since 1989, and more than a 75 percent reduction in re-arrest rates for offenders in drug court mandated treatment as compared to nonparticipants.[2]

California's Explosion Ads

In California, the Attorney General's office received nearly $2 million in federal funds from the Department of Justice to produce anti-drug advertising. With a portion of this money state officials are buying advertising directed at teen and young adult audiences. In a state where busts of methamphetamine labs increased from 465 in 1995 to 1,006 by 1998, officials have developed dramatic ads showing how methamphetamine production destroys innocent lives. These ads typically present images of homes on residential streets with neighbors walking by as a meth lab explodes and engulfs near-by houses in flames. Employing music video production quality, drug enforcement officials are attempting to make teens aware of the potentially volatile chemicals used in methamphetamine production while, for the community-at-large, exploding the myth that meth is confined to the biker community.[3]

> *Methamphetamine is a highly addictive, very dangerous drug and the outcome of meth, whether you're consuming it or making it, is oftentimes death.*
>
> --Deputy Ray Verdugo
> Riverside County
> California Sheriff's Department

Making Better Use of Existing Services

A formidable challenge for local officials is effectively identifying and employing community resources to prevent and reduce the consequences of substance abuse. Two examples, one from Ohio and one from Michigan, show how different communities have risen to this challenge.

> *Effective communities not only better utilize their own resources but they are able to identify and utilize specialized, outside resources. The most effective rural leaders are those who are involved in networks beyond their communities. . . . The keys both to ameliorating substance abuse and rebuilding and sustaining a community are collaboration and cooperation.*
>
> --Daryl Hobbs, Director
> Office of Social and Economic Analysis
> University of Missouri System, Lincoln
> University, Columbia, MO

Franklin County, Ohio's "Promise of a New Day"

Officials in Franklin County, Ohio, have declared substance abuse their number one health problem. *Promise of a New Day* is a five-year, community-wide prevention planning initiative to address substance abuse-related problems of violence, transmission of HIV, teen pregnancy, school failure and drug-exposed infants. Directed by the Franklin County Prevention Institute Community Partnership, this program counts as resources the full landscape of prevention and treatment programs, schools, the media, the workplace and

neighborhoods. To make the best use of these resources, county leaders focus on providing clear directions for targeting resources; documenting how programs and individuals will work together to achieve Franklin County's goals; and defining and tracking ways to measure success.[4]

Michigan's Upper Peninsula Teen Leadership Program (UPTLP)

UPTLP is a comprehensive substance abuse prevention, and early intervention program for high school students that brings together substance abuse prevention and treatment professionals, school district officials, teachers and local PTA's, officials from juvenile, health and human services, as well Northern Michigan University staff and facilities. It relies on peer leadership as well as trained professionals and other interested adults from the local communities to help achieve its goals. Although formal outcome information is not available, process evaluations and feedback from parents, professionals and teens themselves indicate strong support and commitment from the community. In addition, the UPTLP model is being adopted in other areas of Michigan.[5]

Making Better Use of Law Enforcement Resources

To help local communities increase capacity to respond to the drug problem and make better use of existing law enforcement resources, the Drug Enforcement Administration (DEA) launched *the Mobile Enforcement Team Program* (MET) in 1995. Under the program, at the request of local law enforcement officials, the DEA provides a team of trained agents to help communities lacking sufficient resources attack the violent drug organizations in their neighborhoods and restore a safer environment for residents. Between October 1995 and October 1998 the DEA sent METs into 214 communities with the effect of reducing drug related assaults by 10 percent, homicides by 14 percent and robberies by15 percent. These units also made 8,949 arrests and seized 468 pounds of methamphetamine and $20.4 million in assets.[6]

> *We have responded to lab sites where people have been literally blown out of their shoes. We had explosions where their skin has been cooked right off. It does happen, and it happens in neighborhoods.*
>
> --Special Agent Dick Flood
> Bureau of Narcotics Enforcement
> for Southern California

DEA officials also recognized the increase of methamphetamine use and manufacture, particularly in the West and Midwest, and understood that many local law enforcement agencies had neither the technical expertise nor funds to "take down" a meth lab and dismantle what amounts to a volatile toxic waste site. Over the past two years MET II has provided the training, human resources, technical expertise and funds to not only interdict the local manufacture of methamphetamine, but also clean up the laboratory site.[7] The MET programs are the most ambitious domestic enforcement programs undertaken by DEA to attack drug-related crime and violence.

Local law enforcement agencies also are developing creative strategies on their own to combat the manufacture and distribution of illegal drugs. One effective approach is the interdiction of precursor chemicals used to manufacture drugs such as methamphetamine.

> *A second method to assist in pinpointing those involved in the methamphetamine trade is to gain knowledge of the chemicals used to manufacture the drugs and discover the source that the different chemicals can be purchased from . . . distributors may identify persons who are purchasing items or large amounts of certain items that there is no practical use for other than illegitimate use.*
>
> --Chief A.J. Key and Captain Don Dingler
> Police Department, Longview, TX

In *Corpus Christi, Texas* the police department works with local feed store managers who alert officers when large quantities of iodine crystals, an important component of meth, are purchased. In one such case officers in Corpus Christi contacted their counterparts in Missouri, who were able to arrest and convict the purchaser.[8] Similarly, in *Meridian, Idaho* the local government actively works with businesses to remove liquid and crystal iodine from store shelves to prevent their theft. One major supply store also requires identification from individuals who purchase such items and makes lists of purchasers available to law enforcement agencies. In a carrot and stick approach, businesses are recognized for assisting the effort to interdict precursor chemicals, while public pressure is placed on those who do not.[9]

Improving Prevention and Treatment

In less urban areas prevention and treatment services may be complicated by suspicions of mental health and substance abuse treatment, limited program options or programs ill suited to rural clients, and long distances to travel with insufficient public transportation.[10] As a result, prevention messages may go unheeded and clients may find it difficult to remain motivated. A Kentucky initiative illustrates a promising approach to addressing these issues.

> *Each year we see more evidence that prevention and treatment work. They save many times their cost in reduced public expenses. Most important, they eliminate needless pain and suffering.*
>
> --Charles A. Moose, Chief
> Police Bureau, Portland, OR

Eastern and South Central Kentucky--Structured Behavioral Outpatient Rural Therapy

This program uses a case management approach that has been specially adapted to help rural substance abuse clients increase treatment readiness and complete treatment. The case manager not only helps diagnose client treatment and services needs, but plays a key role in identifying and procuring services from the limited number of options. This approach encourages clients to identify and help solve rural-specific barriers to treatment, such as inadequate transportation for long distances that must be traveled or family suspicions about substance abuse treatment. Both clients and treatment providers take full advantage of existing resources present in a rural setting, while treatment is tailored to address the barriers experienced by rural clients.[11]

CHAPTER IV

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V. The Need for Federal Help

Many mayors and local leaders in rural communities and mid-size cities are drawing on their resources to meet the challenge of substance abuse and addiction. They are acutely aware of the importance of helping our children and teens stay away from drugs, alcohol and nicotine. It is important to recognize that an individual who gets through age 21 without using illegal drugs, smoking cigarettes or abusing alcohol is virtually certain never to do so.

Prevention is the only sure way to stop substance abuse and addiction. Mayors should encourage and mobilize parents, educators and clergy to work together to reduce the demand for drugs. Effective prevention efforts require adequate law enforcement capability to reduce the availability of illegal drugs and prevent children from smoking and drinking.

But the resources of these local leaders are limited. Committed as the nation's mayors are to this battle against substance abuse and addiction, they cannot do the job alone. There must be increased coordinated efforts that include the states and the federal government.

The federal government should increase funding to enable mayors to provide timely and effective treatment for everyone who needs it. It should also provide the resources to train local police and sheriffs and, where necessary, increase their capacity with skilled personnel and new equipment. Local communities also need incentives to attract trained health and treatment workers, alcohol and drug counselors and school nurses as well as training for teachers so they can spot the symptoms of substance abuse and know what to do about it. The federal government also can provide local leaders with the expertise and resources needed to establish drug courts. With additional resources, the Drug Enforcement Administration can step up its

efforts to train and assist local law enforcement. Federal resources can also be used to develop model efforts that mobilize all the available resources--local, state and federal--to attack the problem in the most effective way.

The key to making a major difference in this area is the willingness of the Congress and the Administration to provide rural communities and mid-size cities with assistance to enhance prevention, treatment and law enforcement.

Appendix A
Definition of Population Density Categories

Analysis of the drug problem in "rural" and "urban" areas is complicated by the complexity and lack of common definitions for these terms. Different surveys use different definitions, leading to results that are not directly comparable.

The two main sources used to examine the prevalence of drug use for this paper--Monitoring the Future (MTF) and the National Household Survey on Drug Abuse--draw on definitions used by the Office of Management and Budget (OMB) and the Bureau of the Census. OMB uses the units of counties to distinguish metropolitan and nonmetropolitan areas.[1] Metropolitan areas are defined as areas containing: 1) a core county with one or more central cities of at least 50,000 residents or with a Census Bureau-defined urbanized area (UA) and a total metro area population of 100,000 or more, and 2) those fringe counties that are economically integrated with the core county. Nonmetropolitan counties are outside of the boundaries of metropolitan areas and have no cities with over 50,000 people. In 1996, nonmetropolitan counties accounted for 2,522 out of a total of 3,139 counties (80.3 percent), and 19.8 percent of the total US population.

The Bureau of the Census defines urban as comprising all territory, population, and housing units located in UAs and in places (cities, towns, or villages) of 2,500 or more inhabitants outside of UAs. Urban areas include a central city and the surrounding densely settled territories that have a combined population of 50,000 or more and a population density exceeding 1,000 people per square mile. Anything not classified as urban by the Census Bureau is classified as rural. In the 1990 census, 24.8 percent of the U.S. population was classified as rural.

These two systems for classifying areas by population density are not entirely consistent. That is, metropolitan areas might contain both rural and urban populations, and urban areas might overlap with nonmetropolitan as well as metropolitan counties. Thus, in 1990, while 85.2 percent of the metropolitan population was also classified as urban, only 63.6 percent of the nonmetropolitan population was classified as rural. Similarly, while 90.1 percent of the urban population resided in metropolitan areas, only 52.5 percent of the rural population resided in nonmetropolitan areas.

In order to understand differences in substance abuse prevalence among areas of different population density, CASA has chosen three descriptive categories: Large metropolitan, small metropolitan, and rural areas.[*] The definitions of large and small metropolitan areas differ slightly between the MTF and NHSDA. The NHSDA defines large metropolitan areas as metropolitan areas over one million in population, and small metropolitan areas are metropolitan areas between 50,000 and one million. The MTF Study, however, uses a subset of metropolitan areas over one million in its definition of large metropolitan areas. Rural areas refer to the nonmetropolitan areas, and are defined consistently in the two data sets.

To examine prevalence rates by expanded population density categories, NHSDA subdivides small metropolitan areas into areas with populations between 50,000 and 250,000, and areas with populations between 250,000 and one million. Nonmetropolitan areas are subdivided into rural and urban areas, using Census definitions. CASA has labelled nonmetropolitan rural areas as areas less than 2,500, and nonmetropolitan urban areas as areas between 2,500 and 50,000.

[1] This appendix is adapted from Ricketts, T. C., Johnson-Webb, K. D., & Taylor, P. (1998). *Definitions of rural: A handbook for health policy makers and researchers*. Bethesda, MD: Office of Rural Health Policy.

[*] In 1998, rural areas contained approximately 22 percent of the U.S. population, small metropolitan areas contained approximately 35 percent of the U.S. population and large metropolitan areas contained approximately 43 percent of the U.S. population.