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**PRESIDENTIAL ADDRESS ON DRUGS: ALL NETWORKS
TUESDAY, SEPT. 5/9 P.M.**

((GOOD EVENING.))

THIS IS THE FIRST TIME SINCE TAKING THE OATH OF OFFICE THAT I FELT AN ISSUE WAS SO IMPORTANT, SO THREATENING, THAT IT WARRANTED TALKING DIRECTLY WITH YOU, THE AMERICAN PEOPLE. ALL OF US AGREE THAT THE GRAVEST DOMESTIC THREAT FACING OUR NATION TODAY IS DRUGS.

DRUGS HAVE STRAINED OUR FAITH IN OUR SYSTEM OF JUSTICE. OUR COURTS, OUR PRISONS, OUR LEGAL SYSTEM ARE STRETCHED TO THE BREAKING POINT. THE SOCIAL COSTS OF DRUGS ARE MOUNTING. IN SHORT, DRUGS ARE SAPPING OUR STRENGTH AS A NATION.

TURN ON THE EVENING NEWS, OR PICK UP THE MORNING PAPER AND YOU'LL SEE WHAT SOME AMERICANS KNOW JUST BY STEPPING OUT THEIR FRONT DOOR: OUR MOST SERIOUS PROBLEM TODAY IS COCAINE, AND IN PARTICULAR, CRACK.

WHO'S RESPONSIBLE? -- LET ME TELL YOU STRAIGHT
OUT.

EVERYONE WHO USES DRUGS.

EVERYONE WHO SELLS DRUGS.

AND EVERYONE \ \ WHO LOOKS THE OTHER WAY.

TONIGHT, I WILL TELL YOU HOW MANY AMERICANS ARE
USING ILLEGAL DRUGS. I WILL PRESENT TO YOU OUR
NATIONAL STRATEGY TO DEAL WITH EVERY ASPECT OF THIS
THREAT. AND I WILL ASK YOU TO GET INVOLVED IN WHAT
PROMISES TO BE A VERY DIFFICULT FIGHT.

((PICK UP DRUGS)) THIS IS CRACK COCAINE SEIZED A
FEW DAYS AGO BY DRUG ENFORCEMENT ADMINISTRATION AGENTS
IN A PARK JUST ACROSS THE STREET FROM THE WHITE HOUSE.
IT COULD EASILY HAVE BEEN HEROIN OR PCP. IT'S AS
INNOCENT LOOKING AS CANDY, BUT IT IS TURNING OUR CITIES
INTO BATTLE ZONES, AND IT IS MURDERING OUR CHILDREN.
LET THERE BE NO MISTAKE, THIS STUFF IS POISON. ((SET
DRUGS DOWN.))

SOME USED TO CALL DRUGS HARMLESS RECREATION. \\
THEY'RE NOT. DRUGS ARE A REAL AND TERRIBLY DANGEROUS
THREAT TO OUR NEIGHBORHOODS, OUR FRIENDS AND OUR
FAMILIES.

NO ONE AMONG US IS OUT OF HARM'S WAY. WHEN FOUR-
YEAR-OLDS PLAY IN PLAYGROUNDS STREWN WITH DISCARDED
HYPODERMIC NEEDLES AND CRACK VIALS -- IT BREAKS MY
HEART. WHEN COCAINE -- ONE OF THE MOST DEADLY AND
ADDICTIVE ILLEGAL DRUGS -- IS AVAILABLE TO SCHOOL KIDS
-- SCHOOL KIDS -- IT'S AN OUTRAGE. AND WHEN HUNDREDS
OF THOUSANDS OF BABIES ARE BORN EACH YEAR TO MOTHERS
WHO USE DRUGS -- PREMATURE BABIES BORN DESPERATELY SICK
-- THEN EVEN THE MOST DEFENSELESS AMONG US ARE AT RISK.

/\\

THESE ARE THE TRAGEDIES BEHIND THE STATISTICS.
BUT THE NUMBERS ALSO HAVE QUITE A STORY TO TELL. LET
ME SHARE WITH YOU THE RESULTS OF THE RECENTLY COMPLETED
HOUSEHOLD SURVEY OF THE NATIONAL INSTITUTE ON DRUG
ABUSE. IT COMPARES RECENT DRUG USE TO THREE YEARS AGO.
IT TELLS US SOME GOOD NEWS \\\ AND, SOME VERY BAD
NEWS. FIRST, THE GOOD. ((CAMERA CUTS TO SLIDE ONE.))
((PAUSE))

AS YOU CAN SEE IN THE CHART, IN 1985, THE
GOVERNMENT ESTIMATED THAT 23 MILLION AMERICANS WERE
USING DRUGS ON A "CURRENT" BASIS -- THAT IS, AT LEAST
ONCE IN THE PRECEDING MONTH. LAST YEAR, THAT NUMBER
FELL BY MORE THAN A THIRD. THAT MEANS ALMOST NINE
MILLION FEWER AMERICANS ARE CASUAL DRUG USERS. \\\ GOOD
NEWS. ((CAMERA BACK TO PRESIDENT.))

BECAUSE WE CHANGED OUR NATIONAL ATTITUDE TOWARD
DRUGS, CASUAL DRUG USE HAS DECLINED. WE HAVE MANY TO
THANK: OUR BRAVE LAW-ENFORCEMENT OFFICERS, RELIGIOUS
LEADERS, TEACHERS, COMMUNITY ACTIVISTS, AND LEADERS OF
BUSINESS AND LABOR. \ \ WE SHOULD ALSO THANK THE MEDIA
FOR THEIR EXHAUSTIVE NEWS AND EDITORIAL COVERAGE AND,
FOR THEIR AIRTIME AND SPACE FOR ANTI-DRUG MESSAGES. \ \
FINALLY, I WANT TO THANK PRESIDENT AND MRS. REAGAN FOR
THEIR LEADERSHIP. \ ALL OF THESE GOOD PEOPLE TOLD THE
TRUTH -- THAT DRUG USE IS WRONG AND DANGEROUS.

BUT, AS MUCH COMFORT AS WE CAN DRAW FROM THESE
DRAMATIC REDUCTIONS, THERE IS ALSO BAD NEWS -- VERY BAD
NEWS. \ \ \ ROUGHLY EIGHT MILLION PEOPLE HAVE USED
COCAINE IN THE PAST YEAR, ALMOST ONE MILLION OF THEM
USED IT FREQUENTLY \ \ ONCE A WEEK OR MORE.

((CAMERA TO SLIDE TWO))

WHAT THIS MEANS IS THAT, IN SPITE OF THE FACT THAT OVERALL COCAINE USE IS DOWN, FREQUENT USE HAS ALMOST DOUBLED IN THE LAST FEW YEARS. AND THAT'S WHY HABITUAL COCAINE USERS -- ESPECIALLY CRACK USERS ARE THE MOST PRESSING, IMMEDIATE DRUG PROBLEM. ((PAUSE)) ((RETURN TO PRESIDENT.))

\\

WHAT, THEN, IS OUR PLAN? \\ TO BEGIN WITH, I TRUST THE LESSON OF EXPERIENCE: NO SINGLE POLICY WILL CUT IT, NO MATTER HOW GLAMOROUS OR MAGICAL IT MAY SOUND. TO WIN THE WAR AGAINST ADDICTIVE DRUGS LIKE CRACK WILL TAKE MORE THAN JUST A FEDERAL STRATEGY. IT WILL TAKE A NATIONAL STRATEGY, ONE THAT REACHES INTO EVERY SCHOOL, EVERY WORKPLACE, INVOLVING EVERY FAMILY.

EARLIER TODAY, I SENT THIS DOCUMENT, ((HOLD UP RED BOOK)) OUR FIRST SUCH NATIONAL STRATEGY TO THE CONGRESS. IT WAS DEVELOPED WITH THE HARD WORK OF OUR NATION'S FIRST DRUG POLICY DIRECTOR, BILL BENNETT. ((PUT BOOK DOWN)) /\ /\ IN PREPARING THIS PLAN, WE TALKED WITH STATE, LOCAL AND COMMUNITY LEADERS, LAW ENFORCEMENT OFFICIALS AND EXPERTS IN EDUCATION, DRUG PREVENTION, AND REHABILITATION. WE TALKED WITH PARENTS AND KIDS. WE TOOK A LONG HARD LOOK AT ALL THAT THE FEDERAL GOVERNMENT HAS DONE ABOUT DRUGS IN THE PAST: WHAT'S WORKED, AND -- LET'S BE HONEST -- WHAT HASN'T. TOO OFTEN, PEOPLE IN GOVERNMENT ACTED AS IF THEIR PART OF THE PROBLEM -- WHETHER FIGHTING DRUG PRODUCTION, OR DRUG SMUGGLING, OR DRUG DEMAND -- WAS THE ONLY PROBLEM. BUT TURF BATTLES WON'T WIN THIS WAR. \ \ \ TEAMWORK WILL.

TONIGHT, I'M ANNOUNCING A STRATEGY THAT REFLECTS THE COORDINATED, COOPERATIVE COMMITMENT OF ALL FEDERAL AGENCIES. \ \ IN SHORT, THIS PLAN IS AS COMPREHENSIVE AS THE PROBLEM. WITH THIS STRATEGY, WE NOW FINALLY HAVE A PLAN THAT COORDINATES OUR RESOURCES, OUR PROGRAMS AND THE PEOPLE WHO RUN THEM.

OUR WEAPONS IN THIS STRATEGY ARE: THE LAW AND CRIMINAL JUSTICE SYSTEM; OUR FOREIGN POLICY; OUR TREATMENT SYSTEMS, AND OUR SCHOOLS AND DRUG PREVENTION PROGRAMS. SO THE BASIC WEAPONS WE NEED ARE THE ONES WE ALREADY HAVE. WHAT HAS BEEN LACKING IS A STRATEGY TO EFFECTIVELY USE THEM. \\\

LET ME ADDRESS FOUR OF THE MAJOR ELEMENTS OF OUR STRATEGY.

*** FIRST, WE ARE DETERMINED TO ENFORCE THE LAW, TO MAKE OUR STREETS AND NEIGHBORHOODS SAFE. SO TO START, I'M PROPOSING THAT WE MORE THAN DOUBLE FEDERAL ASSISTANCE TO STATE AND LOCAL LAW ENFORCEMENT. AMERICANS HAVE A RIGHT TO SAFETY IN AND AROUND THEIR HOMES.

AND WE WON'T HAVE SAFE NEIGHBORHOODS UNLESS WE ARE
TOUGH ON DRUG CRIMINALS -- MUCH TOUGHER THAN WE ARE
NOW. SOMETIMES THAT MEANS TOUGHER PENALTIES. BUT MORE
OFTEN IT JUST MEANS PUNISHMENT THAT IS SWIFT AND
CERTAIN. WE'VE ALL HEARD STORIES ABOUT DRUG DEALERS
WHO ARE CAUGHT AND ARRESTED -- AGAIN AND AGAIN -- BUT
NEVER PUNISHED. \\\ WELL, HERE THE RULES HAVE
CHANGED: IF YOU SELL DRUGS, YOU WILL BE CAUGHT. AND
WHEN YOU'RE CAUGHT, YOU WILL BE PROSECUTED. AND ONCE
YOU'RE CONVICTED, YOU WILL DO TIME. CAUGHT.
PROSECUTED. PUNISHED. \\\\

/\\

I AM ALSO PROPOSING THAT WE ENLARGE OUR CRIMINAL
JUSTICE SYSTEM ACROSS THE BOARD -- AT THE LOCAL, STATE
AND FEDERAL LEVELS ALIKE. WE NEED MORE PRISONS, MORE
JAILS, MORE COURTS, MORE PROSECUTORS. SO TONIGHT, I'M
REQUESTING -- ALTOGETHER -- AN ALMOST BILLION-AND-A-
HALF DOLLAR INCREASE IN DRUG-RELATED FEDERAL SPENDING
ON LAW ENFORCEMENT.

AND WHILE ILLEGAL DRUG USE IS FOUND IN EVERY COMMUNITY, NOWHERE IS IT WORSE THAN IN OUR PUBLIC HOUSING PROJECTS. YOU KNOW, THE POOR HAVE NEVER HAD IT EASY IN THIS WORLD. BUT IN THE PAST, THEY WEREN'T MUGGED ON THE WAY HOME FROM WORK BY CRACK GANGS. AND THEIR CHILDREN DIDN'T HAVE TO DODGE BULLETS ON THE WAY TO SCHOOL. THAT IS WHY I'M TARGETING FIFTY-MILLION DOLLARS TO FIGHT CRIME IN PUBLIC HOUSING PROJECTS -- TO HELP RESTORE ORDER, AND TO KICK OUT THE DEALERS FOR GOOD.

*** THE SECOND ELEMENT OF OUR STRATEGY LOOKS BEYOND OUR BORDERS, WHERE THE COCAINE AND CRACK, BOUGHT ON AMERICA'S STREETS, IS GROWN AND PROCESSED. IN COLOMBIA ALONE, COCAINE KILLERS HAVE GUNNED DOWN A LEADING STATESMAN, MURDERED ALMOST TWO HUNDRED JUDGES AND SEVEN MEMBERS OF THEIR SUPREME COURT. THE BESIEGED GOVERNMENTS OF THE DRUG-PRODUCING COUNTRIES ARE FIGHTING BACK, FIGHTING TO BREAK THE INTERNATIONAL DRUG RINGS. BUT YOU AND I AGREE WITH THE COURAGEOUS PRESIDENT OF COLOMBIA, VIRGILIO ((VEER-HEEL-LEO)) BARCO, WHO SAID THAT IF AMERICANS USE COCAINE, THEN AMERICANS ARE PAYING \\\ FOR MURDER. \\\ AMERICAN COCAINE USERS NEED TO UNDERSTAND THAT OUR NATION HAS ZERO TOLERANCE FOR CASUAL DRUG USE. WE HAVE A RESPONSIBILITY NOT TO LEAVE OUR BRAVE FRIENDS IN COLOMBIA TO FIGHT ALONE.

THE SIXTY-FIVE-MILLION DOLLAR EMERGENCY ASSISTANCE ANNOUNCED TWO WEEKS AGO WAS JUST OUR FIRST STEP IN ASSISTING THE ANDEAN NATIONS IN THEIR FIGHT AGAINST THE COCAINE CARTELS. COLOMBIA HAS ALREADY ARRESTED SUPPLIERS, SEIZED TONS OF COCAINE AND CONFISCATED PALATIAL HOMES OF DRUG LORDS. BUT COLOMBIA FACES A LONG, UPHILL BATTLE, SO WE MUST BE READY TO DO MORE.

OUR STRATEGY ALLOCATES MORE THAN A QUARTER OF A BILLION DOLLARS FOR NEXT YEAR IN MILITARY AND LAW ENFORCEMENT ASSISTANCE FOR THE THREE ANDEAN NATIONS OF COLOMBIA, BOLIVIA AND PERU. THIS WILL BE THE FIRST PART OF A FIVE-YEAR, TWO-BILLION DOLLAR PROGRAM TO COUNTER THE PRODUCERS, THE TRAFFICKERS AND THE SMUGGLERS.

I SPOKE WITH PRESIDENT BARCO LAST WEEK, AND WE HOPE TO MEET WITH THE LEADERS OF AFFECTED COUNTRIES IN AN UNPRECEDENTED DRUG SUMMIT, ALL TO COORDINATE AN INTER-AMERICAN STRATEGY AGAINST THE CARTELS. WE WILL WORK WITH OUR ALLIES AND FRIENDS -- ESPECIALLY OUR ECONOMIC SUMMIT PARTNERS -- TO DO MORE IN THE FIGHT AGAINST DRUGS. I'M ALSO ASKING THE SENATE TO RATIFY THE U.N. ANTI-DRUG CONVENTION CONCLUDED LAST DECEMBER.

TO STOP THOSE DRUGS ON THE WAY TO AMERICA, I PROPOSE THAT WE SPEND MORE THAN A BILLION-AND-A-HALF DOLLARS ON INTERDICTION. \ \ GREATER INTERAGENCY COOPERATION, COMBINED WITH SOPHISTICATED INTELLIGENCE-GATHERING, AND DEFENSE DEPARTMENT TECHNOLOGY, CAN HELP STOP DRUGS AT OUR BORDERS.

OUR MESSAGE TO THE DRUG CARTELS IS THIS: \\ THE RULES HAVE CHANGED. \\ WE WILL HELP ANY GOVERNMENT THAT WANTS OUR HELP. WHEN REQUESTED, WE WILL FOR THE FIRST TIME MAKE AVAILABLE THE APPROPRIATE RESOURCES OF AMERICA'S ARMED FORCES. WE WILL INTENSIFY OUR EFFORTS AGAINST DRUG SMUGGLERS ON THE HIGH SEAS, IN INTERNATIONAL AIRSPACE AND AT OUR BORDERS. WE WILL STOP THE FLOW OF CHEMICALS FROM THE UNITED STATES USED TO PROCESS DRUGS. WE WILL PURSUE AND ENFORCE INTERNATIONAL AGREEMENTS TO TRACK DRUG MONEY TO THE FRONT MEN AND FINANCIERS. AND THEN WE WILL HANDCUFF THESE MONEY LAUNDERERS, AND JAIL THEM -- JUST LIKE ANY STREET DEALER. AND FOR DRUG KINGPINS, THE DEATH PENALTY.\\\\\\

*** THE THIRD PART OF OUR STRATEGY CONCERNS DRUG TREATMENT. EXPERTS BELIEVE THAT THERE ARE TWO MILLION AMERICAN DRUG USERS WHO MAY BE ABLE TO GET OFF DRUGS WITH PROPER TREATMENT. BUT RIGHT NOW, ONLY 40 PERCENT OF THEM ARE ACTUALLY GETTING HELP. THIS IS SIMPLY NOT GOOD ENOUGH.

MANY PEOPLE WHO NEED TREATMENT WON'T SEEK IT ON THEIR OWN. AND SOME WHO DO SEEK IT ARE PUT ON A WAITING LIST. MOST PROGRAMS WERE SET UP TO DEAL WITH HEROIN ADDICTS, \ BUT TODAY, THE MAJOR PROBLEM IS COCAINE USERS. IT'S TIME WE EXPAND OUR TREATMENT SYSTEMS AND DO A BETTER JOB OF PROVIDING SERVICES TO THOSE WHO NEED THEM.

SO TONIGHT, I'M PROPOSING AN INCREASE OF THREE HUNDRED AND TWENTY-ONE MILLION DOLLARS IN FEDERAL SPENDING ON DRUG TREATMENT.

WITH THIS STRATEGY, WE WILL DO MORE. WE WILL WORK WITH THE STATES. WE WILL ENCOURAGE EMPLOYERS TO ESTABLISH EMPLOYEE ASSISTANCE PROGRAMS TO COPE WITH DRUG USE. AND, BECAUSE ADDICTION IS SUCH A CRUEL INHERITANCE, WE WILL INTENSIFY OUR SEARCH FOR WAYS TO HELP EXPECTANT MOTHERS WHO USE DRUGS.

*** FOURTH, WE MUST STOP ILLEGAL DRUG USE BEFORE IT STARTS. UNFORTUNATELY, IT BEGINS EARLY -- FOR MANY KIDS, BEFORE THEIR TEENS. BUT IT DOESN'T START THE WAY YOU MIGHT THINK, FROM A DEALER OR AN ADDICT HANGING AROUND A SCHOOL PLAYGROUND. MORE OFTEN, OUR KIDS FIRST GET THEIR DRUGS FREE, FROM FRIENDS, OR EVEN FROM OLDER BROTHERS OR SISTERS. PEER PRESSURE SPREADS DRUG USE. PEER PRESSURE CAN HELP STOP IT.

I AM PROPOSING A QUARTER-OF-A-BILLION-DOLLAR INCREASE IN FEDERAL FUNDS FOR SCHOOL AND COMMUNITY PREVENTION PROGRAMS THAT HELP YOUNG PEOPLE AND ADULTS REJECT ENTICEMENTS TO TRY DRUGS. \ \ AND I'M PROPOSING SOMETHING ELSE. \ \ EVERY SCHOOL, COLLEGE AND UNIVERSITY -- AND EVERY WORKPLACE -- MUST ADOPT TOUGH BUT FAIR POLICIES ABOUT DRUG USE BY STUDENTS AND EMPLOYEES. \ \ THOSE THAT WILL NOT ADOPT SUCH POLICIES WILL NOT GET FEDERAL FUNDS. PERIOD.

THE PRIVATE SECTOR ALSO HAS A ROLE TO PLAY. I SPOKE WITH A BUSINESSMAN NAMED JIM BURKE WHO SAID HE WAS HAUNTED BY THE THOUGHT -- A NIGHTMARE REALLY -- THAT SOMEWHERE IN AMERICA, AT ANY GIVEN MOMENT, THERE IS A TEEN-AGE GIRL WHO SHOULD BE IN SCHOOL, INSTEAD OF GIVING BIRTH TO A CHILD ADDICTED TO COCAINE. SO JIM DID SOMETHING. HE LED AN ANTI-DRUG PARTNERSHIP, FINANCED BY PRIVATE FUNDS, TO WORK WITH ADVERTISERS AND MEDIA FIRMS. THEIR PARTNERSHIP IS NOW DETERMINED TO WORK WITH OUR STRATEGY BY GENERATING EDUCATIONAL MESSAGES WORTH A MILLION DOLLARS A DAY . . . EVERY DAY FOR THE NEXT THREE YEARS -- A BILLION DOLLARS WORTH OF ADVERTISING, ALL TO PROMOTE THE ANTI-DRUG MESSAGE. \\\

AS PRESIDENT, ONE OF MY FIRST MISSIONS IS TO KEEP THE NATIONAL FOCUS ON OUR OFFENSIVE AGAINST DRUGS. SO NEXT WEEK I WILL TAKE THE ANTI-DRUG MESSAGE TO THE CLASSROOMS OF AMERICA IN A SPECIAL TELEVISION ADDRESS, ONE THAT I HOPE WILL REACH EVERY SCHOOL, EVERY YOUNG AMERICAN. BUT DRUG EDUCATION DOESN'T BEGIN IN CLASS OR ON T.V. IT MUST BEGIN AT HOME AND IN THE NEIGHBORHOOD. PARENTS AND FAMILIES MUST SET THE FIRST EXAMPLE OF A DRUG-FREE LIFE. AND WHEN FAMILIES ARE BROKEN, CARING FRIENDS, AND NEIGHBORS MUST STEP IN. \\\

THESE ARE THE MOST IMPORTANT ELEMENTS IN OUR STRATEGY TO FIGHT DRUGS. THEY ARE ALL DESIGNED TO REINFORCE ONE ANOTHER, TO MESH INTO A POWERFUL WHOLE. TO MOUNT AN AGGRESSIVE ATTACK ON THE PROBLEM FROM EVERY ANGLE. THIS IS THE FIRST TIME IN THE HISTORY OF OUR COUNTRY, THAT WE TRULY HAVE A COMPREHENSIVE STRATEGY.

AS YOU CAN TELL, SUCH AN APPROACH WILL NOT COME CHEAPLY. LAST FEBRUARY, I ASKED FOR A SEVEN-HUNDRED-MILLION DOLLAR INCREASE IN THE DRUG BUDGET FOR THE COMING YEAR. OVER THE PAST SIX MONTHS OF CAREFUL STUDY, WE HAVE FOUND AN IMMEDIATE NEED FOR ANOTHER BILLION-AND-A-HALF DOLLARS. WITH THIS ADDED 2.2 BILLION, OUR 1990 DRUG BUDGET TOTALS ALMOST EIGHT BILLION DOLLARS -- THE LARGEST INCREASE IN HISTORY.

WE NEED THIS PROGRAM FULLY IMPLEMENTED -- RIGHT
AWAY. \\ THE NEXT FISCAL YEAR BEGINS JUST 26 DAYS FROM
NOW. SO TONIGHT I'M ASKING THE CONGRESS -- WHICH HAS
HELPED US FORMULATE THIS STRATEGY -- TO HELP US MOVE IT
FORWARD IMMEDIATELY.

WE CAN PAY FOR THIS FIGHT AGAINST DRUGS WITHOUT
RAISING TAXES OR ADDING TO THE BUDGET DEFICIT. WE HAVE
SUBMITTED OUR PLAN TO CONGRESS THAT SHOWS JUST HOW TO
FUND IT WITHIN THE LIMITS OF OUR BIPARTISAN BUDGET
AGREEMENT.

I KNOW SOME WILL STILL SAY THAT WE ARE NOT
SPENDING ENOUGH MONEY. BUT THOSE WHO JUDGE OUR
STRATEGY ONLY BY ITS PRICE TAG, SIMPLY DON'T UNDERSTAND
THE PROBLEM. LET'S FACE IT, WE'VE ALL SEEN IN THE PAST
THAT MONEY ALONE WON'T SOLVE OUR TOUGHEST PROBLEMS.

TO BE STRONG AND EFFICIENT, OUR STRATEGY NEEDS
THESE FUNDS. BUT THERE IS NO MATCH FOR A UNITED
AMERICA, A DETERMINED AMERICA, AN ANGRY AMERICA. OUR
OUTRAGE AGAINST DRUGS UNITES US, BRINGS US TOGETHER
BEHIND THIS ONE PLAN OF ACTION, \\ AN ASSAULT ON EVERY
FRONT.

THIS IS THE TOUGHEST DOMESTIC CHALLENGE WE'VE
FACED IN DECADES. AND IT IS A CHALLENGE WE MUST
FACE -- NOT AS DEMOCRATS OR REPUBLICANS, LIBERALS OR
CONSERVATIVES -- BUT AS AMERICANS. THE KEY IS A
COORDINATED, UNITED EFFORT. WE HAVE RESPONDED
FAITHFULLY TO THE REQUEST OF THE CONGRESS TO PRODUCE
OUR NATION'S FIRST NATIONAL DRUG STRATEGY. I'LL BE
LOOKING TO THE DEMOCRATIC MAJORITY AND OUR REPUBLICANS
IN CONGRESS FOR LEADERSHIP AND BIPARTISAN SUPPORT. AND
OUR CITIZENS DESERVE COOPERATION, NOT COMPETITION; A
NATIONAL EFFORT, NOT A PARTISAN BIDDING WAR.

TO START, CONGRESS NEEDS NOT ONLY TO ACT ON THIS
NATIONAL DRUG STRATEGY, BUT ALSO TO ACT ON OUR CRIME
PACKAGE ANNOUNCED LAST MAY; A PACKAGE TO TOUGHEN
SENTENCES, BEEF UP LAW ENFORCEMENT AND BUILD NEW PRISON
SPACE FOR 24,000 INMATES.

\\ YOU AND I BOTH KNOW THE FEDERAL GOVERNMENT
CAN'T DO IT ALONE. THE STATES NEED TO MATCH TOUGHER
FEDERAL LAWS WITH TOUGHER LAWS OF THEIR OWN -- STIFFER
BAIL, PROBATION, PAROLE AND SENTENCING.

AND WE NEED YOUR HELP. IF PEOPLE YOU KNOW ARE
USERS, HELP THEM GET OFF DRUGS. IF YOU ARE A PARENT,
TALK TO YOUR KIDS ABOUT DRUGS -- TONIGHT.

CALL YOUR LOCAL DRUG PREVENTION PROGRAM. BE A BIG
BROTHER OR SISTER TO A CHILD IN NEED. PITCH IN WITH
YOUR LOCAL NEIGHBORHOOD WATCH PROGRAM. WHETHER YOU
GIVE YOUR TIME OR TALENT, EVERYONE COUNTS.

\\//

EVERY EMPLOYER WHO BANS DRUGS FROM THE WORKPLACE.

EVERY SCHOOL THAT'S TOUGH ON DRUG USE.

EVERY NEIGHBORHOOD IN WHICH DRUGS ARE NOT WELCOME.

\\//

AND MOST IMPORTANT, EVERY ONE OF YOU WHO REFUSES
TO LOOK THE OTHER WAY. EVERY ONE OF YOU COUNTS.

OF COURSE, VICTORY WILL TAKE HARD WORK AND TIME.
BUT TOGETHER WE WILL WIN -- TOO MANY YOUNG LIVES ARE AT
STAKE. \\\

/\\

NOT LONG AGO, I READ A NEWSPAPER STORY ABOUT A LITTLE BOY NAMED DOONEY, WHO, UNTIL RECENTLY, LIVED IN A CRACK HOUSE IN A SUBURB OF WASHINGTON, D.C. IN DOONEY'S NEIGHBORHOOD, CHILDREN DON'T FLINCH AT THE SOUND OF GUNFIRE. AND WHEN THEY PLAY, THEY PRETEND TO SELL TO EACH OTHER SMALL WHITE ROCKS THEY CALL CRACK.

LIFE AT HOME WAS SO CRUEL THAT DOONEY BEGGED HIS TEACHERS TO LET HIM SLEEP ON THE FLOOR AT SCHOOL. AND, WHEN ASKED ABOUT HIS FUTURE, 6-YEAR-OLD DOONEY ANSWERS: "I DON'T WANT TO SELL DRUGS, \\ BUT I WILL PROBABLY HAVE TO." ((PAUSE)) \\\

WELL, DOONEY DOES NOT HAVE TO SELL DRUGS. NO CHILD IN AMERICA SHOULD HAVE TO LIVE LIKE THIS. TOGETHER, AS A PEOPLE, WE CAN SAVE THESE KIDS. WE HAVE ALREADY TRANSFORMED A NATIONAL ATTITUDE OF TOLERANCE INTO ONE OF CONDEMNATION. BUT THE WAR ON DRUGS WILL BE HARD-WON, NEIGHBORHOOD BY NEIGHBORHOOD, BLOCK BY BLOCK, CHILD BY CHILD. \\

IF WE FIGHT THIS WAR AS A DIVIDED NATION, THEN THE
WAR IS LOST. ((PICK UP DRUGS, HOLD IT IN FRONT OF
YOU)) BUT, IF WE FACE THIS EVIL AS A NATION UNITED,
THIS WILL BE NOTHING BUT A HANDFUL OF USELESS
CHEMICALS. ((SET VIAL DOWN, OFF CAMERA))

VICTORY . . . ((PAUSE)) VICTORY OVER DRUGS IS
OUR CAUSE, A JUST CAUSE, AND WITH YOUR HELP, WE ARE
GOING TO WIN.

THANK YOU, GOD BLESS YOU AND GOOD NIGHT.

#

August 11, 1989*

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INTRODUCTION

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In late July of this year, the Federal government's National Institute on Drug Abuse (NIDA) released the results of its ninth periodic Household Survey -- the first such comprehensive, national study of drug use patterns since 1985. Much of the news in NIDA's report was dramatic and startling. The estimated number of Americans using any illegal drug on a "current" basis (in other words, at least once in the 30-day period preceding the survey) has dropped 37 percent: from 23 million in 1985 to 14.5 million last year. Current use of the two most common illegal substances -- marijuana and cocaine -- is down 36 and 48 percent respectively.

This is all good news -- very good news. But it is also, at first glance, difficult to square with commonsense perceptions. Most Americans remain firmly convinced that drugs represent the gravest present threat to our national well-being -- and with good reason. Because a wealth of other, up-to-date evidence suggests that our drug problem is getting worse, not better.

Crime. Fear of drugs and attendant crime are at an all-time high. Rates of drug-related homicide continue to rise -- sometimes alarmingly -- in cities across the country. **Felony**

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drug convictions now account for the single largest and fastest growing sector of the Federal prison population. Three-fourths of all robberies and half of all felony assaults committed by young people (statistically, the most crime-prone age group) now involve drug users. Reports of bystander deaths due to drug-related gunfights and drive-by shootings continue to climb.

Health. The threat drugs pose to American public health has never been greater. Intravenous drug use is now the single largest source of new AIDS virus infections, and perhaps one-half of all AIDS deaths are drug-related. The number of drug-related emergency hospital admissions increased by 121 percent between 1985 and 1988. As many as 200,000 babies are born each year to mothers who use drugs. Many of these infants suffer low birth weight, severe and often permanent mental and physical dysfunction or impairment, or signs of actual drug dependence. Many other such babies -- born many weeks or months premature -- do not survive past infancy.

The Economy. Drug trafficking, distribution, and sales in America have become a vast, economically debilitating black market. One U.S. Chamber of Commerce estimate puts annual gross drug sales at \$110 billion -- more than our total gross agricultural income, and more than double the profits enjoyed by all the Fortune 500 companies combined. Such figures cannot truly be calculated with any real precision, but it is all too clear that drug use acts as a direct and painful brake on

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American competitiveness. One study reports that on-the-job drug use alone costs American industry and business \$60 billion a year in lost productivity and drug-related accidents.

NATIONS LEARNING THAT THEY CANNOT EXPORT...

Overseas. In Southeast and West Asia, South and Central America, and the Caribbean, drug exporting networks and domestic drug use are causing serious social, economic, and political disruptions. Intense drug-inspired violence or official corruption have plagued a number of Latin American countries for years; in more than one of them, drug cartel operations and associated local insurgencies are a real and present danger to democratic institutions, national economies, and basic civil order. In Pakistan, the number of heroin addicts has more than tripled in the past four years alone. And so, because our national security directly depends on regional stability throughout the Americas and across the globe, drugs have become a major concern of U.S. foreign policy.

Availability. Finally, undeniably, the fact remains that here in the United States, in every State -- in our cities, in our suburbs, in our rural communities -- drugs are potent, drugs are cheap, and drugs are available to almost anyone who wants them.

Insofar as this crisis is the product of individual choices to take or refuse drugs, it has been -- and continues to be -- a crisis of national character, affecting and affected by the

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Dr Chisnoo
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myriad social structures and agencies that help shape individual American lives: our families, our schools, our churches and community organizations, even our broadest messages to one another through popular culture and the media. At least in part, NIDA's most recent Household Survey is proof that grassroots America can meet the challenge of drugs, and meet it well.

Not so long ago, drug use was an activity widely thought of as harmless fun or isolated self-indulgence. Today it is seen -- just as widely, and far more accurately -- to be a personal, social, medical, and economic catastrophe. In less than a decade, parents, educators, students, clergy, and local leaders across the country have changed and hardened American opinion about drugs. The effectiveness of their activism is now largely vindicated. Despite the persistent widespread availability of illegal drugs, many millions of Americans who once used them regularly appear to have recently given them up altogether. Many others -- young people for the most part -- have been successfully induced not to try drugs in the first place.

What, then, accounts for the intensifying drug-related chaos that we see every day in our newspapers and on television? One word explains much of it. That word is crack.

Cocaine in Our Cities

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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

EMBARGOED FOR RELEASE AT 10:00 A.M. EST
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HHS Secretary Louis W. Sullivan, M.D., today released results from the Department's 1988 National Household Survey on Drug Abuse, which show significant declines in the "current use" of illicit drugs by Americans nationwide, but also indicate continued severe problems with heavy drug users, especially frequent users of cocaine.

Presenting the findings at a press conference with Director of National Drug Control Policy William J. Bennett, Secretary Sullivan called the overall findings "very encouraging," but said they "should not be viewed as a declaration of success" in the nation's anti-drug abuse efforts.

The survey, ninth in a series by the HHS' National Institute on Drug Abuse (NIDA), reports the nature and extent of drug abuse among the American household population age 12 and over.

The 1988 survey, conducted last fall, showed a decrease of 37 percent in "current use" of illicit drugs compared with results of the most recent previous Household Survey, conducted in 1985. In other words, based on survey responses, persons who used marijuana, cocaine, or any other illicit drug within the last 30 days dropped from 23 million in 1985 to 14.5 million in 1988.

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In addition, users of any illicit drug "within the last year" decreased almost 25 percent, from 37 million to 28 million.

The number of "current" cocaine users also dropped, by 50 percent, from 5.8 million in 1985 to 2.9 million in 1988. And those who used cocaine in the past year fell from 12 million to 8 million.

However, the 1988 survey found continued intense use of cocaine within the cocaine user population. Some 862,000 used cocaine once a week or more, compared with 647,000 in 1985; and some 292,000 used the drug daily or almost daily, compared with 246,000 in 1985.

"For these individuals, the survey underscores what we have already learned from research--that cocaine is an extremely addictive drug that frequently entraps its victims," Dr. Sullivan said.

Cocaine use was highest among the unemployed (4.6 percent) and those aged 18-25 (4.5 percent). The survey also found there were almost half a million current crack users among the 2.9 million current cocaine users.

"Of great concern are the 600,000 young people age 12-17 who have used cocaine within the past year, placing them at heavy risk for addiction, and severe medical and social consequences," Dr. Sullivan added.

"Mindful of the destructive power of drugs and those who peddle them," the Secretary said, "this survey should not be

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viewed as a declaration of success, but as a rallying point for sustained and invigorated demand and supply reduction initiatives."

"While we celebrate our impressive gains, let us resolve to reinforce and build on them," he stated.

Alcohol and cigarette use also declined from 1985 to 1988. The number of current drinkers of alcohol declined from 113 million in 1985 to 106 million in 1988. Current cigarette users declined from 60 million in 1985 to 57 million in 1988. "The decline in alcohol and cigarette use is a significant development because the use of these two substances has a disproportionate impact on the public health system," Dr. Sullivan emphasized.

The survey found current users of marijuana continued to decrease, from 18 million in 1985 to 12 million in 1988. "As the most widely abused illicit drug, marijuana has led the decline in illicit drug use since 1979, especially among youth and young adults, where the rates are at the lowest level since the survey began in 1972," explained Dr. Charles R. Schuster, Director of NIDA.

"But we must still realize that there are almost 2 million teenagers currently using illicit drugs," Dr. Schuster added.

Other findings of the survey include:

-- Among 20 to 40 year old full-time employed Americans, 22 percent used an illicit drug in the past year, and 12 percent used an illicit drug in the past month. Ten percent used marijuana, and 3 percent used cocaine in the past month.

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-- Over 5 million (9 percent) of the nearly 60 million women 15-44 years of age, the childbearing years, have used an illicit drug in the past month. Almost 1 million (2 percent) have used cocaine and 3.8 million (6 percent) have used marijuana in the past month.

-- Current nonmedical use of psychotherapeutic drugs, including sedatives, tranquilizers, stimulants, and analgesics, decreased from 3.2 percent in 1985 to less than 2 percent in 1988.

-- Use of hallucinogens, such as LSD and PCP, did not change significantly for any age group between 1985 and 1988.

"Illicit drug use by Americans remains much too high," Secretary Sullivan said. "Its consequences in health, crime, and cost to society remain unacceptable. But the dramatic declines in overall drug use identified in the Household Survey are very encouraging."

"Attitudes are changing. And this is testimony to years of hard work by parents, educators, health care providers, employers and religious leaders, as well as government efforts, to create a general social attitude that drug use is wrong and intolerable."

The National Household Survey is a probability-based sample of 8,814 people representative of the U.S. household population age 12 and over. The survey will be conducted again next year in order to closely monitor changes in drug use.

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SPEAKERS

1988 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE

Press Conference

July 31, 1989

U.S. Department of Health and Human Services

Frederick K. Goodwin, M.D., Administrator, Alcohol,
Drug Abuse, and Mental Health Administration, DHHS
(Moderator)

Louis W. Sullivan, M.D., Secretary, U.S. Department of
Health and Human Services

William J. Bennett, Director, Office of National Drug
Control Policy

Charles R. Schuster, Ph.D., Director, National
Institute on Drug Abuse, ADAMHA, DHHS

THE NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE, 1988
THE NATIONAL INSTITUTE ON DRUG ABUSE

The 1988 National Household Survey on Drug Abuse is the ninth in a series that began in 1971 under the auspices of the National Commission on Marijuana and Drug Abuse. Since 1974 the survey has been sponsored by the National Institute on Drug Abuse. The 1988 survey was conducted by the Research Triangle Institute in North Carolina at a cost of \$2.5 million.

The survey covers the population age 12 and older living in households in the contiguous United States (excluding Hawaii and Alaska.). The results are based on personal interviews combined with self-administered questionnaires from 8,814 respondents, randomly selected from the household population, the largest sample ever used in this survey. This year for the second time, blacks and Hispanics were over-sampled in order to provide more accurate data on these special population groups. In addition, the 1988 survey collected information on health consequences and measures of dependency. Not included in the survey are persons living in military installations, dormitories, and other group quarters, and institutions such as hospitals and jails.

Four major population groups are covered in this survey:

Youth age 12 to 17 Young adults age 18 to 25
Mid-adults age 26 to 34 Older adults age 35 and older

Data are also reported by Metropolitan Area:

Large--SMSAs with a population of 1,000,000 or more in 1980
Small--SMSAs with a population under 1,000,000
Non-metropolitan--Areas that are not part of a SMSA

Data are also reported by Region:

NORTHEAST includes CT, ME, MA, NH, RI, VT, NJ, NY, PA;
NORTH CENTRAL includes IL, IN, MI, OH, WI, IA, KS, MN, MO, NE, ND, SD;
SOUTH includes DE, DC, FL, GA, MD, NC, SC, VA, WV, AL, KY, MS, TN, AR, LA, TX, OK;
WEST includes AZ, CA, CO, ID, MT, NV, NM, OR, UT, WA, and WY.

The survey data provide the basis for prevalence estimates and other statistics which contribute to an understanding of the extent of drug use in the United States in 1988. As with any sample survey, the results of this survey are estimates of the values that would be obtained if the data were collected from all members of the population from which the sample was drawn. Statistically, since the sample was drawn according to strict random (probability-based) procedures, each sample result is the single best estimate of the corresponding population value.

STATEMENT BY
LOUIS W. SULLIVAN, M.D.
SECRETARY OF HEALTH AND HUMAN SERVICES

JULY 31, 1989

I am pleased to report to you today the findings of the 1988 National Household Survey on Drug Abuse, and to share with you some very hopeful results. While the survey shows that drug abuse remains a severe problem in our country, I am happy to say that it also shows some very encouraging and widespread declines in drug abuse. It finds positive trends throughout the country, and these trends are occurring in many of the most important categories which are used to measure illicit drug use.

Most of all, I believe these survey results show what can be achieved when the Nation commits itself to an "all fronts" effort against drug abuse in our society.

The survey found significant decreases in illicit drug use since the last survey in 1985. Whereas, in 1985, some 37 million Americans had used marijuana, cocaine, or other illicit drugs at least once in the past year, this year's survey found a decrease of almost 25 percent, to 28 million. Even better news, the number who used illicit drugs in the past month (classified as "current users") is also down -- a sharp decrease of 37 percent, from 23 million in 1985 to 14.5 million in 1988.

Of course, these numbers are still much too high. But these trends are positive and impressive.

We are also very encouraged by the overall trend in cocaine use -- but at the same time, we continue to confront undiminished problems of frequent use among those who are still using this drug.

The number of current cocaine users decreased by half, from 5.8 million in 1985 to 2.9 million in 1988. This drop in cocaine use shows that the American public is responding to the warnings about the dangers of this drug and its social and legal consequences. More and more people are avoiding cocaine in the first place, or, if they already use it, are stopping cocaine use either on their own or with treatment.

There are many others, unfortunately, who continue to use cocaine. The survey found that the use of cocaine did not change significantly among Blacks or Hispanics. The percentages of Blacks who used cocaine in the past year was 6.2 percent in 1985 compared to 4.4 percent in 1988. Hispanic use was 5.1 percent in 1985 compared to 5.7 percent in 1988. There was also a significant increase in lifetime prevalence of cocaine use among Hispanics, from 7.3 percent in 1985 to 11 percent in 1988.

The use of crack, a highly addictive form of cocaine, has been of great concern to all of us. The survey found that almost a half million people in all age groups currently use crack. And more than one million people had used crack in the past year.

Of the eight million who had used any form of cocaine in the last year, the survey found that 862,000 used the drug once a week or more, compared with 647,000 in 1985; and some 292,000 used the drug daily or almost daily in 1988, compared with 246,000 in 1985. For these individuals, the survey underscores what we have already learned from research--that cocaine is an extremely addictive drug which frequently entraps its victims.

Another troublesome fact is that the highest rates of cocaine use were among young adults aged 18-25 and the unemployed. Large metropolitan areas also had high rates, as did the Western United States.

Of great concern, 600,000 young people aged 12 to 17 had used cocaine within the past year, which places them at heavy risk for continued use, addiction and severe medical consequences, as well as the potential social consequences of dropping out of school, juvenile crime, and unplanned pregnancy, which can be the result of prostitution in exchange for drugs.

Another very serious problem that we have been hearing and reading about all too often is the increasing number of babies born suffering from the consequences of their mother's drug use. For instance, here in the District of Columbia, officials recently released a report attributing the rise in infant mortality to heavy drug use among women of child-bearing age. The Household Survey found that more than five million (9 percent) of nearly 60 million women in the child-bearing years of 15-44 had used an illicit drug in the past month. Almost one million had used cocaine and four million had used marijuana in the past month.

The Department is all too aware of this alarming situation. The National Institute on Drug Abuse is funding numerous grants to learn more about the immediate and long-term adverse effects of drug use during pregnancy. And our Office for Substance Abuse Prevention has awarded grants for demonstration programs to develop effective prevention, education, and treatment services for substance abusing pregnant and post-partum women and their infants.

With regard to alcohol and cigarette use, I am pleased to be able report a decline. This is especially significant because use of these two drugs has a disproportionate impact on the public health system. According to the 1988 survey, current drinkers of alcohol decreased from 113 million in 1985 to 106 million in 1988. Current smokers declined from 60 million in 1985 to 57 million in 1988.

What do these survey findings mean for the future? Although the general decline in drug use indicates that our national media campaigns, school- and community-based prevention programs, and intervention efforts in the workplace are having an impact, the most difficult and challenging part of the drug abuse problem is now apparent. We need to strengthen our efforts to reach those who require more intensive prevention efforts and those who need treatment.

For instance, we need to help those young people who are the most vulnerable to drug abuse because of drug abuse in their families, limited opportunities to succeed in school, and the attraction of a drug underworld whose immediate promise of material benefits appears deceptively to outweigh the long-term advantages of education and employment.

A greater commitment will be needed to provide treatment and rehabilitation services for those who are addicted. We in the Department have accelerated our research program to discover new diagnostic techniques, therapeutic approaches, and medications to assist in cocaine and other drug abuse treatment. We look forward to these efforts resulting in further improvements in the care of drug dependent people.

Many Americans feel helpless in the face of the drug problem because it is one of many social problems that defies a simple solution. But we must continue to work to change the way people think about drugs and their tolerance for drug use.

Illicit drug use by Americans remains much too high. Its consequences in health, crime, and cost to society remains unacceptable. But the dramatic declines in overall drug use identified in the Household Survey are very encouraging.

Attitudes ARE changing. And this is testimony to years of hard work by parents, educators, health care providers, employers and religious leaders, as well as government efforts, to create a general social attitude that drug use is wrong and intolerable. The media has given valuable assistance in carrying out this effort, and we will need their help in the future.

Mindful of the destructive power of drugs and those who peddle them, the survey should be viewed not as a declaration of success, but as a rallying point for sustaining and invigorating initiatives to reduce the demand for, and supply of illicit drugs. While we celebrate these impressive gains, let us resolve to reinforce and build on them.

Now I would like to welcome and introduce, Mr. William Bennett, the Director of the White House Office of National Drug Control Policy.

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OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

STATEMENT BY DIRECTOR WILLIAM J. BENNETT

PRESS CONFERENCE AT RELEASE OF THE
1988 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE

MONDAY, JULY 31, 1989
WASHINGTON, D.C.

Secretary Sullivan has nicely summarized the essential "good news, bad news" character of NIDA's latest figures. I'd put it this way: there's some very good news, and some very bad news. I won't restate the numbers in detail. They speak for themselves. And they confirm a wealth of already available data -- both empirical and anecdotal -- about the changing shape and size of the nation's drug problem.

With this Household Survey, the government is reporting what most drug enforcement, drug treatment, and drug prevention experts know to be the truth -- though in much sharper relief. Here's your headline for tomorrow: Most use of most drugs by most Americans -- overall drug use -- is off sharply. But cocaine addiction has dramatically intensified.

There are two basic points to be made about these new statistics, insofar as future drug policy is concerned. First, they mean that the people who say "all is lost" and "we can't win" have never been more wrong. Drugs are potent, cheap, and available almost everywhere, and yet millions of Americans who once used them regularly appear now to have recently given them

up altogether. In my view, this is primarily a triumph of changed attitudes. I know some of the drug awareness campaigns of past years have been caricatured and ridiculed. Today I think the men and women active in those campaigns -- parents; educators; students; clergy; local, state, and federal officials across the country -- have been fully vindicated. I want to salute the media for its efforts. It has paid attention, and that has paid off. All these efforts have worked. Their message has been heard. And we'll need more from them in the months and years ahead.

The second point to be made is even more important: We are not out of the woods yet, not by a long shot. The reductions in American drug use highlighted by this report are not the whole story, as anyone who watches television, reads a newspaper, or lives in a city can see for himself. Drug crime is up, drug trafficking is up, drug deaths are up, drug emergencies in our hospitals are up -- all since 1985. And much of this can be explained in one word: crack.

Secretary Sullivan gave you the bad news about cocaine. Among those who report any use of cocaine, the percentage using the drug "frequently" -- one or more times a week -- has doubled since 1985. And despite overall reductions in cocaine use nationwide, the estimated number of Americans who are "frequent" cocaine users has climbed 33 percent since 1985. That is a shocking and unacceptable jump in just three years. It also exactly coincides with the appearance of crack on our inner-city

streets. The fact that first sightings of crack are now reported almost daily in suburbs and rural areas around the country is an alarming portent for the future.

So we are now fighting two drug wars, not just one. The first and more manageable one is against "casual" use of drugs by most Americans, and though it is not yet won, we are winning it. The other, much more difficult war is against chronic and addictive cocaine use. And on this second front, we are not winning. We have to do better -- fast. This Administration intends to mobilize the country to provide help to those individuals and neighborhoods being ravaged by crack. On that front we must -- and we will -- start to win.

So here's where we are, to paraphrase Churchill: This is not the end, not even the beginning of the end. But it may well be the end of the beginning. Our drug problem remains acute, it remains national in scope and size, and it continues to involve drugs of every sort. President Bush will announce a comprehensive drug strategy early next month, and I think you'll see it reflects a full and sensitive understanding of these Household Survey numbers -- and everything else that we know about the problem.

STATEMENT OF CHARLES R. SCHUSTER, PH.D.
DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Press Conference

National Household Survey on Drug Abuse

July 31, 1989

Thank you Dr. Goodwin. As we have seen this morning, the good news is the continued, and quite dramatic, decline in the abuse of most illicit drugs. As Secretary Sullivan said, 28 million Americans used illicit drugs at least once in the past year, down from 37 million. Current use is also down, from 23 million in 1985 to 14.5 million in 1988. Current cocaine use has been cut in half from almost 6 million to less than 3 million.

But we also must recognize that there are still almost two million teenagers currently using illicit drugs. These youngsters require intensive interventions especially designed to address their needs. As Dr. Sullivan said, these youth are at risk for a variety of reasons and our prevention research is devoted to addressing the causes of their drug problems to help develop effective prevention and intervention programs.

Over the past few years, the abuse of cocaine and its freebase derivative, crack, has become the number one drug problem of concern. We are very pleased to see the significant reductions in cocaine abuse, but many still suffer its severe consequences and have difficulty in trying to stop their drug use. Of the 8 million

who used cocaine in the last year, 862,000 or 10.5 percent, used the drug once a week or more. Over half (55%) of the weekly users made at least one attempt during the year to cut down on their use. Even chronic cocaine users are trying to cut down or discontinue their cocaine use, which is consistent with overall decreases found in the survey.

In addition, our Drug Abuse Warning Network (DAWN), which tracks medical emergencies and deaths, has found a five-fold increase in medical emergencies due to cocaine abuse since 1984--from 8,831 to over 46,000 in 1988. Cocaine-related deaths have more than doubled in the same period. Emergency room episodes related to crack, or smoking freebase cocaine, have increased from 549 cases in 1984 to over 15,000 in 1988--a 28-fold increase. We have expanded our treatment research efforts to address the increased intensity of cocaine use and its concomitant medical consequences.

The household survey found geographic differences in cocaine abuse. The highest rates were found in the Western region where 6.1 percent of the population have used cocaine in the last year and in large metropolitan areas where 5.1 percent have used during that time.

The household survey also shows the differential rates of drug abuse among the employed vs. the unemployed. Among 20-to-40 year olds, 12 percent of the full-time employed currently used illicit drugs as compared to 24 percent of the unemployed. Three percent of the full-time employed currently used cocaine, compared to 7

percent of the unemployed. Those who are unemployed remain at higher risk to drug abuse.

As for marijuana, the most widely abused illicit drug, the survey found that current use of marijuana decreased from 18 million in 1985 to 12 million in 1988. Marijuana has led the decline in illicit drug use since 1979, especially among youth and young adults where the rates are at the lowest level since the survey began in 1972.

Despite this decline, almost 66 million Americans, or 33 percent of the population, age 12 and over, have tried marijuana, including virtually all segments of society--black, white, Hispanic, the prosperous, the poor, college graduates, high school dropouts--no segment has been immune.

The 1988 survey shows that many of the people who have tried marijuana have used the drug extensively. Twenty-one million Americans have used marijuana in the past year. When we look at the frequency of use for these marijuana smokers, we see that almost one-third used once a week or more, and almost one-fifth used the drug daily or almost daily.

It is difficult to report these findings without placing special emphasis on the level of drug use by our teenagers. The 1988 survey reports decreases in the percentage of 12 and 13 year olds who have experimented with drugs. The survey shows the percentage of 12 and 13 year olds who tried marijuana dropped from 5.8 percent in 1985 to 4.2 percent in 1988. Cigarette smoking decreased from 28 percent in 1985 to 23 percent in 1988 in this age

group.

We are making progress in changing attitudes about illicit drug use. Among our youth, 37 percent saw "great risk" in smoking marijuana regularly in 1985. This increased to 44 percent in 1988.

The behavior and attitude trends we see in the Household Survey generally parallel the trends we have measured among high school seniors and young adults in our 1988 National High School Senior Survey. Both surveys strongly demonstrate the relationship between negative attitudes towards drugs and antidrug behaviors. These are very good signs that media campaigns, school- and community-based prevention programs, and workplace initiatives appear to be working.

We are making important inroads into the drug abuse problem. Millions of people among the general population have decided to never try an illicit drug; and millions of others are stopping their drug use on their own or with help. While we must maintain the momentum of our efforts with the general population, we must recognize the tough job that still remains in many of our communities. This is the time to redouble our efforts to reach those we haven't reached--the chronic users, the children of substance abusers, the poorly educated, the unemployed. That should be our goal for the future.

Thank you for your attention. We will now be glad to entertain questions.

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NIDA

Capsules



Issued by the Press Office of the National Institute on Drug Abuse
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OVERVIEW OF THE 1988 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE

The 1988 National Household Survey on Drug Abuse is the ninth in a series that began in 1971 under the auspices of the National Commission on Marijuana and Drug Abuse and has been sponsored by the National Institute on Drug Abuse since 1974.

The survey covers the population age 12 and older living in households in the contiguous United States. The results are based on personal interviews combined with self-administered answer sheets from 8,814 respondents, randomly selected from the household population. This is the largest sample ever used in this survey and includes an oversampling of Blacks, Hispanics, and young people, enabling us to make reliable estimates about the levels of drug use among these populations. Not included in the survey are the homeless, persons living in military installations, dormitories, and other group quarters, and institutions such as hospitals and jails.

Three major age groups are covered in this survey: youth age 12 to 17; young adults age 18 to 25; and older adults age 26 and over. The survey data provide the basis for prevalence estimates and other statistics which contribute to an understanding of the extent of drug use in the United States in 1988.

As with any sample survey, the results of this survey are estimates of the values that would be obtained if the data were collected from all members of the population from which the sample was drawn.

The following tables show the trends in prevalence of drug use, based on the surveys from 1972 through 1988.

Source: National Household Survey on Drug Abuse, 1988, National Institute on Drug Abuse, Division of Epidemiology and Prevention Research.

Lifetime Prevalence of Drug Use: 1972 to 1988
(Use in lifetime)

Youth Age 12-17

Drug (Unweighted N)	1972 (880)	1974 (952)	1976 (986)	1977 (1,272)	1979 (2,165)	1982 (1,581)	1985 (2,246)	1988 (3,095)
Marijuana & Hashish	14.0	23.0	22.4	28.0	30.9	26.7	23.6	17.4+++
Inhalants	6.4	8.5	8.1	9.0	9.8	--	9.2	8.8
Hallucinogens	4.8	6.0	5.1	4.6	7.1	5.2	3.3	3.5
Cocaine	1.5	3.6	3.4	4.0	5.4	6.5	4.9	3.4+
Heroin	0.6	1.0	0.5	1.1	0.5	.	.	0.6
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	7.3	10.3	12.1	7.7+++
Stimulants	4.0	5.0	4.4	5.2	3.4	6.7	5.6	4.2
Sedatives	3.0	5.0	2.8	3.1	3.2	5.8	4.1	2.4+
Tranquilizers	3.0	3.0	3.3	3.8	4.1	4.9	4.8	2.0+++
Analgesics	--	--	--	--	3.2	4.2	5.8	4.2
Cigarettes	--	52.0	45.5	47.3	54.1	49.5	45.2	42.3
Alcohol	--	54.0	53.6	52.6	70.3	65.2	55.5	50.2+

Young Adults Age 18-25

Drug (Unweighted N)	1972 (772)	1974 (849)	1976 (882)	1977 (1,500)	1979 (2,044)	1982 (1,283)	1985 (1,813)	1988 (1,505)
Marijuana & Hashish	47.9	52.7	52.9	59.9	68.2	64.1	60.3	56.4
Inhalants	--	9.2	9.0	11.2	16.5	--	12.4	12.5
Hallucinogens	--	16.6	17.3	19.8	25.1	21.1	11.3	13.8
Cocaine	9.1	12.7	13.4	19.1	27.5	28.3	25.2	19.7++
Heroin	4.6	4.5	3.9	3.6	3.5	1.2	1.2	0.4+
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	29.5	28.4	26.0	17.6+++
Stimulants	12.0	17.0	16.6	21.2	18.2	18.0	17.1	11.3+++
Sedatives	10.0	15.0	11.9	18.4	17.0	18.7	11.0	5.5+++
Tranquilizers	7.0	10.0	9.1	13.4	15.8	15.1	12.0	7.8++
Analgesics	--	--	--	--	11.8	12.1	11.3	9.4
Cigarettes	--	68.8	70.1	67.6	82.8	76.9	75.6	75.0
Alcohol	--	81.6	83.6	84.2	95.3	94.6	92.6	90.3

Older Adults Age 26+

Drug (Unweighted N)	1972 (1,613)	1974 (2,221)	1976 (1,708)	1977 (1,822)	1979 (3,015)	1982 (2,760)	1985 (3,979)	1988 (4,214)
Marijuana & Hashish	7.4	9.9	12.9	15.3	19.6	23.0	27.2	30.7+
Inhalants	--	1.2	1.9	1.8	3.9	--	5.0	3.9
Hallucinogens	--	1.3	1.6	2.6	4.5	6.4	6.2	6.6
Cocaine	1.6	0.9	1.6	2.6	4.3	8.5	9.5	9.9
Heroin	.	0.5	0.5	0.8	1.0	1.1	1.1	1.1
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	9.2	8.8	13.8	11.3+
Stimulants	3.0	3.0	5.6	4.7	5.8	6.2	7.9	6.6
Sedatives	2.0	2.0	2.4	2.8	3.5	4.8	5.2	3.3++
Tranquilizers	5.0	2.0	2.7	2.6	3.1	3.6	7.2	4.6+++
Analgesic	--	--	--	--	2.7	3.2	5.6	4.5
Cigarettes	--	65.4	64.5	67.0	83.0	78.7	80.5	79.6
Alcohol	--	73.2	74.7	77.9	91.5	88.2	89.4	88.8

* Low precision; no estimate reported.

+Difference between 1985 and 1988 statistically significant at the .05 level.

++Difference between 1985 and 1988 statistically significant at the .01 level.

+++Difference between 1985 and 1988 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1988.

Current Prevalence of Drug Use: 1972 to 1988
(Use in past month)

Youth Age 12-17								
Drug (Unweighted N)	1972 (880)	1974 (952)	1976 (986)	1977 (1,272)	1979 (2,165)	1982 (1,581)	1985 (2,246)	1988 (3,095)
Marijuana & Hashish	7.0	12.0	12.3	16.0	16.7	11.5	12.0	6.4+++
Inhalants	1.0	0.7	0.9	0.7	2.0	--	3.4	2.0+
Hallucinogens	1.4	1.3	0.9	1.0	2.2	1.4	1.2	0.8
Cocaine	0.6	1.0	1.0	0.8	1.4	1.6	1.5	1.1
Heroin	*	*	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	2.3	3.0	3.0	2.4
Stimulants	--	1.0	1.2	1.3	1.2	2.0	1.0	1.2
Sedatives	--	1.0	*	0.8	1.1	1.3	1.0	0.6
Tranquilizers	--	1.0	1.1	0.7	0.6	0.9	0.6	0.2
Analgesics	--	--	--	--	0.6	0.7	1.0	0.9
Cigarettes ¹	--	25.0	23.4	22.3	12.1	14.7	15.3	11.8++
Alcohol	--	34.0	32.4	31.2	37.2	30.2	31.0	25.2++

Young Adults Age 18-25								
Drug (Unweighted N)	1972 (772)	1974 (849)	1976 (882)	1977 (1,500)	1979 (2,044)	1982 (1,283)	1985 (1,813)	1988 (1,505)
Marijuana & Hashish	27.8	25.2	25.0	27.4	35.4	27.4	21.8	15.5+++
Inhalants	--	*	0.5	*	1.2	--	0.8	1.7
Hallucinogens	--	2.5	1.1	2.0	4.4	1.7	1.9	1.9
Cocaine	--	3.1	2.0	3.7	9.3	6.9	7.6	4.5++
Heroin	--	*	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	6.2	7.0	6.3	3.8+
Stimulants	--	3.7	4.7	2.5	3.5	4.7	3.7	2.4
Sedatives	--	1.6	2.3	2.8	2.8	2.6	1.6	0.9
Tranquilizers	--	1.2	2.6	2.4	2.1	1.6	1.6	1.0
Analgesics	--	--	--	--	1.0	1.0	1.8	1.5
Cigarettes ¹	--	48.8	49.4	47.3	42.6	39.5	36.8	35.2
Alcohol	--	69.3	69.0	70.0	75.9	70.9	71.4	65.3++

Older Adults Age 26+								
Drug (Unweighted N)	1972 (1,613)	1974 (2,221)	1976 (1,708)	1977 (1,822)	1979 (3,015)	1982 (2,780)	1985 (3,979)	1988 (4,214)
Marijuana & Hashish	2.5	2.0	3.5	3.3	6.0	6.6	6.1	3.9++
Inhalants	--	*	*	*	0.5	--	0.5	0.2
Hallucinogens	--	*	*	*	*	*	*	*
Cocaine	--	*	*	*	0.9	1.2	2.0	0.9++
Heroin	--	*	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	1.1	1.2	2.5	1.2++
Stimulants	--	*	*	0.6	0.5	0.6	0.7	0.5
Sedatives	--	*	0.5	*	*	*	0.6	0.3
Tranquilizers	--	*	*	*	*	*	1.0	0.6
Analgesics	--	--	--	--	*	*	0.9	0.4+
Cigarettes ¹	--	39.1	38.4	38.7	36.9	34.6	32.8	29.8+
Alcohol	--	54.6	56.0	54.9	61.3	59.8	60.6	54.8++

* Low precision; no estimate reported.

¹For 1979, includes only persons who ever smoked at least 5 packs.

+Difference between 1985 and 1988 statistically significant at the .05 level.

++Difference between 1985 and 1988 statistically significant at the .01 level.

+++Difference between 1985 and 1988 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1988.

Past Year Prevalence of Drug Use: 1972 to 1988
(Use in past year)

Youth Age 12-17

Drug (Unweighted N)	1972 (888)	1974 (952)	1976 (986)	1977 (1,272)	1979 (2,165)	1982 (1,581)	1985 (2,246)	1988 (3,895)
Marijuana & Hashish	--	18.5	18.4	22.3	24.1	20.8	19.7	12.6+++
Inhalants	2.9	2.4	2.9	2.2	4.6	--	5.1	3.9
Hallucinogens	3.6	4.3	2.8	3.1	4.7	3.6	2.7	2.8
Cocaine	1.5	2.7	2.3	2.6	4.2	4.1	4.0	2.9
Heroin	*	*	*	0.6	*	*	*	0.4
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	5.6	8.3	8.5	5.4++
Stimulants	--	3.8	2.2	3.7	2.9	5.6	4.3	2.8+
Sedatives	--	2.0	1.2	2.0	2.2	3.7	2.9	1.7
Tranquilizers	--	2.0	1.8	2.9	2.7	3.3	3.4	1.8++
Analgesics	--	--	--	--	2.2	3.7	3.8	3.0
Cigarettes ¹	--	--	--	--	13.3	24.8	25.8	22.8
Alcohol	--	51.0	49.3	47.5	53.6	52.4	51.7	44.6+++

Young Adults Age 18-25

Drug (Unweighted N)	1972 (772)	1974 (849)	1976 (882)	1977 (1,500)	1979 (2,044)	1982 (1,283)	1985 (1,813)	1988 (1,505)
Marijuana & Hashish	--	34.2	35.0	38.7	46.9	40.4	36.9	27.9+++
Inhalants	--	1.2	1.4	1.7	3.8	--	2.1	4.1+
Hallucinogens	--	6.1	6.0	6.4	9.9	6.9	4.0	5.8
Cocaine	--	8.1	7.0	10.2	19.6	18.8	16.3	12.1+
Heroin	--	0.8	0.6	1.2	0.8	*	0.6	0.3
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	16.3	16.1	15.6	11.3++
Stimulants	--	8.0	8.8	10.4	10.1	10.8	9.9	6.4++
Sedatives	--	4.2	5.7	8.2	7.3	8.7	5.0	3.3
Tranquilizers	--	4.6	6.2	7.8	7.1	5.9	6.4	4.6
Analgesics	--	--	--	--	5.2	4.4	6.6	5.5
Cigarettes ¹	--	--	--	--	46.7	47.2	44.3	44.7
Alcohol	--	77.1	77.9	79.8	86.6	87.1	87.2	81.7++

Older Adults Age 26+

Drug (Unweighted N)	1972 (1,613)	1974 (2,221)	1976 (1,708)	1977 (1,822)	1979 (3,015)	1982 (2,760)	1985 (3,979)	1988 (4,214)
Marijuana & Hashish	--	3.8	5.4	6.4	9.0	10.6	9.5	6.9++
Inhalants	--	*	*	*	1.0	--	0.8	0.4
Hallucinogens	--	*	*	*	0.5	0.8	1.0	0.6
Cocaine	--	*	0.6	0.9	2.0	3.8	4.2	2.7++
Heroin	--	*	*	*	*	*	*	0.3
Nonmedical Use of Any Psychotherapeutic	--	--	--	--	2.3	3.1	6.2	4.7+
Stimulants	--	*	0.8	0.8	1.3	1.7	2.6	1.7+
Sedatives	--	*	0.6	*	0.8	1.4	2.0	1.2+
Tranquilizers	--	*	1.2	1.1	0.9	1.1	2.8	1.8+
Analgesics	--	--	--	--	0.5	1.0	2.9	2.1
Cigarettes ¹	--	--	--	--	39.7	38.2	36.0	33.7
Alcohol	--	62.7	64.2	65.8	72.4	72.0	73.6	68.6+++

* Low precision; no estimate reported.

¹For 1979, includes only persons who ever smoked at least 5 packs.

+Difference between 1985 and 1988 statistically significant at the .05 level.

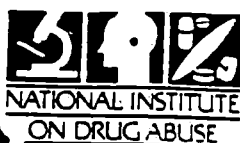
++Difference between 1985 and 1988 statistically significant at the .01 level.

+++Difference between 1985 and 1988 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1988.

NIDA

Capsules



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HIGHLIGHTS OF THE 1988 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE NATIONAL INSTITUTE ON DRUG ABUSE

TREND ANALYSIS

- o Current use (past month) of illicit drugs continued a decreasing trend which began in 1979 and accelerated between 1985 and 1988. Current prevalence rates for any illicit drug use decreased from 23 million (12%) of the population aged 12 and over in 1985 to 14.5 million (7%) in 1988.
- o Between 1985 and 1988, current drug use declined significantly in all age categories, among both men and women, and for blacks, whites, and Hispanics. The decline also was seen in all regions of the United States and for all levels of educational attainment.
- o Alcohol and cigarette use also declined from 1985 to 1988. There were 105.8 million current drinkers of alcohol in 1988, compared with 113.1 million in 1985. This represents a decrease in the rate from 59% to 53% for those aged 12 and over. Current cigarette use in this period dropped from 32% to 29%. This is a decrease of 3.2 million in the number of cigarette smokers.

1988 ANALYSIS

- o Overall, 72.4 million Americans age 12 or older (37 percent of the population) had tried marijuana, cocaine or other illicit drugs at least once in their lifetime.
- o Twenty-eight million Americans (14%) had used marijuana, cocaine or other illicit drugs at least once in the past year.
- o Among youth (aged 12 to 17), 17% used an illicit drug in the past year and 9% used an illicit drug at least once in the past month. Comparable rates for young adults (aged 18-25) are 32% and 18%, respectively; for mid-adults (aged 26 to 34), 23% and 13%, respectively; and for older adults (aged 35+) 6% and 2%.
- o While the overall current prevalence of (any) illicit drug use was 7%, the rate for males (9%) was higher than the rate for females (6%). Other demographic subgroups with elevated current rates were those in large metro areas (9%), those living in the West (10%), those employed part time (9%) and the unemployed (18%).

(more)

- o Over 5 million (9%) of the nearly 60 million women 15-44 years of age, the childbearing years, have used an illicit drug in the past month. Almost 1 million (2%) have used cocaine and 3.8 million (6%) have used marijuana in the past month.
- o Among 20-40 year old full-time employed Americans, 22% used an illicit drug in the past year, and 12% used an illicit drug in the past month. Ten percent used marijuana and 3% used cocaine in the past month.

ANALYSIS BY DRUG

Cocaine

- o The number of current cocaine users decreased significantly from 5.8 million in 1985 to 2.9 million in 1988. The rate decreased from 3% of the household population aged 12 and older in 1985 to 1.5% in 1988.
- o Among the 8.2 million people who used cocaine in the past year, 11% used the drug once a week or more, and 4% used the drug daily or almost daily. Although this represents a decrease in past year users from 12.2 million in 1985, only 5% of the 1985 users were weekly users and 2% were daily or almost daily users.
- o Rates of use of cocaine in the past year declined for youth from 4% to 3%; for young adults (aged 18-25) from 16% to 12%; and for older adults (aged 26+) from 4% to 3%.
- o Over half (53%) of youth in 1988 believed that trying cocaine poses a great risk, compared to only 31% of youth in 1985. A similar increase in awareness of the danger of cocaine use occurred in young and older adults.
- o The rate of current (past month) cocaine use was 1.5% overall. The demographic subgroups for which the rates of current cocaine use were the highest were the unemployed (4.6%) and those aged 18-25 (4.5%). The rate of current cocaine use for males (2%) was twice as high as that for females (1%).
- o While lifetime prevalence of cocaine use remained stable for whites and blacks, a significant increase occurred among Hispanics between 1985 and 1988, from 7% to 11%. The Hispanic population also did not experience a decrease in current cocaine use during the period.
- o Approximately 1.9 million (8%) lifetime cocaine users have used cocaine intravenously at some time in their lives and 2% have done so during the past year. Thirty-one percent of past year users smoked cocaine during the past year.
- o Approximately 1.3% of the population aged 12 and over have used crack at some time in their life, and one-half of one percent used in the past year. This translates to about one million past year crack users. Past year use is highest among 18-25 year olds (2%).

Marijuana

- o Marijuana remains the most commonly used illicit drug in the United States. Almost 66 million Americans (33%) have tried marijuana at least once in their lives. Four million youth, 17 million young adults, and over 45 million adults aged 26 and older have tried marijuana.
- o In 1988, the lifetime rate of marijuana use for youth was 17%; the rate for young adults was 56%. These rates have been steadily decreasing since 1979, when they were 31% and 68%, respectively. The lifetime rate among adults 26 and older was 31% in 1988 and has been steadily increasing since 1972. The increase in this age group is largely explained by the aging of individuals who began using drugs in previous years.
- o Current use of marijuana continued to decrease, as it has since 1979, for all age groups. The number of current users declined from 18 million (9%) in 1985 to 12 million (6%) in 1988. Prevalence rates for youth and young adults were the lowest measured since the survey was first done in 1972.
- o Of the 21 million people who used marijuana (at least once) in the past year, almost one-third, or 6.6 million, used the drug once a week or more.

Alcohol and Tobacco Products

- o Half (50%) of the youth have tried an alcoholic beverage at some time in their lives. Use in the past year (45%) is almost as high; and 25% have had at least one drink during the past month. These rates are all significantly lower than comparable rates for youth in 1985 (56%, 52% and 31%, respectively).
- o For young adults, the prevalence of drinking (alcohol) is substantially higher than for youth: 90% have tried alcohol, 82% had used alcohol in the preceding year, and 65% had used alcohol during the preceding month. The 1988 rates for drinking among young adults in both the last year and last month, however, are significantly lower than those for the 1985 (87% and 71%, respectively).
- o Of the 135 million people who drank (alcohol) in the past year (68%), more than one-third, or 47 million, drank once a week or more often.
- o Three-quarters of the American population (75%) have tried cigarettes, and between a quarter and a third (29%) are current smokers. Current use of cigarettes among youth is 12%; among young adults, it is 35%; and among adults 26 and older, it is 30%. There were significant decreases in the current prevalence rates for smoking among youth and older adults between 1985 and 1988, but this was not true for young adults.
- o Seven percent of youth and 9% of young adults used smokeless tobacco during the past year. Among youth, more males (13%) than females (1%) used smokeless tobacco in the past year. Comparable figures for young adults are 17% for males and less than one half a percent for females.

Other drugs

- o Hallucinogens, which first gained prominence during the mid-sixties, include such drugs as LSD, PCP, mescaline, and peyote. Prevalence rates for hallucinogens did not change significantly for any age group between 1985 and 1988. Lifetime prevalence is highest among 26-34 year olds (18%).
- o While too many youth (9%) have experimented with inhalants, current use is rare: only 2% of youth and young adults, and less than one-half of 1% of older adults (aged 26+) used an inhalant in the past month.
- o Current nonmedical use of psychotherapeutic drugs, that is, sedative, tranquilizers, stimulants, and analgesics, decreased from 3.2% in 1985 to less than 2% of the population in 1988.
- o The rate of current use of psychotherapeutic drugs was slightly higher for females than males (2% versus 1.4%), and the rate was higher for those in the 18-25 age group (4%) than for those in any other age group (1% to 3%). The rate of use for psychotherapeutic drugs, however, was down from 1985 for females and those 18-25, as it has for most other demographic subgroups.

POPULATION ESTIMATES OF LIFETIME AND CURRENT DRUG USE, 1988

The following are estimates of the number of people 12 years of age and older who report they have used drugs nonmedically. Drugs used under a physician's care are not included. The estimates were developed from the 1988 National Household Survey on Drug Abuse.

	12 - 17 yrs. (pop. 20,250,000)				18-25 yrs. (pop. 29,688,000)				26 + years** (pop. 148,409,000)				TOTAL*** (pop. 198,347,000)			
	%	Ever Used	%	Current User	%	Ever Used	%	Current User	%	Ever Used	%	Current User	%	Ever Used	%	Current User
Marijuana & Hashish	17	3,516,000	6	1,296,000	56	16,741,000	16	4,594,000	31	45,491,000	4	5,727,000	33	65,748,000	6	11,616,000
Hallucinogens	3	704,000	1	168,000	14	4,093,000	2	569,000	7	9,810,000	*	*	7	14,607,000	*	*
Inhalants	9	1,774,000	2	410,000	12	3,707,000	2	514,000	4	5,781,000	*	*	6	11,262,000	1	1,223,000
Cocaine	3	683,000	1	225,000	20	5,858,000	5	1,323,000	10	14,631,000	1	1,375,000	11	21,171,000	2	2,923,000
Crack	1	188,000	*	*	3	1,000,000	1	249,000	*	*	*	*	1	2,483,000	*	484,000
Heroin	1	118,000	*	*	*	*	*	*	1	1,686,000	*	*	1	1,907,000	*	*
Stimulants	4	852,000	1	245,000	11	3,366,000	2	718,000	7	9,850,000	1	791,000	7	14,068,000	1	1,755,000
Sedatives	2	475,000	1	123,000	6	1,633,000	1	265,000	3	4,867,000	*	*	4	6,975,000	*	*
Tranquilizers	2	413,000	*	*	8	2,319,000	1	307,000	5	6,750,000	1	822,000	5	9,482,000	1	1,174,000
Analgesics	4	840,000	1	182,000	9	2,798,000	1	440,000	5	6,619,000	*	*	5	10,257,000	1	1,151,000
Alcohol	50	10,161,000	25	5,097,000	90	26,807,000	65	19,392,000	89	131,530,000	55	81,356,000	85	168,498,000	53	105,845,000
Cigarettes	42	8,564,000	12	2,389,000	75	22,251,000	35	10,447,000	80	118,191,000	30	44,284,000	75	149,005,000	29	57,121,000
Smokeless Tobacco	15	3,021,000	4	722,000	24	6,971,000	6	1,855,000	13	19,475,000	3	4,497,000	15	29,467,000	4	7,073,000

* Amounts of less than .5% are not listed

Terms:

Ever Used: used at least one in a person's lifetime.

Current User: used at least once in the 30 days prior to the survey.

C-84-3

Revised August 1989

NIDA
Capsules

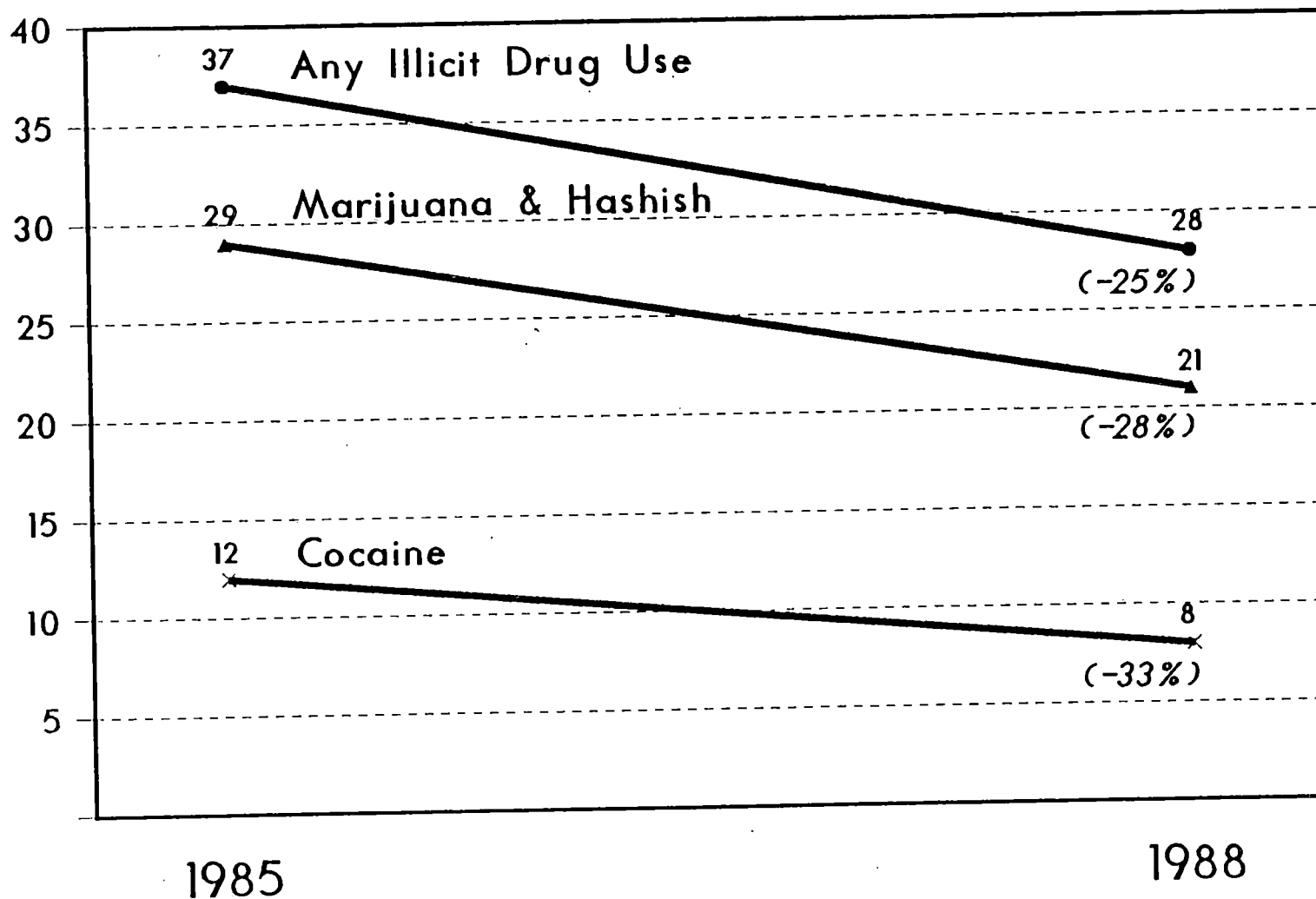


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Annual Use of Illicit Drugs

(In Millions)

Millions



Weekly Use Among Past Year Cocaine Users

Millions

18

15

12

9

6

3

12

1985

8

1988

1

0.8

0.6

0.4

0.2

647,000

1985

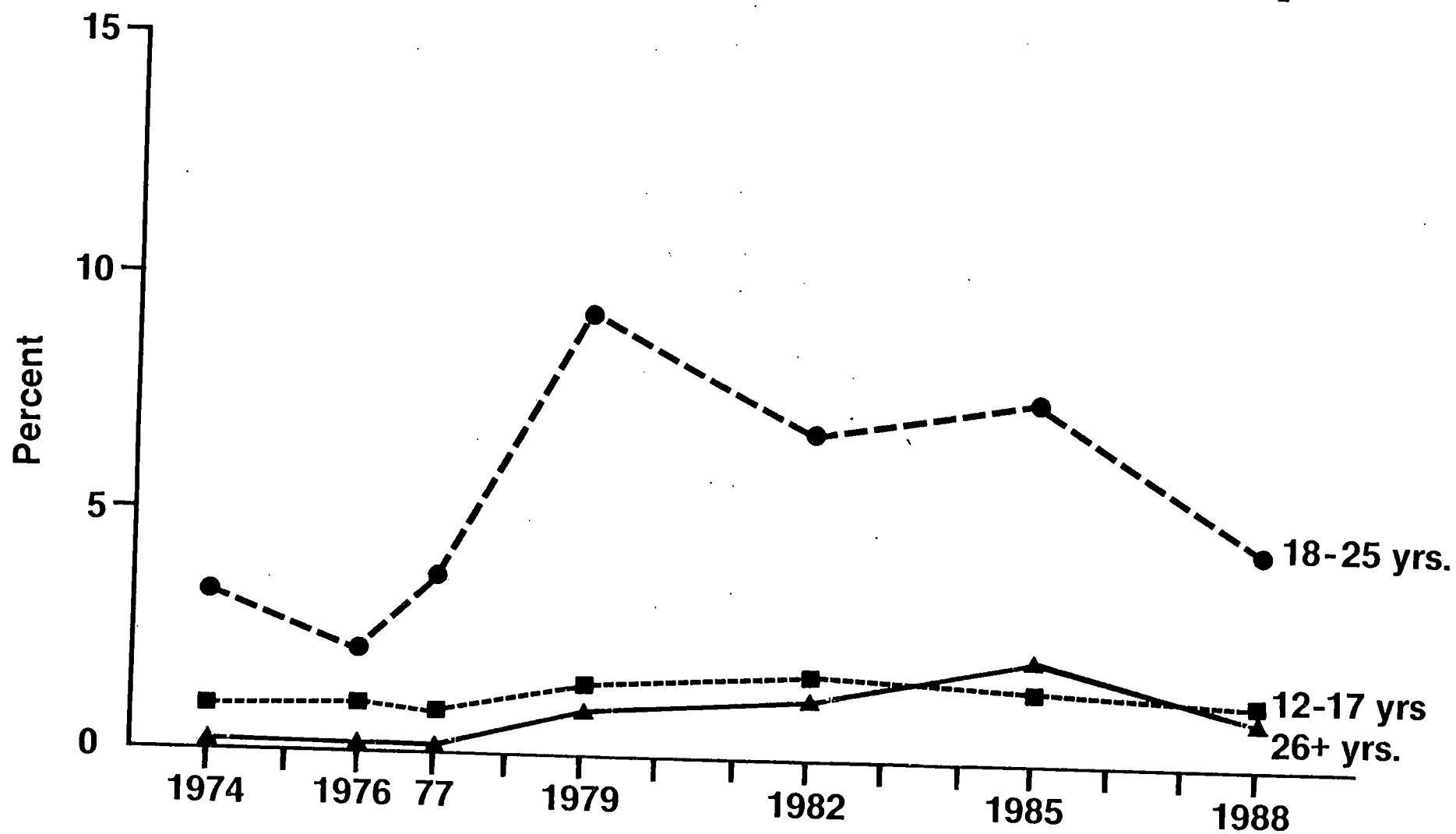
862,000

1988

Numbers of Past Year Cocaine Users

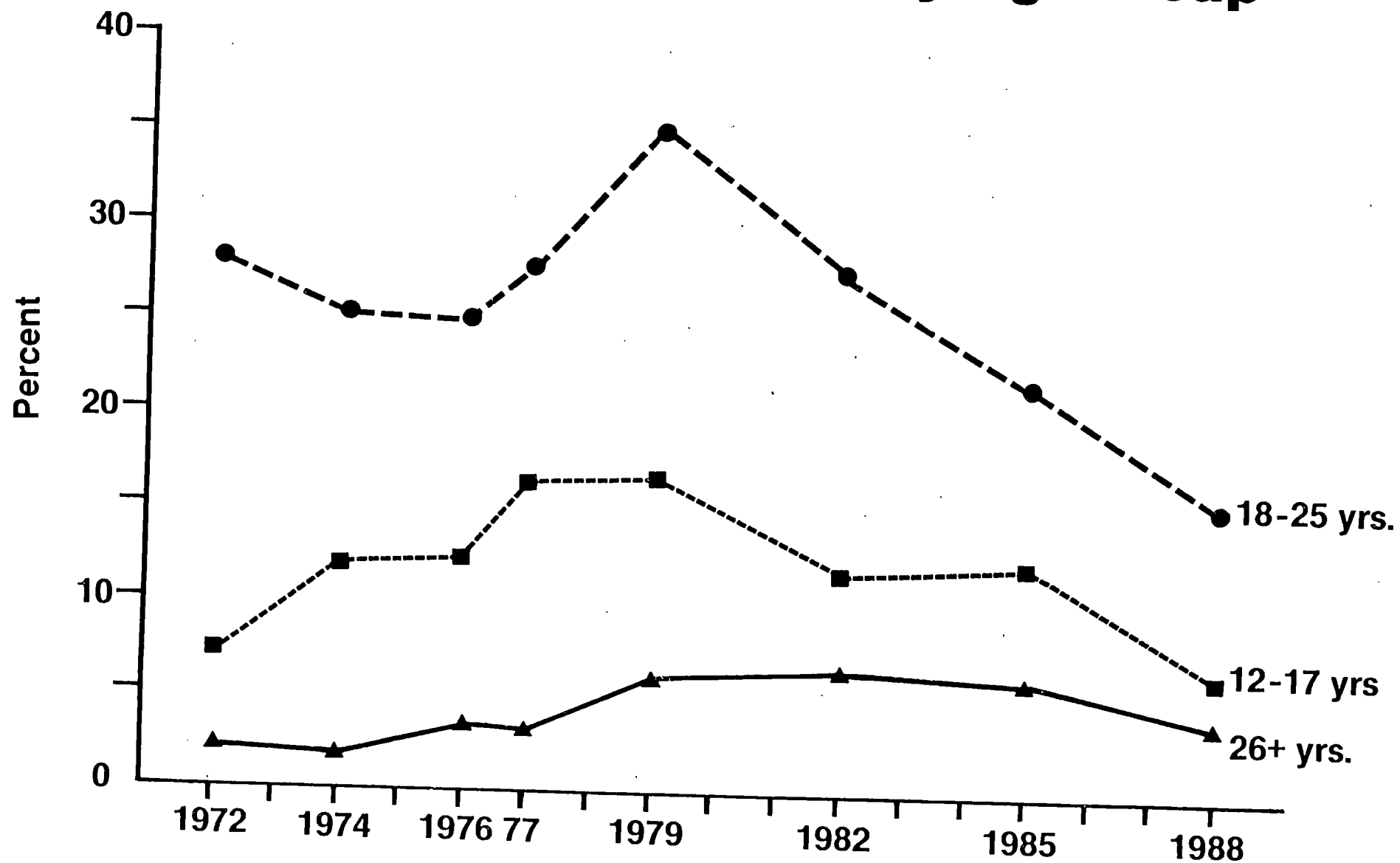
Cocaine

Trends in Past Month Use by Age Group



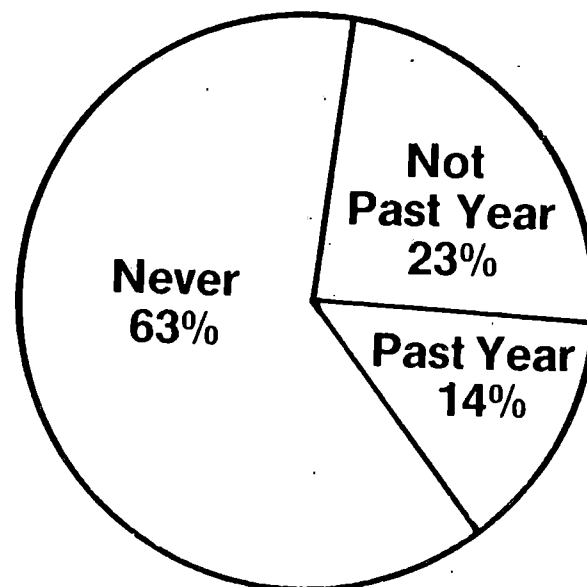
In 1974, 1976 and 1977 the estimates were less than .5% for the 26+ yrs. age group.
Source: National Institute on Drug Abuse, National Household Survey on Drug Abuse.

Marijuana Trends in Past Month Use by Age Group



Source: National Institute on Drug Abuse, National Household Survey on Drug Abuse.

Any Lifetime Experience with Illicit Drug Use* 1988



Household Population 12 and Older

	Youth 12-17	Young Adults 18-25	Adults 26 to 34	Adults 35 and Older
Never	75	41	36	77
Past Year	17	32	23	6
Not Past Year	8	27	41	17

*Includes Marijuana, Hallucinogens, Inhalants, Cocaine, Heroin, or Prescription-type Psychotherapeutic Drugs (Stimulants, Sedatives, Tranquillizers and Analgesics) for Nonmedical Purposes.

Source: National Institute on Drug Abuse, National Household Survey on Drug Abuse, 1988.

USE AND CONSEQUENCES OF COCAINE

Trends in Past Year and Past Month Use of Cocaine by Age Category - 1972-1988

Estimated Percent of the Household Population

	<u>1972</u>	<u>1974</u>	<u>1976</u>	<u>1977</u>	<u>1979</u>	<u>1982</u>	<u>1985</u>	<u>1988</u>
Age 12-17								
Used in Past Year	1.5	2.7	2.3	2.6	4.2	4.1	4.0	2.9
Used in Past Month	.6	1.0	1.0	.8	1.4	1.6	1.5	1.1
Age 18-25								
Used in Past Year	NA	8.1	7.0	10.2	19.6	18.8	16.3	12.1
Used in Past Month	NA	3.1	2.0	3.7	9.3	6.8	7.6	4.5
Age 26 and Above								
Used in Past Year	NA	*	.6	.9	2.0	3.8	4.2	2.7
Used in Past Month	NA	*	*	*	.9	1.2	2.0	.9

*less than 0.5 percent

NA = Not Available

Source: National Household Survey on Drug Abuse, 1988.

1988 Population Estimates of Cocaine Use

	<u>Age 12-17</u>	<u>Age 18-25</u>	<u>Age 26 & Older</u>	<u>Total</u>
Ever Used Cocaine	683,000	5,858,000	14,630,000	21,171,000
Used in Past Year	591,000	3,584,000	4,034,000	8,209,000
Current Use of Cocaine	225,000	1,323,000	1,375,000	2,923,000

Note: Current use: Use in the month prior to the survey.

Source: National Household Survey on Drug Abuse, 1988

(More)

Trends in Lifetime, Past Year, Past Month and Daily Use
of Cocaine and Crack by High School Seniors - 1981-1988

Class of:	1981	1982	1983	1984	1985	1986	1987	1988
Ever Used Cocaine	16.5	16.0	16.2	16.1	17.3	16.9	15.2	12.1
Used in Past Year	12.4	11.5	11.4	11.6	13.1	12.7	10.3	7.9
Used in Past Month	5.8	5.0	4.9	5.8	6.7	6.2	4.3	3.4
Used Daily	.3	.2	.2	.2	.4	.4	.3	.2
Ever Used Crack							5.6	4.8
Used Crack in Past Month							1.5	1.6

Terms:

Ever Used: Used at least one time.

Used in Last Year: Used at least once in the 12 months prior to the survey.

Used in Past Month: Used at least once in the 30 days prior to the survey.

Used Daily: Used 20 or more times in the month before the survey.

Source: National Institute on Drug Abuse, Monitoring the Future Study, 1988

(More)

Trends in Hospital Emergency Rooms (ER) and Medical Examiner (ME)
Mentions of Cocaine

Total DAWN System and Metropolitan Areas	1984	1985	1986	1987	1988
Total ER Mentions*	8,831	11,099	20,383	34,661	46,020
of which:					
New York	2,643	2,944	4,515	6,486	6,540
Washington, D.C.	522	793	1,350	3,182	5,211
Detroit	600	992	2,596	4,633	4,422
Philadelphia	399	570	1,306	2,670	4,156
Chicago	521	714	1,635	2,817	3,907
New Orleans	477	501	442	1,907	3,221
Los Angeles	1,006	1,606	2,339	2,248	2,988
Baltimore	148	221	498	962	1,341
Dallas	77	157	480	985	1,381
Seattle	238	246	434	839	1,321
Total ME Mentions* (excludes New York)	628	717	1,223	1,724	1,589**
of which:					
Philadelphia	21	36	72	173	254
Los Angeles	176	151	378	447	198
San Francisco	67	63	86	152	155
Washington, D.C.	57	61	92	179	124
Miami	90	70	124	47	91
Detroit	14	41	107	159	83
Boston	14	51	74	56	33
Newark	47	53	46	160	81

*Based on consistently-reporting ERs with at least 90 percent reporting in the first 12 months, the second 12 months, and the last 36 months. The metropolitan areas listed represent those which make up 76 percent of ER and 67 percent of ME mentions in calendar year 1988.

**Provisional data due to lag in reporting.

Source: NIDA, Drug Abuse Warning Network (DAWN) March 1989 data file.

(more)

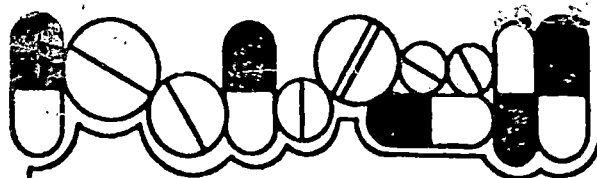
Trends in Hospital Emergency Rooms (ER)
By Number of Mentions of Smoking or Injecting Cocaine - 1984-1988

Total DAWN System and Metropolitan Areas	1984	1985	1986	1987	1988
Total ER Cocaine Mentions:*	8,831	11,099	20,383	34,661	46,020
Number Smoking Cocaine	549	1,166	4,400	10,698	15,306
By Selected Metro Area:					
New York	99	140	1,252	2,681	2,846
Detroit	51	159	948	2,419	2,522
Washington, D.C.	12	29	219	1,132	2,191
New Orleans	11	12	25	466	1,459
Los Angeles	243	561	746	726	1,048
Philadelphia	13	31	171	623	1,013
Chicago	33	70	276	717	883
Number Injecting Cocaine	3,717	4,210	6,041	9,754	12,461
By Selected Metro Area:					
Philadelphia	167	226	443	921	1,485
New York	1,102	1,148	1,170	1,471	1,416
Baltimore	92	113	281	605	1,283
New Orleans	304	324	202	988	1,238
Chicago	186	246	521	918	1,224
Los Angeles	193	280	515	615	833
Washington, D.C.	234	330	395	674	684

*Based on consistently-reporting ERs with at least 90 percent reporting in the first 12 months, the second 12 months, and the last 36 months.

Source: NIDA, Drug Abuse Warning Network (DAWN) March 1989 data file.

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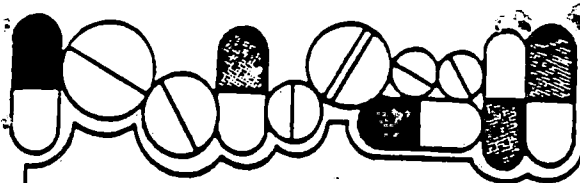
NIDA Capsules

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P.O. Box 2345, Rockville, MD 20852
(301) 488-2600

NIDA CAPSULES

In response to your recent request, we have enclosed information on Drug Abuse

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ABOUT THE NATIONAL INSTITUTE ON DRUG ABUSE

Functions

The National Institute on Drug Abuse (NIDA) is the lead Federal agency for drug abuse research. The Institute provides a national focus for the Federal effort to increase knowledge and promote effective strategies to deal with health problems and issues associated with drug abuse. In carrying out these responsibilities, the Institute sponsors and conducts research into incidence and prevalence of drug abuse, its causes and consequences, and improved approaches to prevention and treatment.

NIDA was established on May 14, 1974, as one of the three Institutes which comprise the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services.

Staffing and Budget

The Institute has 278 full-time equivalent employees and an annual budget of \$199,009,000 in fiscal year 1988. Approximately \$131 million of this total amount is spent on research; \$51.5 million on AIDS demonstrations; \$2.3 million on research training; and the remaining \$14.4 million is spent in the category of Direct Operations, which includes operating expenses, AIDS technical assistance, and NIDA's drug-free workplace initiative.

The President's Initiative

NIDA's role in The Anti-Drug Abuse Act of 1986 is to develop more effective ways of preventing and treating drug abuse. To meet this role, over the next two years, NIDA will place added emphasis on research in those areas which offer the promise of providing practical results in the near future. Those areas singled out for special attention include research in the the following areas:

- 1) The efficacy of drug abuse treatment programs.
- 2) The development of new, more effective drug abuse treatment approaches including development of new therapeutic drugs, such as buprenorphine.
- 3) The development of new, more effective prevention programs.
- 4) The ability to identify those individuals most at risk for drug abuse.
- 5) The development of more effective and reliable techniques for screening for drug use.

(more)

C-83-4

Revised June 1988

CAP 01

NIDA's Drug-Free Workplace Initiative

In February 1987, NIDA established the Office of Workplace Initiatives (OWI). The OWI develops policies and provides leadership for the implementation and administration of a national program to eliminate the use of illegal drugs in the workplace. Its programs include research, treatment, training and prevention activities as well as projects related to the development of a comprehensive Drug-Free Workplace program which includes policy development, supervisory training, employee education, employee assistance and drug testing components.

OWI has developed Mandatory Guidelines for Federal Workplace Drug Testing Programs which include Scientific and Technical Requirements and Certification Standards for Laboratories Engaged in Urine Drug Testing for Federal Agencies. In addition, OWI is conducting research to determine the extent of drug abuse in the workplace, performing cost-benefit analyses of comprehensive drug-free workplace programs, and analyzing and recommending EAP policy models for employers. OWI is also supporting the development of guidelines for a comprehensive federal EAP program, the publication of a drug abuse curriculum for EAP practitioners, the filming and distribution of a four-part videotape series on drugs at work, and the publication of a directory of educational resources in the employee assistance area.

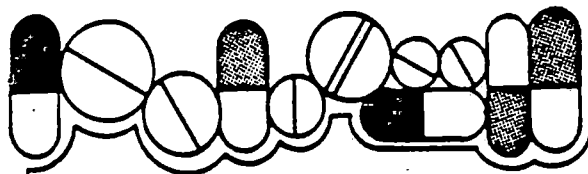
NIDA's AIDS Program

The emergence of AIDS as a major national health problem has introduced an entirely new element in the threat posed by drug abuse. Intravenous (IV) drug abuse is the second leading risk factor for AIDS, with about 25 percent of all AIDS cases involving IV drug use.

NIDA has begun a major program to find ways to curb the spread of AIDS among IV drug users and from IV drug users to their sexual partners and children. This includes supporting research in the following areas:

- 1) Research to clearly determine the prevalence of IV drug use, identification of risk factors associated with IV drug use, ethnographic studies of IV drug-using subcultures, identification of high risk drug use patterns among IV drug users, the influence of social and cultural factors on IV drug use, and comparisons of IV and non-IV drug users on personality and behavioral characteristics.
- 2) Research to determine whether drug use itself is a factor in the development of AIDS.
- 3) Research to develop effective strategies for preventing the onset of IV drug use and needle sharing among IV drug users.

In addition, NIDA supports a number of activities designed to educate the public about the role of drug use in the transmission of AIDS and provides technical assistance to State, local, and private treatment professionals concerning the treatment of IV drug users.



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ADDICTION RESEARCH CENTER

Fifty years ago, the opening of an addiction research program in a PHS hospital in Lexington, Kentucky heralded the search for a scientific understanding of drug addiction. This program, later named the Addiction Research Center (ARC), was destined to play an historic role in the emerging field of drug abuse and mental health research and served as a training ground for future leaders in these fields. Many of the drug addiction studies conducted at the Center have contributed greatly to our present knowledge of brain functioning.

Dr. Jerome Jaffe, director of the ARC, describes the work of the center as unique. "We are pleased to be able to house within this newly renovated facility, NIDA's intramural research program. With the clinical and preclinical labs reunited at a single site, scientists are once again able to collaborate in their research. Their work ranges from basic molecular studies to preclinical work with animals and clinical studies with human volunteers.

In 1935, when the hospital in Lexington opened under the direction of the pioneering drug addiction researcher, Dr. Lawrence Kolb, it was the only government facility available for treating narcotic addicts. The research unit, headed by Dr. Clifton K. Himmelsbach, set out to discover whether a nonaddicting alternative to morphine could be found and it soon became the sole facility capable of conducting clinical studies of the abuse potential of drugs proposed for use as analgesics. An equally important early goal was to find new pharmacological agents to free addicts from the destructive cycle of addiction. For example, during the 1950's, the ARC introduced methadone to help patients withdraw from opiate dependence.

The ARC became the intramural research component of NIDA when the Institute was created in late 1973. The clinical program moved from Lexington to Baltimore in 1979, with the preclinical laboratories joining it in 1984. The ARC, under the direction of Dr. Jaffe, has become the largest research facility in the U.S. devoted to the problem of drug abuse and addiction.

Major accomplishments of the ARC include:

-- Abuse liability studies have been a function of the ARC for 50 years. The ARC developed methods to determine the dependence potential of new psychoactive drugs that are proposed for therapeutic use. Those found to have a high potential for abuse are placed in a special legal category that limits their availability.

--ARC scientists pioneered the use of methadone as an aid in detoxifying patients addicted to opiates. The ARC has also demonstrated that methadone itself has abuse potential.

--ARC scientists were the first to recognize that symptoms of withdrawal or abstinence can persist for several months.

--ARC researchers have described the abstinence syndrome for many classes of drugs, including opiates, barbiturates and alcohol.

--Relapse following treatment is a continuing problem that confounds those who work with drug abusers. The ARC led the way in the discovery of the role that conditioning and learning factors play in drug dependence and relapse.

--ARC researchers provided the evidence for the concept of multiple opioid receptors in the nervous system.

--ARC researchers recognized the value of narcotic antagonists in the treatment of drug addiction and pain. Research there was instrumental in the development of naltrexone, a synthetic drug which blocks the effects of opiates without causing physical dependence and so can be an effective treatment for opiate addiction. A series of new synthetic drugs now used in the treatment of pain also developed from ARC research.

Addiction Research Center Branches

1. Clinical Pharmacology Branch: With volunteer patients as subjects, this branch tests drugs for abuse liability and dependence potential, develops new pharmacological treatments, analyzes the metabolic pathways of drugs, and devises drug detection systems for screening drugs in body fluids. Studies of nicotine and cocaine addiction and the development of new approaches to drug abuse treatment are also conducted.

2. Preclinical Pharmacology Branch: This branch conducts animal research, including self-administration studies of cocaine, barbiturates and other drugs to assess their reinforcing effects. In addition, the scientists investigate how animals discriminate between different drugs based on internal cues. Other studies explore the effects of particular drugs at different sites in the brain.

3. Neurosciences Branch: Working at an even more basic level, this new branch locates areas of the nervous system where drugs exert their actions, as well as identifying receptors for diverse classes of drugs, such as opiates, sedative-hypnotics, nicotine, and hallucinogens. Other investigations include studies of the effects of these drugs on neurotransmitters and neurohormones, as well as studies of the endogenous opiates.

4. Psychopathology and Early Intervention Branch: Here, research is conducted with volunteers on the psychological, biological and familial origins of drug dependence. One goal is to isolate factors that may underlie self-destructive and antisocial behavior often associated with drug abuse. Such studies will include efforts to identify possible relationships between alterations in receptor states, brain biochemistry, and the pathological processes involved in drug abuse.

Budget of the ARC:

FY 1984 Actual	\$5,655,000
FY 1985 Estimate	\$5,958,000

Size of the Staff - 85

Address: Addiction Research Center
Francis Scott Key Medical Center
4940 Eastern Avenue
Baltimore, Maryland 21224

Phone: Addiction Research Center - 301 955-7502
NIDA Press Office - 301 443-6245

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DRUG ABUSE AND AIDS

PUBLIC EDUCATION PROGRAM

Acquired immunodeficiency syndrome (AIDS) is a significant health problem among intravenous (IV) drug users. IV drug users currently comprise 26 percent of all persons with AIDS, second only to homosexual and bisexual men. The President's AIDS Commission report, released in June 1988, points to the control of IV drug use as a critical factor in not only controlling the spread of AIDS among drug users, but also beyond those users to their sex partners and their newborn babies.

Transmission of the AIDS virus often occurs by sharing drug paraphernalia with another user, and most users share needles or other equipment at least some time during their drug use. Blacks and Hispanics are over-represented among intravenous drug users and have been disproportionately affected by the epidemic.

Although black Americans represent 12 percent of the population in the United States, they account for 26 percent of all people with AIDS. Hispanics account for six percent of the U.S. population and 14 percent of people with AIDS. Minorities account for 80 percent of cases among heterosexual IV drug abusers, 81 percent of heterosexually transmitted AIDS cases, and 76 percent of pediatric AIDS cases.

It is clear that IV drug users, their sexual partners, and others close to them form a critically important audience for AIDS education. NIDA's new Drug Abuse and AIDS Public Education Program provides specially targetted radio and print materials aimed at precisely this audience. The materials deal with three closely-related issues of Human Immunodeficiency Virus (HIV) infection: sharing needles, sexual relations, and childbirth. The materials were tested thoroughly with target audience members, and reflect cultural and ethnic realities. They are described in the attached fact sheet.

These materials will provide support to street outreach workers, drug abuse treatment program staff, voluntary organizations, emergency room personnel, and others designing educational programs for intravenous drug users and their sexual partners.

(more)

C-88-05

August, 1988

CAP 03

DRUG ABUSE AND AIDS PUBLIC EDUCATION PROGRAM

PRINT AND RADIO MATERIALS

The target audience for the program is intravenous drug users, about 20 to 40 years old, their sexual partners, and others close to them. The materials deal with three related areas concerning HIV infection:

- 1) Sharing needles
- 2) Infection through sexual relations
- 3) Pregnancy and childbirth

PRINT MATERIALS

A series of black and white print ads (mini posters), posters and bus cards are available in three sizes: 8 1/2 by 11 inches (print ad); 17 by 22 inches (poster); and 11 by 28 inches (bus card). Not all materials are in all sizes; the size(s) for each item are listed below.

1. When you share needles you could be shooting up AIDS. (Print ad, poster, bus card) - Shows a syringe and a cooker.
2. Sharing needles can get you more than high. It can get you AIDS. (Print ad, bus card) - Shows a syringe being passed from one person's hand to another person's hand.
3. A man who shoots up can be very giving. He can give you and your baby AIDS. (Print ad, poster) - Shows a pregnant woman. (Three racial/ethnic versions: i.e., Black, Hispanic, and White.)
4. Guess who else can get AIDS if you shoot drugs. Your baby can. (Print ad, poster, bus card) - Shows a baby bottle.
5. Most babies with AIDS are born to mothers or fathers who have shot drugs. (Print ad, poster, bus card) - Shows a baby carriage and an intravenous drip.
6. If you ever shot drugs, get tested before you get pregnant. Don't make them the AIDS generation. (Print ad only) - Shows four happy babies.

(more)

RADIO MATERIALS

This series consist of 30-second spots and one 60-second "rap."

1. "Scared"
 - a. White speaker
 - b. Black speaker
2. "Person with AIDS"
 - a. Black speaker
 - b. Hispanic speaker
 - c. White speaker
3. "Shooting Gallery"
4. "IVDUs and Treatment"
5. "My Man"
6. "IVDUs and Sex"
7. "Baby"
8. "IVDUs and Pregnancy"
9. "Rap" (60 seconds)

Numbers 1 through 4 and 9 address needle-sharing; numbers 5 and 6 deal with infection through sex; and numbers 7 and 8 address pregnancy and childbirth. Number 2, "Person with AIDS," is available in several versions. Each will features an infected person sharing his or her experiences and concerns.

Copies of these print and radio materials may be obtained from:

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, Md. 20852
(301) 468-2600

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NIDA



NATIONAL INSTITUTE
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DRUG ABUSE AND AIDS

WHAT IS AIDS?

AIDS (Acquired Immunodeficiency Syndrome) is a condition caused by a virus and characterized by a defect in the body's natural immunity to disease. People with AIDS are vulnerable to severe illnesses which usually are not a threat to anyone whose immune system is intact. Over half of the persons diagnosed with AIDS have died. Eighty percent of all persons with AIDS die within two years of diagnosis. Although several risk factors are related to AIDS, this paper focuses only on intravenous drug use.

EXTENT OF THE PROBLEM

Data from the Centers for Disease Control (CDC) show that as of March 31, 1989, there were 90,990 cases reported with AIDS. Of these cases, 27 percent or 24,406 reported injection of an illicit substance prior to diagnosis with AIDS. Intravenous (IV) drug users are the second largest at-risk group for AIDS, exceeded only by homosexual and bisexual men who account for 61 percent of persons with AIDS. The population of cases involving intravenous drug abuse has increased over the past two years. Since January 1, 1989, thirty percent of all AIDS cases have involved IV drug abuse.

There are considerable geographic differences in reported AIDS cases among IV drug abusers. Over half of the IV drug abuse related AIDS cases were reported from the Northeast, which represents 20 percent of the U.S. population. In Connecticut, New Jersey, New York, and Puerto Rico the number of AIDS cases in heterosexual IV drug abusers exceeds those in non-IV drug abusing homosexual/bisexual men. While some believe that AIDS only affects large metropolitan areas on the east and west coasts, it is important to realize that at least one IV drug abuser with AIDS has been reported from all 50 states.

There are an estimated 1.1 to 1.3 million IV drug abusers in the U.S. and of these, over 24,000 are people with AIDS. Experts estimate nearly 500,000 IV drug abusers inject heroin regularly, while thousands of others inject cocaine or amphetamines. All of these individuals are at increased risk for AIDS.

The belief that AIDS is a disease of gay white men is a myth. Minorities are over-represented among IV drug users and a disproportionate number of persons with AIDS have been Blacks and Hispanics. Although Black Americans represent 12 percent of the population in the United States, they account for 27 percent of all people with AIDS. Hispanics account for six percent of the U.S. population and 15 percent of people with AIDS. Minorities account for 80 percent of cases among heterosexual IV drug abusers, 80 percent of heterosexually transmitted AIDS cases, and 77 percent of pediatric AIDS cases. Members of minority groups survive for a shorter period of time after being diagnosed as having AIDS than do Whites with the disease.

(more)

C-85-4

Revised May 1989

CAP 04

METHODS OF TRANSMISSION

The virus which causes AIDS, Human Immunodeficiency Virus (HIV), is transmitted through the exchange of body fluids, including blood and semen, from an infected individual to a non-infected one. Casual contact does not spread AIDS. It is not an airborne disease.

Among IV drug users, transmission of the AIDS virus often occurs by sharing drug paraphernalia. Small amounts of contaminated blood left in needles or syringes can carry the AIDS virus from user to user. Almost all IV drug abusers share needles at some time during their IV drug use and many continue to share needles when they inject such drugs as narcotics, cocaine, or amphetamines. Those who frequent "shooting galleries" (gathering places where drug users share their needles, syringes, cookers and drugs) are particularly vulnerable.

HIV can also be transmitted from IV drug users to their sexual partners, and from IV drug users and their sexual partners to their children prior to or during childbirth. In fact, surveillance data from the Centers for Disease Control show that most cases of heterosexually and perinatally acquired AIDS are associated with IV drug abuse. Of U.S.-born AIDS cases attributed to heterosexual transmission, approximately 72 percent are individuals who have had sexual intercourse with IV drug users. And almost three-fourths of perinatal AIDS cases are born to IV drug users or their sexual partners.

IV drug-related transmission is especially significant for women. Of women who have AIDS, 52 percent are IV drug users, while approximately 18 percent are the sexual partners of IV drug users. And researchers believe that HIV-infected mothers will infect their infants prior to or at birth about 50 percent of the time.

The potential spread of AIDS by prostitutes is of special concern, since a substantial portion of female IV drug users and some male users resort to prostitution to support their drug habits. In one study of prostitutes in seven communities across the U.S., approximately one-half of the prostitutes were intravenous drug abusers. Thus, there is considerable opportunity for the spread of HIV from IV drug users to the non-using population.

Health care workers who treat intravenous drug abusers are at very low risk of contracting HIV infection as long as they follow the Centers for Disease Control's AIDS precautions when handling body fluids from persons with AIDS and IV drug users. Special care must be taken in handling used needles.

WHAT CAN BE DONE?

Since intravenous drug abuse contributes significantly to the AIDS epidemic, IV drug abusers and those who come in contact with them need to be aware of the facts concerning AIDS and IV drug abuse.

Intravenous drug abusers can reduce their risk of contracting AIDS by stopping the use of drugs. Those who continue to inject drugs despite the demonstrated risk to their health should refrain from sharing drugs or equipment, use only new (not re-bagged) needles, and avoid shooting galleries.

(more)

Those who insist on injecting drugs may be able to reduce the risk of transmitting the AIDS virus by removing any blood or other residual material from the needle, syringe, or other "works" (drug paraphernalia) and flushing the needle and syringe at least twice with a bleach.

Sexual relationships with IV drug abusers should be avoided. At a minimum, sexual partners of IV drug users should refrain from practices involving exchange of body fluids (such as blood and semen) to reduce the risk of exposure to the AIDS virus.

Condoms should be used when having intimate contact with high risk individuals. It is important to know that, while condoms might make sex with an IV drug user safer, there is no such thing as "safe sex" with a person at high risk for AIDS. In addition, sexual practices that cause injury to tissue, such as anal intercourse, should be avoided.

Drug counselors and therapists need to be informed about AIDS so they can intelligently address the concerns of patients and their families.

The National Institute on Drug Abuse (NIDA) has funded studies to examine the spread of the AIDS virus among drug abusers, their sexual partners, and their children. Research is also being supported to improve the effectiveness of drug abuse treatment and to develop other effective AIDS-prevention strategies. NIDA is also studying the immunosuppressive effect of many common drugs of abuse to better understand their relationship to AIDS.

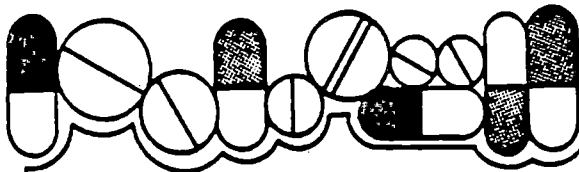
NIDA has established an AIDS outreach and counseling demonstration research program targeted at intravenous drug abusers and their sexual partners. The goals of the program are to encourage IV drug abusers to enter drug abuse treatment and to encourage IV drug abusers and their sexual partners to change their drug using and sexual behaviors that place them at risk for AIDS. Both comprehensive outreach programs that employ multiple outreach strategies, and targeted outreach demonstration projects that focus on one strategy, are conducted and evaluated.

Recognizing that changing high-risk drug abuse and sexual behaviors is seldom achieved simply through information dissemination, these outreach programs aggressively seek out individuals at risk, educate them regarding risk reduction, encourage behavior change, and reinforce change through followup contacts. Together these comprehensive and targeted outreach programs are able to reach approximately 130,000 IV drug abusers and sexual partners annually.

For further information on AIDS and drug abuse, contact:

National Institute of Drug Abuse
5600 Fishers Lane, Room 10A-54
Rockville, MD 20857
(301) 443-6245

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COCAINE ABUSE

Cocaine is one of the most powerfully addictive of the drugs of abuse. Most clinicians estimate that approximately 10 percent of the people who begin to use the drug "recreationally" will go on to serious, heavy use. An individual cannot predict or control the extent to which he or she will use the drug.

DANGERS OF COCAINE ABUSE

Some regular users of cocaine report feelings of restlessness, irritability, and anxiety. High doses of cocaine and/or chronic use can trigger paranoia. When some individuals stop using cocaine after extended periods they may become depressed. This may lead to further cocaine use to alleviate depression.

Occasional cocaine use may produce nasal congestion and a runny nose. A possible consequence of chronic cocaine snorting is ulceration of the mucous membrane of the nose. Heavy cocaine use can sufficiently damage the nasal septum to cause it to collapse.

Cocaine used at high doses or chronically can have toxic effects. Cocaine overdose deaths are a result of physiological seizures followed by respiratory arrest and coma, or sometimes by cardiac arrest.

The scientific evidence does not suggest that cocaine produces physical dependence, defined as a character pattern of withdrawal symptoms after discontinuation of use. However, cocaine is a powerful psychological reinforcer. Severe psychological dependence to cocaine and compulsive drug-seeking behavior can result from heavy or continuous use at relatively high dosages.

In summary, cocaine is an extremely dangerous drug. Occasional use can lead to heavy, uncontrollable use of the drug.

METHODS OF USE

Cocaine is usually sniffed or "snorted" at doses of 10-40 mg and absorbed through the mucous membranes in the nose. It can also be injected, or after chemical conversion to a purified form known as "freebase," it can be

(More)

C82-2(a)

Revised January 1986

CAP 05

smoked. Of particular concern are recent reports that smoking of cocaine paste is becoming more common among users. Originally noted in a somewhat different form by investigators in South America, this practice, as observed with the refined drug in the United States, increases the pharmacological effect of the drug. Unfortunately, it appears that compulsive cocaine use may develop even more rapidly if the substance is smoked rather than ingested intranasally. Cocaine use ranges from episodic or occasional use to repeated or compulsive use, with a variety of patterns between these extremes.

METHODS OF ACTION

Cocaine is a very strong central nervous system stimulant. Specific physical effects include constricted peripheral blood vessels, dilated pupils, and increased temperature, heart rate and blood pressure. Cocaine's immediate euphoric effects, which include hyperstimulation, reduced fatigue, and mental clarity, last approximately 30 to 60 minutes.

Cocaine is a tightly controlled drug with legitimate medical uses. Its properties as a topical anesthetic and a vasoconstrictor make cocaine the drug of choice for certain types of surgery involving the nose, throat, larynx, and lower respiratory passages.

EXTENT OF COCAINE USE

The National Institute on Drug Abuse (NIDA) estimates that between 20 and 24 million Americans have tried cocaine at least once in their lives; between 11 and 13 million have used cocaine during the last year; and between 3 and 5 million have used cocaine during the last month. Since 1972, the rate of increase for cocaine use across all age groups has been noticeably larger than the rate of increase for marijuana use.

National Household Survey

The National Household Survey, conducted by NIDA in 1982, found that since the early 1970's the rate of increase for cocaine use across all age groups has been noticeably larger than the rate for marijuana. Older adults (age 26 and over) show the most significant increase in lifetime cocaine use in 1982: 9 percent have tried the drug at least once, a significant increase from the 4 percent rate in 1979. Young adults (age 18-25) show the highest percent of lifetime cocaine use: 28 percent have tried the drug at least once in their lifetime, the same rate as shown in the 1979 survey.

(more)

Current use (use in the past month) among young adults has declined from 9 percent in 1979 to 7 percent in 1982. Of those young adults who have ever tried cocaine, 7.4 percent have used it once or twice compared to approximately 2.5 percent of the older adults. Over 12 percent of the young adults and 3 percent of the older adults had used cocaine 11 or more times during their lifetime.

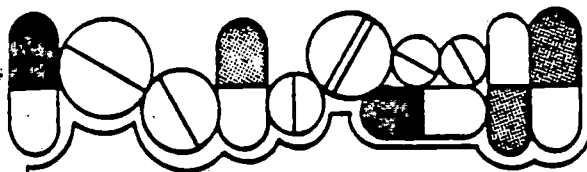
High School Survey

A survey of 16,300 high school seniors, conducted in 1985 for NIDA by the University of Michigan Institute for Social Research, found that the use of cocaine by high school seniors, which was fairly steady for the prior two years, showed an increase in 1985. The percentage of seniors who have ever used cocaine rose from 16.2 percent in 1983 to 17.3 percent in 1985, and the percentage of those who were currently using cocaine went from 4.9 percent in 1983 to 6.7 percent in 1985. These are the highest rates observed so far in this study.

Emergency Room and Medical Examiner Mentions

NIDA's Drug Abuse Warning Network (DAWN) collects data on drug abuse morbidity and mortality through reports from selected hospital emergency rooms and medical examiners in 26 major metropolitan areas. In 1984, with 10,996 mentions from DAWN emergency rooms, cocaine ranked third on the list of drugs most frequently mentioned. Among cocaine emergency room episodes: 67 percent were male; 37 percent were white and 43 percent were black; and 52 percent were 20- to 29-year olds.

In 1984, medical examiners in the DAWN system reported 604 deaths involving cocaine alone or in combination with other drugs, including 181 deaths in which cocaine was used alone. The drug ranked third on the list of substances most frequently mentioned by medical examiners. Among cocaine related deaths: 77 percent were male; 57 percent were white and 33 percent were black; and the majority of cases were 20- to 39-year olds.



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COCAINE FREEBASE

Freebase is a form of cocaine that is smoked. It is extremely dangerous, yet increasing in popularity. In 1982, almost 7 percent of clients admitted to treatment facilities were freebasing cocaine, up from 1 percent in 1979. Of the almost 11,000 hospital emergency room visits reported to NIDA's Drug Abuse Warning Network in 1984, 6.1 percent involved cocaine smoking, up from 2.2 percent in 1983.

Freebase is the result of a chemical process whereby "street cocaine" (cocaine hydrochloride) is converted to a pure base by removing the hydrochloride salt and many of the "cutting" agents. The end product, freebase, is not water soluble. Therefore, the only way to get it into the system is to smoke it.

Freebase is smoked in a water pipe. It's more dangerous than "snorting" cocaine because it reaches the brain within seconds, resulting in a sudden and intense high. The euphoria a user experiences, however, quickly disappears and the user faces an enormous craving to freebase again and again. Consequently, freebasers often increase the dose and the frequency of the dose, resulting in a severe addiction which may include physical debilitation and financial ruin.

The reported symptoms of freebasing cocaine include weight loss, increased heart rate and blood pressure, depression, paranoia, and hallucinations. Manic paranoia or depressive psychoses have been seen in some heavy users. There is also some concern that smoking freebase may have a specific effect on the lungs.

CRACK

Of growing concern is the apparent increase in the use of "crack". While there is no way of estimating the extent of "crack" in the U.S., it appears to be increasing in popularity. "Crack" is the street name given to freebase cocaine that has been processed from cocaine hydrochloride to a base, using ammonia or baking soda and water and heating it to remove the hydrochloride, rather than the more volatile method of processing which uses ether. The process to convert cocaine hydrochloride to "crack" does not necessarily result in the elimination of hydrochloride, fillers and impurities in the cocaine, and sodium bicarbonate. The term "crack" refers to the crackling sound that is heard when the mixture is smoked (heated), presumably due to the sodium bicarbonate.

(more)

C-86-4

May 1986

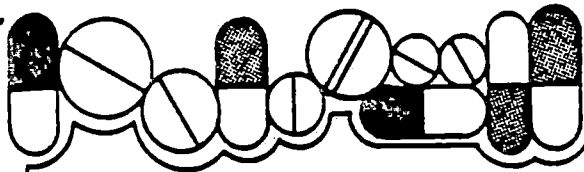
CAP 08

What is particularly alarming about "crack" is that, for the first time, it is being mass marketed on the streets in its freebase form, eliminating the need for the user to process "street cocaine" into freebase.

"Crack" resembles hard shavings similar to slivers of soap. It is sold in small vials, in folding papers, or in heavy tinfoil. It is smoked in a pipe. The cost of one or two doses (300 milligrams) reportedly range from \$5.00 to \$10.00.

"Crack" is sometimes called "rock" which should not be confused with "rock cocaine". "Rock cocaine", sold in California, is a cocaine hydrochloride product for intranasal snorting. It is white in color, about the size of a pencil eraser, and sells for about \$20.

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USE AND CONSEQUENCES OF COCAINE

Trends in Past Year and Past Month Use of Cocaine By Age Category, 1972-1982

		<u>Estimated Percent of the Household Population</u>					
		<u>1972</u>	<u>1974</u>	<u>1976</u>	<u>1977</u>	<u>1979</u>	<u>1982</u>
Age 12-17							
Used in Past Year.....	1.5%	2.7%	2.3%	2.6%	4.2%	4.1%	
Used in Past Month....	.6	1.0	1.0	.8	1.4	1.6	
Age 18-25							
Used in Past Year.....	N/A	8.1%	7.0	10.2	19.6	18.8	
Used in Past Month....	N/A	3.1	2.0	3.7	9.3	6.8	
Age 26 and Above							
Used in Past Year.....	N/A	*	.6	.9	2.0	3.8	
Used in Past Month....	N/A	*	*	*	.9	1.2	

N/A = Not Available
* = Less than 0.5%

Source: NIDA, National Household Survey on Drug Abuse, 1982

Population Projections of Cocaine Use

	<u>Age 12-17</u>	<u>Age 18-25</u>	<u>Age 26 & Older</u>	<u>Total</u>
Ever Used Cocaine.....	1,490,000	9,260,000	10,820,000	21,570,000
Current Use of Cocaine....	380,000	2,230,000	1,550,000	4,170,000

Note: Current use is defined as use one or more times in the month prior to the survey.

Source: NIDA, National Household Survey on Drug Abuse, Population Projections, 1982

(More)

Revised
July, 1986

C84-04

CAP 07

HIGH SCHOOL SENIOR SURVEY

Trends in Lifetime, Past Year, Past Month and Daily Use
of Cocaine by High School Seniors, 1979-1985

	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Ever Used.....	15.4	15.7	16.5	16.0	16.2	16.1	17.3
Used in Last Year.....	12.0	12.3	12.4	11.5	11.4	11.6	13.1
Used in Past Month.....	5.7	5.2	5.8	5.0	4.9	5.8	6.7
Used Daily.....	.2	.2	.3	.2	.2	.2	.4

Terms:

Ever Used: Used at least one time in lifetime

Used in Last Year: Used at least once in the 12 months prior to the survey.

Used in Past Month: Used at least once in the 30 days prior to the survey.

Used Daily: Used 20 or more times in the month before the survey.

Source: National Institute on Drug Abuse, Monitoring the Future, 1985

(More)

CONSEQUENCES OF COCAINE

Trends in Hospital Emergency Room Mentions of Cocaine

	Year				
	1981	1982	1983	1984	1985
<u>Total Hospital Mentions</u>	3,296	4,277	5,783	8,470	9,946
of which:					
New York.....	1,122	1,421	1,975	2,324	2,390
Miami.....	249	405	547	869	953
Los Angeles.....	233	334	506	619	769
Washington DC.....	157	196	288	502	765
Detroit.....	136	203	437	443	644
Philadelphia.....	82	155	201	394	555
Chicago.....	134	128	217	440	549

Note: Data are derived from a panel of consistently reporting hospital emergency rooms in 26 metropolitan areas.

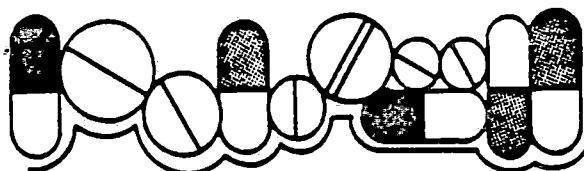
Trends in Medical Examiner Mentions of Cocaine

	Year				
	1981	1982	1983	1984	1985
<u>Total Medical Examiner Mentions.....</u>	195	217	323	581	613*
of which:					
Los Angeles.....	33	46	79	176	131
Washington, DC.....	5	8	30	57	61
San Francisco.....	28	46	35	67	62
Miami.....	48	27	66	90	65

Note: Data are derived from a panel of consistently reporting Medical Examiners in 25 metropolitan areas (excluding the New York metropolitan area because data from New York City are not reported to DAWN).

* Provisional data due to lag in reporting.

Source: NIDA, Drug Abuse Warning Network (unpublished data, file ending 3/86)



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COCAINE. THE BIG LIE.

PHASE II

To counter increasing cocaine use among older teenagers and young adults, the National Institute on Drug Abuse (NIDA) launched a multimedia Cocaine Abuse Prevention Campaign, COCAINE. THE BIG LIE., in March 1986. This public service campaign, developed by DDB Needham Worldwide, under the auspices of The Advertising Council, Inc., focuses on the addictive qualities of cocaine, its potential for producing severe health consequences and the need to seek treatment. In support of this campaign, NIDA established an 800-toll-free telephone number, 1-800-662-HELP, which directs users to treatment facilities in their local community. Almost 90,000 callers have received help since the telephone service was inaugurated last April.

The next phase of the campaign will focus on crack, the preprocessed smokeable form of cocaine, and teenagers who are becoming addicted to crack in major metropolitan areas around the country. Crack is particularly dangerous because it is highly potent and relatively cheap when it is first used. Young people can become addicted in a short period of time.

NIDA will be releasing radio, print and television public service announcements (psa's) for high school and college students on crack and cocaine and a specially designed help message for family members of cocaine users. Results of the hotline have shown the importance of helping family members find support for themselves and approaches to getting their loved ones into drug abuse treatment.

The materials are currently being produced. Release is planned for mid to late February 1988.

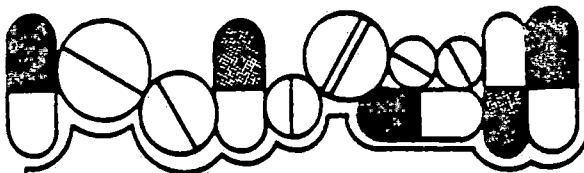
Currently available are two booklets on cocaine: Cocaine/Crack. The Big Lie., an update of Cocaine Addiction: It Costs Too Much, and When Cocaine Affects Someone You Love, designed for family members of cocaine users.

As in the past, the psa's will be distributed directly to stations by the Ad Council. Tapes of the material will be sent simultaneously to State agencies, parents organizations and other groups who are interested in the campaign.

C-88-02

March 1988

CAP 08



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DRUG ABUSE INFORMATION AND TREATMENT REFERRAL LINE 1-800-662-HELP

INTRODUCTION

The National Drug Information and Treatment Hotline, 1-800-662-HELP is a toll-free number that can be dialed from any State in the country, Puerto Rico and the Virgin Islands. Its purpose is to provide drug related information to the general public, facilitate the placement of drug users in treatment programs and to acquaint those affected by the drug use of a friend or family member (i.e., significant other) with much needed support groups and/or services.

The Hotline is staffed from 9:00 a.m. - 3:00 a.m., Monday through Friday and 12 noon - 3:00 a.m. Saturday and Sunday. Information Specialists trained to provide counseling, information, and referrals spend an average of 10-15 minutes with each caller. All Hotline staff are caring individuals who have been carefully chosen for their sensitivity, insight, and understanding of the issues involved in drug use.

BACKGROUND

The Hotline has been operated by the National Institute on Drug Abuse (NIDA) since its inception in mid-April, 1986. It was initially publicized through public service announcements during phase one of NIDA's "Cocaine: The Big Lie" campaign. Subsequent media attention continues to promote public awareness of the Hotline number.

SERVICES

The Hotline provides confidential discussion and/or referrals. Callers who request treatment are referred to drug treatment programs, including profit/nonprofit, Federal/State, inpatient/outpatient or residential facilities. The main source of referrals is the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs.

Because many callers have few resources due to their drug use, frequent referrals are made to public or nonprofit programs. Callers receive the name, address and phone number of facilities close to them along with information about the range of services at the facility. As a backup, callers are given the number of their State Substance Abuse Agency.

C-86-10

Revised April, 1988

CAP 09

Referrals are also made to State and local crisis or information hotlines and support groups such as Cocaine Anonymous, Narcotics Anonymous and Alcoholics Anonymous. Support group referrals that focus on concerns of significant others of drug users, such as National Federation of Parents, CO-ANON, NAR-ANON and Families Anonymous are also made. Free NIDA pamphlets and brochures are sent to those seeking written information.

STATISTICS/NUMBER OF CALLS

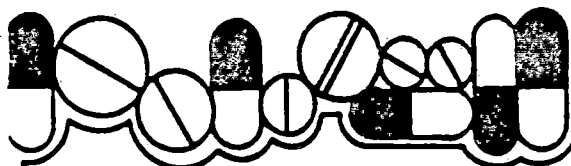
During the first year of operation nearly 50,000 calls were answered. Now after two years, Hotline staff has handled in excess of 120,000 calls, averaging over 6,000 per month, and 250 per day. While calls originate from all over the country, the greatest number have come from California, New York and Florida. Of course this may reflect frequency in the airing of cocaine-related campaign materials as much as the extent of drug use in those States.

Findings from a preliminary sampling of calls conducted by NIDA revealed that:

- 75% of the calls were received between 8 a.m. and 8 p.m. EST.
- 50% of callers were seeking help for themselves, usually during the crash/depression period. The majority in this group were males. Of the remaining 50%, the majority called with concerns about the drug use of others. These callers were typically female. Other callers sought general drug information, including literature or contacts for prevention and education efforts.
- The majority of users were over 18 years of age.

FUTURE DIRECTIONS (AIDS)

NIDA has begun a major AIDS and Intravenous (IV) drug use public education campaign. It is designed to educate and inform IV drug users of their risks and encourage them to get treatment. The 1-800-662-HELP number will be printed on all NIDA-produced materials on AIDS and IV drug use. Calls from IV drug users who are in need of treatment as well as calls from sexual partners and others close to drug users are expected to increase.



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"DESIGNER DRUGS"

"Designer Drugs" are structural analogs of substances already scheduled under the Controlled Substances Act (CSA). They are prepared by underground chemists to mimic the psychoactive effects of controlled drugs. Because these analogs are not structurally identical to their parent compound, their manufacture and distribution is not now a violation of that Federal law. Theoretically, the number of potential synthetic analogs that can be made and distributed is very large and virtually anyone with a background in college chemistry can obtain the information necessary to synthesize them. At present there are three types of synthetic analog drugs available through the illicit drug market: analogs of phencyclidine (PCP), analogs of fentanyl and meperidine (both synthetic narcotic analgesics), and analogs of amphetamine and methamphetamine (which have hallucinogenic and stimulant properties).

PCP Analogs

PCP is a controlled substance under Section II of the Controlled Substance Act. Over the past eight years, PCP analogs have been identified in confiscated street samples and three of these analogs have been placed in Schedule I of the CSA. The use of these analogs is not widespread.

Fentanyl Analogs

Fentanyl is used in over 70% of the surgical procedures performed in the U.S. as a pre-anesthetic analgesic. Theoretically, hundreds of fentanyl analogs could be prepared and most would have pharmacological properties similar to heroin or morphine. These analogs, many of which are far more potent than heroin, create addiction similar to the opiate narcotics, and present a significant drug abuse problem because of the potential for overdose. Street names of these drugs, such as "synthetic heroin," "China White," and "new heroin," are often used interchangeably to designate a wide variety of analogs of fentanyl. In 1979, the fentanyl analog, alphamethylfentanyl, became widely available in California. A number of overdose deaths were attributed to this potent narcotic. As a result, alphamethylfentanyl was placed in Schedule I of the CSA.

Since the control of alphamethylfentanyl, law enforcement laboratories have identified other fentanyl analogs clandestinely produced and distributed in California. In 1984 California health officials, based on the results of routine urinalysis tests of methadone clinic patients in Los Angeles, estimated that 20 percent of the patients may have been users of fentanyl or one of its analogs. Between 1983 and 1985 the Drug Enforcement Administration (DEA) confiscated 75 samples of another analog, 3-methylfentanyl, in the San Francisco bay area and one sample in Brooklyn, NY. This substance and several other fentanyl analogs are believed to be responsible for numerous hospital emergency room visits and over 100 deaths during 1983-85. Other anecdotal reports suggest that the analogs of fentanyl may have caused deaths in Arizona, Oregon, and Florida. In 1985, 3-methylfentanyl, along with several other related analogs, were placed under Schedule I of the CSA.

C-86-5

(More)

June, 1986

Meperidine Analogs (MA)

Meperidine, known by the trade name of "Demerol," is a narcotic, controlled under Schedule II of the CSA. Over the past decade, the illicit use of meperidine has increased during periods when heroin was scarce. Two "designer drugs" which are structurally similar to meperidine have also appeared on the streets. These analogs, 1-methyl-4-phenyl-4-propionoxypiperidine (MPPP) and 1-(2-phenylethyl)-4-acetyloxypiperidine (PEPAP), are much more potent than meperidine. While both of these substances present significant risks of overdose, an impurity formed during the clandestine manufacture of MPPP, called MPTP (1-methyl-4-phenyl-1,2,3,6-tetrahydropyridine), has been shown to be a potent neurotoxin and has caused irreversible brain damage in several individuals. The damage is manifested in a syndrome very similar to Parkinsonism. MPTP was identified in several street samples in California, in 1982, and in one sample in Florida, in 1985.

PEPAP, 1-(2-phenylethyl)-4-phenyl-4-acetyloxypiperidine, is a recent addition to the street scene, having been identified by the DEA in California in 1985. Its action is similar to that of MPPP.

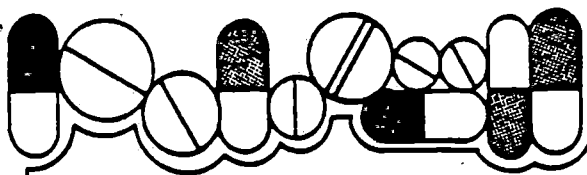
AMPHETAMINE AND METHAMPHETAMINE ANALOGS

Several dozen analogs of amphetamine and methamphetamine are hallucinogenic. Some have appeared on the street and have been scheduled under the CSA, but others have not. Amphetamine analogs currently of concern include 3,4-methylenedioxymphetamine (MDA) and 3,4-methylenedioxymethamphetamine (MDMA). MDMA, known on the streets as "Ecstasy" or "Adam", has received considerable attention from the media. It is reported as widely used on college campuses as a euphoriant and, to some extent, by clinicians as an adjunct to psychotherapy, although studies have not been done on its safety and efficacy.

MDMA can result in a variety of psychological difficulties including confusion, depression, anxiety and paranoia. Physical symptoms include muscle tension, nausea, blurred vision, and faintness, chills or sweating. It also increases the heart rate and blood pressure. MDMA has been shown to destroy serotonin-producing neurons in animals. These neurons play a direct role in regulating aggression, mood, sexual activity, sleep, and sensitivity to pain.

MDMA is similar in structure to MDA, which has been shown to be neurotoxic to the serotonergic nerve cells. In animal studies, the doses of MDA which produce neurotoxicity are only 2 or 3 times more than the minimum dose needed to produce a psychotropic response. This suggests that individuals who are self-administering the drug may be administering a neurotoxic dose. The relationship between the neurotoxic dose and the psychotropic dose of MDMA is currently under investigation.

DEA officials have said that the drug is available in at least 21 states and Canada. It is especially popular with college students and young professionals. Because of its neurotoxic effects and its abuse potential, MDMA was placed in Schedule I of the CSA on an emergency basis in July, 1985.



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HEROIN

Health Hazards

Heroin is an illegal and highly addictive narcotic. Addictive or dependence-producing properties are exhibited by (1) persistent regular use of a drug, (2) attempts to stop such use which lead to significant and painful withdrawal symptoms, (3) continued use despite damaging physical and/or psychological problems, (4) compulsive drug-seeking behavior, and (5) need for increasing doses of the drug.

- o Heroin exerts its primary addictive effect by activating both the region of the brain that is responsible for producing the pleasurable sensation of "reward" and the region which produces the classic physical dependence syndrome. Together, these actions account for the user's loss of control and the drug's habit-forming action.
- o Many health problems related to heroin use are caused by uncertain dosage levels (due to fluctuations in purity), use of unsterile equipment, contamination of heroin by cutting agents, or use of heroin in combination with other drugs such as alcohol or cocaine. Typical problems include skin abscesses, inflammation of the veins, serum hepatitis, and addiction with withdrawal symptoms.
- o Utilization of unsterile needles by multiple individuals (needle sharing) increases the risk of exposure to HIV, the causative agent for Acquired Immune Deficiency Syndrome (AIDS). Heroin itself, as well as a drug-abusing lifestyle, may depress the body's ability to withstand infection.
- o While intravenous drug users account for approximately 25 percent of all reported AIDS cases, their proportion of the AIDS population appears to be increasing. In the first half of 1985, intravenous drug users accounted for 33 percent of all new AIDS cases. Moreover, 54 percent of newborns contracting AIDS have a parent who is an intravenous drug user, and intravenous drug users account for a similarly disproportionate share of the percentage of heterosexually transmitted AIDS cases.
- o The reported symptoms and signs of heroin use include euphoria, drowsiness, respiratory depression, constricted pupils and nausea. Withdrawal symptoms include watery eyes, runny nose, yawning, loss of appetite, tremors, panic, chills, sweating, nausea, muscle cramps and insomnia. Elevations in blood pressure, pulse, respiratory rate and temperature occur as withdrawal progresses.
- o Symptoms of heroin overdose include shallow breathing, clammy skin, convulsions, and coma. Death may result.

C-86-7

(More)

August 1986

CAP 11

- o By modifying the molecular structure of certain controlled substances, underground chemists have been able to create new forms of drugs grouped under the term "designer drugs." Some of these, the fentanyl analogs, are capable of producing effects many times greater than those achieved with heroin. Others, the meperidine analogs such as MPTP, have been implicated in a growing number of drug reactions which mimic Parkinsonism and which may result in death.
- o Heroin use during pregnancy is associated with stillbirths, placental abruptions, and sudden infant death. Unless the mother is receiving treatment, her baby is likely to show symptoms of withdrawal and to be below normal birth weight.

Prevalence of Use

While heroin use continues to be a major concern in several cities, estimates indicate that the total number of addicts has been reduced since the early 1970s. During the past 3 years, the number of addicts has held relatively constant at around half a million.

- o Eighty-four percent of admissions were 25-44 years of age in 1984, compared to 75 percent in 1979. This reflects, in part, a stable and aging pool of users.

Risk Factors

The consumption of alcohol in combination with heroin street preparations of uncertain composition is one of the major causes of heroin-related deaths. The occasional user faces increased danger of accidental overdose because he/she does not have tolerance to the drug.

- o The number of heroin-related deaths may increase with an increase in the purity and availability of heroin street preparations.

User Characteristics

- o In each of the four recognized heroin epidemics occurring in the last 2 decades, the age at first use for those new users entering drug abuse treatment generally increased. For example, in the 1967-1971 epidemic, 43 percent of the new users were in the 12-17 age bracket as opposed to 9 percent in the latest epidemic.
- o While more of the new users were Black than white in the heroin epidemic of 1967-1971, in subsequent epidemics the racial composition reversed with more white initiates than Black entering drug abuse treatment.
- o Approximately 36 percent of heroin users entering drug treatment programs are women (1984). Moreover, nearly a third of these women are involved in prostitution, making them particularly vulnerable to HIV infection and its transmission. Thus, over 90 percent of heterosexually-linked AIDS cases are female.

(More)

Patterns of Use

- o According to the hospital drug emergency mentions reported to the total DAWN system in 1985, the preferred method of administering heroin is by injection (90.5 percent of the heroin patients showed this route of administration).
- o Few street heroin users utilize sterilized equipment, thus "track marks," or the skin discolorations caused by unsterilized needles and the injection contaminants, are visible at injection sites.
- o The relative price of heroin in terms of purity and availability is believed to influence drug preference for many users. Dilaudid, amphetamines, and cocaine are frequently abused by heroin users in preference to poor quality heroin.
- o Cocaine was the leading secondary drug reported by heroin clients in treatment data reported to NIDA (1984); 19 percent of heroin users reported cocaine as a secondary drug.

Prevalence of Health Consequences

During the past few years, heroin abuse has been a regional problem. Certain areas experienced increases in heroin-related emergencies or deaths, while other areas showed a declining or stable trend.

- o Demographically, more than 60 percent of the emergency room episodes in 1985 involving heroin and reporting to the DAWN system occurred among individuals 30 years old or older. Fifty-three percent were Black, 30 percent white, and 13 percent were Hispanic. Seventy percent were male.
- o Similar distributions were seen among DAWN deaths involving heroin by sex and age, i.e., the majority were male (82 percent), 68 percent were 30 years old or older, about equal proportions were white (44 percent) or Black (40 percent). Fifteen percent were Hispanic.
- o As "speedballing," or the combined use of cocaine and heroin has become more common, so have the health consequences associated with the injection of this combination of drugs. Cocaine and heroin mentions in DAWN emergency rooms more than tripled between FY 1981 and FY 1985.
- o In 1985, almost 41 percent of the heroin-related emergency room cases reported the use of heroin in combination with other drugs. The most prevalent combinations were heroin and cocaine, and heroin and alcohol.
- o Between 1981 and 1985 heroin-related deaths almost doubled, from 700 to approximately 1300. Almost 95 percent of the heroin-related deaths occurred in combination with other drugs. The combination of heroin and alcohol accounted for almost 50 percent of the cases.

(More)

Supplies of Heroin

The cultivation of opium and its refinement into heroin is a worldwide problem. Production sites are widely distributed and often found in areas which are not policed or effectively controlled by central governments. Consequently, curbing the diversion of heroin to America is a high U.S. priority which involves favorable U.S. decisions on foreign aid and other matters to countries which cooperate in promoting a vigorous drug enforcement program within their borders.

- o According to the Drug Enforcement Administration's Heroin Signature Program, the proportion of Southwest Asian (SWA) heroin available in the U.S. increased slightly, representing half of the total U.S. supply. Mexican heroin remained at about one-third nationally, while Southeast Asian (SEA) heroin accounted for about 17 percent of the total available.
- o According to reports from the National Institute on Drug Abuse's (NIDA) Community Epidemiology Workgroup in June 1986, fourteen cities reported the growing availability of a potent form of heroin known as "black tar," "gumball," or "tootsie roll." Previously, the presence of this substance had only been reported in the western section of the country. The source country for this form of heroin is Mexico.

NIDA

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MARIJUANA UPDATE

Marijuana is still by far the most extensively used illicit drug. According to the latest survey (1985) almost 62 million Americans have tried marijuana in their lifetime and 29 million used the drug in the past year. Current use of marijuana decreased from 20 million in 1982 to 18 million in 1985 for the 12 and older population. Among employed 20-40 year-olds, 16 percent reported using marijuana at least once in the past month.

Starting in 1979 there has been a gradual decline in marijuana use among high school seniors. Marijuana use peaked in 1978 when almost 11 percent of high school seniors reported daily or almost daily use and has gradually declined to 2.7 percent in 1988.

A 1985 NIDA survey of clients admitted to drug abuse treatment programs shows that one in seven clients reported marijuana as their primary drug of abuse, second only to heroin.

The National Institute on Drug Abuse (NIDA) has supported extensive research into the effects of marijuana. Findings from several of these studies follow.

Effects of Marijuana on the Brain

Significant progress has been made recently by several NIDA grantees in determining how marijuana acts on the brain. Several animal studies have focused attention on the hippocampus, the major component of the brain's limbic system that is crucial for learning, memory, and the integration of sensory experiences with emotions and motivation. Taken together, these results may provide the first clue to the mechanisms underlying marijuana induced euphoria and loss of memory and provide the definitive evidence for a toxic effect of marijuana on brain nerve cells.

Researchers have found that THC, the psychoactive ingredient in marijuana, changes the way in which sensory information gets into and is acted on by the hippocampus. Studies have found that the information processing system and the activity of the neurons and nerve fibers are altered. Investigations have also shown that THC exerts an action directly on a part of the brain that scientists believe may underlie memory.

C-88-06

Revised May, 1989

cap 12

Two other studies found evidence that chronic THC exposure damages and destroys nerve cells and causes other pathological changes in the brain. The loss of cells appears to be similar to the loss seen with normal aging. This raises many concerns among which is that mild functional losses due to aging may interact with the effects of marijuana in an additive fashion, possibly placing long-term marijuana users at risk for serious or premature memory disorders as they age.

Effect on the Lungs

Scientists at the University of California, Los Angeles, found that the daily use of 1 to 3 marijuana joints appears to produce approximately the same lung damage and potential cancer risk as smoking 5 times as many cigarettes. The study results suggest that the way smokers inhale marijuana, in addition to its chemical composition, increases the adverse physical effects. The same lung cancer risks associated with tobacco also apply to marijuana users even though they smoke far less. The study findings refute the argument that marijuana is safer than tobacco because users only smoke a few joints a day.

Effect on Heart Rate and Blood Pressure

Recent findings indicate that smoking marijuana while shooting up cocaine has the potential to cause severe increases in heart rate and blood pressure. Each drug alone produced cardiovascular effects. When they were combined, the effects were greater and lasted longer. The heart beat of the subjects in the study increased 29 beats per minute with marijuana alone and 32 beats per minute with cocaine alone. When the drugs were given together, the heart rate increased by 49 beats per minute and persisted for a longer time. The drugs were given with the subjects sitting quietly. In normal circumstances, an individual may smoke marijuana and inject cocaine and then do something physically stressful that may significantly increase risks of overload to the cardiovascular system.

Effect on Reproduction in Women

The first controlled study in women on the acute effects of marijuana has shown that smoking a single marijuana cigarette after ovulation decreases the plasma level of one of the hormones essential for normal reproductive functioning. The luteinizing hormone is essential for implantation of the fertilized egg in the uterus. A single dose of marijuana during the luteal phase of the menstrual cycle suppressed the level of the hormone, suggesting the possibility that chronic use of marijuana may adversely affect reproductive functioning in women.

Additional Research Advances

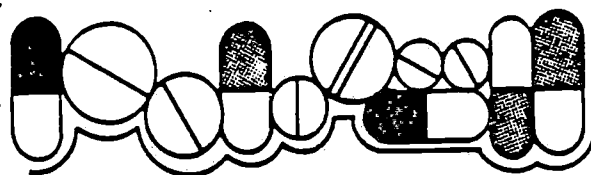
Marijuana Found in Blood of Accident Victims

A study recently examined 1,023 trauma patients admitted to the shock trauma unit at the Maryland Institute for Emergency Medical Services in Baltimore. This unit received only the most seriously injured accident victims directly from the scene of the injury. This study found that one-third of all admitted patients had detectable levels of marijuana in their blood, indicating use of marijuana within two to four hours prior to admission to the unit. The study also found that four of every ten persons 30 years or younger were under the influence of marijuana at the time of the accident.

Adults Using Marijuana Heavily Fail to Confront Problems

A series of indepth case studies by a research team at the Center for Psychosocial Studies in New York City found that adults who smoked marijuana daily believed it helped them function better, improving self-awareness and relationships with others. In reality, the drug served as a buffer enabling users to tolerate problems, rather than make changes that might increase their satisfaction with life. The study indicated that these subjects used marijuana to avoid dealing with their difficulties and the avoidance inevitably made their problems worse. The most striking observation is the discrepancy between what study participants say and what is actually going on. Although users believed the drug enhanced understanding of themselves, it actually served as a barrier against self awareness.

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NIDA Capsules

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MDMA

MDMA, called "ADAM," "Ecstasy," or "X-TC," on the street, is a synthetic, psychoactive (mind-altering) drug with hallucinogenic and amphetamine-like properties. Its chemical structure (3-4-methylenedioxymethamphetamine) is very similar to two other synthetic drugs: MDA and methamphetamine, which are known to cause brain damage. MDMA is a so-called "designer drug," which, according to the Drug Enforcement Administration (DEA), has become a nationwide problem as well as a serious health threat. It has been known to be the cause of at least two deaths.

Beliefs about Ecstasy are reminiscent of similar claims made about LSD in the 1950's and 1960's, which proved to be untrue. According to its proponents, MDMA can make people trust one another and break down barriers between therapists and patients, lovers, and family members.

Many of the problems users encounter with MDMA are similar to those found with the use of amphetamines and cocaine. They are:

Psychological difficulties, including confusion, depression, sleep problems, drug craving, severe anxiety and paranoia--during and sometimes weeks after taking MDMA. Even psychotic episodes have been reported.

Physical symptoms such as muscle tension, involuntary teeth clenching, nausea, blurred vision, rapid eye movements, faintness and chills or sweating.

Increases in heart rate and blood pressure, a special risk for people with circulatory or heart disease.

The National Institute on Drug Abuse (NIDA) has arranged to have MDMA synthesized so qualified researchers can conduct studies on the drug's long-term neurotoxicity and abuse potential. It is believed that this research will indicate that it causes brain damage, just as MDA and methamphetamine do.

MDA, the parent drug of MDMA, is an amphetamine-like drug which has also been abused and is very similar in chemical structure to MDMA. According to NIDA-supported researchers Drs. L.S. Seiden and C.R. Schuster of the University of Chicago, MDA destroys serotonin-producing neurons, which play a direct role in regulating aggression, mood, sexual activity, sleep, and sensitivity to pain. It is probably this action on the serotonin system which gives MDA its purported properties of heightened sexual experience, tranquility, and conviviality.

MDMA is also related in structure and effects to methamphetamine. Methamphetamine has been shown by the Chicago researchers to cause degeneration of neurons containing the neurotransmitter dopamine. Damage to these neurons is the underlying cause of the motor disturbances seen in Parkinson's disease.

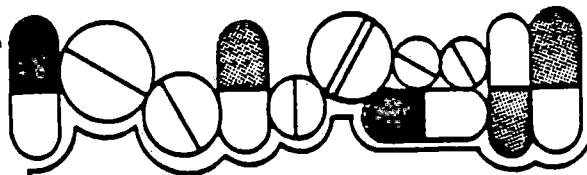
In laboratory experiments, a single exposure to methamphetamine at high doses or prolonged use at low doses destroys up to 50 percent of the brain cells which use dopamine. Although this damage may not be immediately apparent, scientists feel that with aging or exposure to other toxic agents, Parkinsonian symptoms may eventually emerge. These symptoms begin with lack of coordination and tremors and may eventually result in a form of paralysis.

DEA officials have said that the drug is available in at least 21 states and Canada and is especially popular with college students and young professionals. Areas of concentrated use include California, Texas, Florida, New York and New England. Treatment authorities in California report at least 3-4 MDMA related cases per month in 1985.

In June, 1985, DEA banned MDMA, placing the drug in the Schedule I classification based on the Controlled Substances Act. The emergency scheduling was effective July 1, 1985. Schedule I drugs are generally dangerous narcotics that have a high potential for abuse and no medical usefulness. Other drugs in Schedule I include heroin, LSD, and MDA. Manufacturers and sellers of Schedule I drugs are subject to fines of up to \$125,000 and 15 year prison terms. The scheduling will be effective for one year, during which time authorities will decide how best to classify MDMA based on hearings and scientific research. Until it became illegal, MDMA was used by some psychiatrists and therapists as an aid in psychotherapy.

The Justice Department has proposed legislation to combat designer drugs such as MDMA. A "designer drug" is a term used to refer to a substance that appears in the illicit drug market that is a chemical analogue or variation of another psychoactive drug. Underground chemists produce these new drugs by slightly changing the chemical composition of illegal drugs so that they are technically legal. In many cases, the new designer drugs are more dangerous and more potent than the original drug. Legislation would call for a 15 year prison sentence and \$250,000 fine for those convicted of producing such drugs.

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PCP (Phencyclidine)

Health Hazards

- o Phencyclidine (PCP) is an hallucinogenic drug - i.e. one that produces profound alterations in sensation, mood and consciousness that may involve the senses of hearing, touch, smell, or taste, as well as visual experiences that depart from reality.
- o Since its effects are highly unpredictable, including bizarre behavior and disorientation, there is a significant risk of accidental injuries and death such as drowning, falling and automobile accidents. PCP users may also commit homicides under the influence of the drug.
- o Because PCP is an anesthetic compound it produces an inability to feel pain which can lead to serious bodily injury.
- o Health hazards resulting from the use of PCP are complicated by the use of many other substances that are similar to PCP and produce the same effects, but are frequently more toxic than pure PCP. One of these, PCC (or 1-piperidinocyclohexane carbonitrile), a substance that is formed during the manufacture of PCP, is very toxic, and it frequently contaminates the PCP that is sold on the street.
- o Mothers who used PCP throughout pregnancy delivered babies who had visual, auditory and motor disturbances, as well as sudden outbursts of agitation and other rapid changes in awareness similar to responses in adults intoxicated with PCP.
- o Unlike other hallucinogens, PCP produces feelings of mental depression in some individuals; and when used regularly, memory, perception, concentration and judgment are often disturbed. In large doses it may cause permanent brain dysfunction.
- o PCP can induce a psychotic state in many ways indistinguishable from schizophrenia.

C-86-8

(More)

Revised August, 1986

CAP 14

Prevalence of Use

- o Among high school seniors, PCP use in the past 30 days increased from 1.0 percent in 1984 to 1.6 percent in 1985.
- o Washington, D.C. is second only to Los Angeles as the city with the largest number of emergency room mentions for PCP abuse nationwide.

Risk Factors

- o People who abuse other substances appear to be more at risk for abusing PCP, than those who are not multiple drug users. Most of those using PCP reported that they used marijuana and alcohol, prior to trying PCP.
- o Young people, who use PCP in addition to marijuana and alcohol, seem to identify strongly with groups of peers who look favorably on the use of drugs. They appear to use PCP to dispel boredom and enhance the pace of life - and to regard risktaking and adventure as fundamental components of their lifestyle.
- o Other risk factors that have emerged, that predispose to PCP, use include a previous history of treatment either for substance use or emotional problems, including self-destructive behaviors.

User Characteristics

- o Half of the high school seniors who use PCP start before entering tenth grade.

Patterns of Use

- o In a study of young adult male PCP users 21-38 years, 86 percent reported using over-the-counter caffeine preparations; 81 percent alcohol; 81 percent cannabis preparations; 62 percent other hallucinogens; 58 percent tobacco products; and 20 percent cocaine, amphetamines and other stimulants, concomitant with PCP.
- o Over fifty percent of a group of 100 PCP users reported using it at an average frequency of at least once a week, and forty percent said they used two or more times a week.

Prevalence of Health Consequences

- o Although PCP and other hallucinogens are not abused (used) to the same extent as marijuana and cocaine, the health consequences of PCP abuse are substantive.

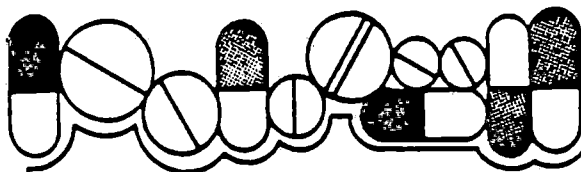
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- o In a study of 1,000 cases of PCP intoxication, fifty percent exhibited significant cognitive, behavioral, or medical deficit.
- o In the same study of 1,000 cases, the major behavioral consequences were violent, unpredictable outbursts including shooting, stabbing, self-inflicted injuries, etc. (35 percent); agitation (34 percent); bizarre behavior--driving at 10 miles per hour on the freeway, lying down in the middle of busy streets, wandering or wild behavior in the nude in public, etc. (32 percent); hallucinating or delusional (19 percent); mute and staring (11 percent).
- o Treatment of PCP overdosage is not very satisfactory. No specific antidotes are known, and treatment of the psychotic manifestations with other drugs has only questionable benefits.
- o Approximately 45 percent of PCP emergency room cases are in combination. Almost 60 percent of the cases are between 20 and 29, and almost 56 percent occur among Blacks. The combinations cited most often are PCP and alcohol, PCP and cocaine, and PCP and marijuana.

Supplies

- o Clandestine laboratories supply all of the PCP found in the U.S. illicit market. The number of laboratory seizures in 1984 increased 38 percent over 1983.
- o Piperidine, a compound from which PCP is synthesized, is now controlled by the government and this has significantly reduced the supplies of the drug as well as PCP deaths and hospital emergencies.
- o PCP has gained a "bad" street reputation due to its unpredictable side effects, which has probably discouraged widespread use and experimentation. There is currently, however, a localized pattern of use in certain urban areas including Washington, D.C., Los Angeles, and New Orleans.

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PCP: UPDATE ON ABUSE

PCP (phencyclidine) continues to be a significant problem in the U.S., with reports of epidemic levels of use in certain localities. It is conservatively estimated to have been used by more than five percent of all youth age 12-17; twenty-one percent of all young adults age 18-25; and six percent of all adults over 26 years of age. It has been associated with almost 11,000 hospital emergency room visits and approximately 226 deaths in 1984.

PCP was first synthesized over fifty years ago. It was originally used as a local anesthetic for humans. Due to psychotic and hallucinogenic reactions, however, the use of this drug for humans was discontinued in 1967. It is now used legally only in veterinary medicine as an animal immobilizing agent.

PCP was first used illicitly in 1967 on the West Coast and rapidly developed a bad street reputation. Since that time its popularity has peaked and declined, and shifted from one region of the country to another. Various means of taking the drug (pill and liquid form, smoking, and snorting) have affected use patterns.

Although PCP is pharmacologically an extremely complex drug, it is relatively simple to synthesize. It can be produced from only a few readily available chemicals and with a minimum of equipment. Consequently, it is easily manufactured illicitly in basement-, van-, and garage-type laboratories all over the country.

Acute and Chronic Effects

PCP has a street reputation as a "bad" drug, and many people, after using the drug once, will not knowingly use it again. Yet others use it consistently and chronically. The reasons that are often cited by users as factors in their continued PCP use are: feelings of strength, power, invulnerability, and a numbing effect on the mind that often results in anger, rage and the disappearance of unpleasant memories. Some PCP users are cocaine addicts who resort to PCP because it is less expensive.

PCP effects one's senses, vital signs, behavior and motor functions. Users feel a sense of distance and removal from their surroundings, a slow down in time and body movements, and sparse and mangled speech. They stagger and have a decreased awareness of touch and pain. These effects are not perceived as unpleasant while they are occurring.

PCP is toxic when consumed at high dose. Individual differences in sensitivity make it difficult to predict when a toxic reaction will occur. The symptoms of toxicity range from a coma to high excitement that is often confused with a schizophrenic psychotic episode. Another form of toxicity is the catatonic syndrome, where the user becomes mute, lethargic, disoriented and makes meaningless repetitive movements.

C-80-13

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Revised April 1986

CAP 15

Chronic users of PCP report memory loss, speech difficulties, depression and weight loss. When given psychomotor tests, PCP users tend to have lost their fine motor skills and short term memory. Mood disorders also occur.

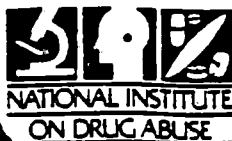
PCP RESEARCH

Our present knowledge about PCP, including the extent of its use, is still modest. We are just beginning to understand the toxic reaction to PCP, why toxic doses vary from one person to another, and why such disparate symptoms occur in different persons. The possibility of lasting physiological deficits resulting from PCP use must be further explored. In clinical tests, when psychomotor defects were measured, the defects could not be related directly to the dose of the drug or the duration of its use.

A recent research discovery of two receptor sites in the brain for PCP may help explain the diverse effects this drug produces. A small peptide has been isolated in the brain that binds to one PCP receptor and produces PCP like effects in animals. This suggests that PCP acts on a neuronal systems already functioning in the brain. This finding has led to the development of PCP antagonists and antibodies to decrease PCP toxicity in animals. Further work with these substances may lead to useful therapeutic agents for PCP users in psychotic episodes.

NIDA

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COLLEGE STUDENTS SURVEY ON DRUG USE 1980 - 1988

The following tables are part of the nationwide survey of drug use among high school seniors, conducted annually for the National Institute on Drug Abuse by the University of Michigan Institute for Social Research. Each year since 1977, some participants from all previously graduated high school classes have been followed through the use of mailed questionnaires. These follow-up surveys include a sample of about 1,200 full time American college students one to four years past high school.

Trends in Annual Prevalence of Fourteen Types of Drugs Among College Students 1-4 Years Beyond High School

	Percent who used in last twelve months									'87-'88 change
	1980	1981	1982	1983	1984	1985	1986	1987	1988	
Approx. Wtd. N =	(1040)	(1130)	(1160)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	
Marijuana	51.2	51.3	44.7	45.2	40.7	41.7	40.9	37.0	34.6	-2.4
Inhalants ^b	3.0	2.5	2.5	2.8	2.4	3.1	3.9	3.7	4.1	+0.4
LSD	6.0	4.8	6.3	4.3	3.7	2.3	3.9	4.0	3.6	-0.4
Cocaine	16.8	16.0	17.2	17.3	16.3	17.3	17.1	13.7	10.0	-3.7 ^{ns}
"Crack" ^c	NA	NA	NA	NA	NA	NA	1.3	2.0	1.4	-0.6
Heroin	0.4	0.3	0.1	0.0	0.1	0.2	0.1	0.2	0.2	0.0
Other Opiates ^a	5.1	4.3	3.8	3.8	3.8	2.4	4.0	3.1	3.1	0.0
Stimulants ^a	22.4	22.2	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted ^{a,d}	NA	NA	21.1	17.3	15.7	11.9	10.3	7.2	6.2	-1.0
Sedatives ^a	8.3	8.0	8.0	4.5	3.5	2.5	2.8	1.7	1.5	-0.2
Barbiturates ^a	2.9	2.8	3.2	2.2	1.9	1.3	2.0	1.2	1.1	-0.1
Methaqualone ^a	7.2	6.5	6.6	3.1	2.5	1.4	1.2	0.8	0.5	-0.3
Tranquilizers ^a	6.9	4.8	4.7	4.6	3.5	3.6	4.4	3.8	3.1	-0.7
Alcohol	90.5	92.5	92.2	91.8	90.0	92.0	91.5	90.9	89.6	-1.3
Cigarettes	38.2	37.8	34.3	36.1	33.2	35.0	35.3	38.0	36.6	-1.4

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, nss = .001.
NA indicates data not available.

^a Only drug use which was not under a doctor's orders is included here.

^b This drug was asked about in four of the five questionnaire forms. N is four-fifths of N indicated.

^c This drug was asked about in one of the five questionnaire forms in 1986 (N is one-fifth of N indicated), and in two of the five questionnaire forms thereafter (N is two-fifths of N indicated).

^d Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

C-86-6

Revised May 1989
Cap 16

**Trends in Thirty-Day Prevalence of Fourteen Types of Drugs
Among College Students 1-4 Years Beyond High School**

	Percent who used in last thirty days									'87-'88 change
	1980	1981	1982	1983	1984	1985	1986	1987	1988	
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	
Marijuana	34.0	33.2	26.8	26.2	23.0	23.6	22.3	20.3	16.8	-3.5s
Inhalants ^b	1.5	0.9	0.8	0.7	0.7	1.0	1.1	0.9	1.3	+0.4
LSD	1.4	1.4	1.7	0.9	0.8	0.7	1.4	1.4	1.1	-0.3
Cocaine	6.9	7.3	7.9	6.5	7.6	6.9	7.0	4.8	4.2	-0.4
"Crack" ^c	NA	NA	NA	NA	NA	NA	NA	0.4	0.5	+0.1
Heroin	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Other Opiates ^a	1.8	1.1	0.9	1.1	1.4	0.7	0.6	0.8	0.8	0.0
Stimulants ^a	13.4	12.3	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted ^{a,d}	NA	NA	9.9	7.0	5.5	4.2	3.7	2.3	1.8	-0.5
Sedatives ^a	3.8	3.4	2.5	1.1	1.0	0.7	0.8	0.6	0.6	0.0
Barbiturates ^a	0.9	0.8	1.0	0.5	0.7	0.4	0.6	0.5	0.5	0.0
Methaqualone ^a	3.1	3.0	1.9	0.7	0.5	0.3	0.1	0.2	0.1	-0.1
Tranquilizers ^a	2.0	1.4	1.4	1.2	1.1	1.4	1.9	1.0	1.1	+0.1
Alcohol	81.8	81.9	82.8	80.3	79.1	80.3	79.7	78.4	77.0	-1.4
Cigarettes	25.8	25.9	24.4	24.7	21.5	22.4	22.4	24.0	22.6	-1.4

NOTES: Level of significance of difference between the two most recent years:

s = .05. ss = .01, sss = .001.

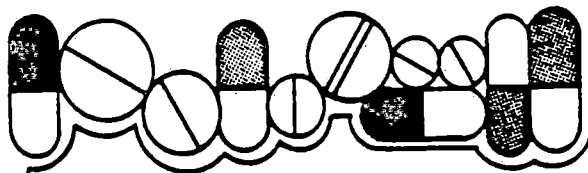
NA indicates data not available.

^aOnly drug use which was not under a doctor's orders is included here.

^bThis question was asked in four of the five questionnaire forms. N is four-fifths of N indicated.

^cThis question was asked in two of the five questionnaire forms. N is two-fifths of N indicated.

^dBased on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.



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FACTS ABOUT TEENAGERS AND DRUG ABUSE

Data from three National Institute on Drug Abuse surveys, the 1985 National Household Survey, the 1987 National High School Senior Survey, and the Drug Abuse Warning Network (DAWN), indicate a significant decline in the use of many illicit drugs among teenagers from the peak levels attained during the 1970's, but serious problems remain. These surveys found that:

National Household Survey on Drug Abuse (1985)

- Nearly 6.4 million (29.6%) young people aged 12-17 have tried an illicit drug at least some time during their lives; 5.1 million (23.6%) have used it within the past year; and 3.3 million (15.1%) have used within the past month.
- Approximately 3.5 million (31.3%) males 12-17 years old and 2.9 million (27.7%) females in this age group have used an illicit drug at least once during their life.
- Approximately 5.1 million (23.7%) young people have tried marijuana; 4.3 million (19.9%) have used it within the past year; and 2.7 million (12.2%) have used marijuana in the past month.
- Among 12-17 year olds, past month marijuana use (12.2% overall) ranged by region from 8.8% in the South to 11.6% in the North Central to 13.3% in the Northeast to 17.1% in the West.
- By race/ethnicity, past month marijuana use was 8.2% for Black youth, 9.9% for Hispanics and 13.2% for Whites..
- Over 1.1 million (5.2%) young people have tried cocaine; 960,000 (4.2%) have used cocaine within the past year; and 390,000 (1.7%) have used cocaine within the past month.

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C-83-07a

Revised April, 1988

CAP 17

National High School Senior Survey (Monitoring the Future, 1987)

- Cocaine use decreased in 1987 reflecting the first substantial decline among American High School Seniors. The use of other illicit drugs also declined, however, 42% of high school seniors still reported using some illicit drug during the past year.
- Past month marijuana use declined to 21.0% in 1987, down from 23.4% in 1986 and substantially below the peak of 37.1% observed for the class of 1978. Daily marijuana use which peaked at 10.7% in 1978 had declined to 3.3% in 1987.
- Well over half of young people (57%) have tried an illicit drug at least once before they graduate from high school.
- Three percent of high school seniors have used PCP at least once; 1.3% have used in the past year; and 0.6% have used in the past month.
- Nearly all high school seniors (92%) have had experience with alcohol and two-thirds (66%) have used in the past month. Nearly 38% have had five or more drinks in a row on at least one occasion in the past two weeks.
- Nearly one-fifth (18.7%) of high school seniors are daily cigarette smokers by the time they leave high school.
- Among high school seniors, 87% disapproved of even trying cocaine and 97% disapprove of regular cocaine use. Forty-eight percent of high school seniors saw "great risk" of harm associated with trying cocaine once or twice.

Drug Abuse Warning Network (DAWN) (1986)

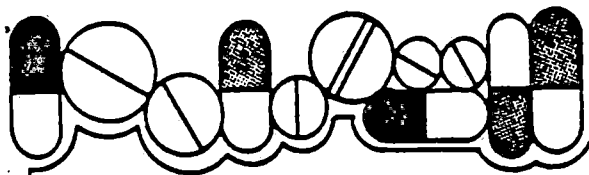
DAWN Emergency Rooms (ER)

- In 1986, ER's reported 119,263 drug abuse episodes; 13,343 (11.2%) of the episodes involved patients 10-17 years old.
- Approximately 6 out of 10 of the youth ER visits were related to a suicide attempt or gesture. The drugs mentioned most frequently by young ER patients were aspirin, acetaminophen, alcohol-in-combination, marijuana and cocaine.

DAWN Medical Examiners (ME)

- ME's reported a total of 4,138 drug abuse deaths; 55 involved decedents 10-17 years old.
- Approximately 46% of the ME cases for children under 18 were classified as suicides. Alcohol-in-combination and cocaine were the drugs mentioned most frequently in the ME cases.

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FREQUENCY OF DRUG MENTIONS IN DRUG-RELATED MEDICAL EMERGENCIES AND DEATHS IN 1986

The following tables list the twenty drugs most frequently mentioned in 1986 in emergency room (ER) visits and medical examiner (ME) reports of deaths involving drug abuse. This data is collected by the National Institute on Drug Abuse (NIDA), through the Drug Abuse Warning Network (DAWN). In 1986, a total of 119,263 ER episodes and 4,138 deaths were reported. Examples of commonly encountered brand names are listed with drug name where applicable.

1986 Most Frequently Reported Drugs In Emergency Rooms

<u>Drug Name</u>	<u>Emergency Room Mentions</u>		<u>Drug Rank</u>	
	<u>1986</u>	<u>1985</u>	<u>1986</u>	<u>1985</u>
Cocaine.....	24,847	13,501	1	3
Alcohol-in-combination.....	21,801	21,090	2	1
Heroin/Morphine.....	15,832	14,696	3	2
Diazepam (Valium).....	7,653	8,324	4	4
PCP/PCP Combinations.....	6,421	5,677	5	6
Marijuana.....	6,046	5,271	6	8
Acetaminophen (Tylenol, Datril).....	5,591	5,778	7	5
Aspirin.....	5,589	5,557	8	7
Alprazolam (Xanax).....	3,403	2,727	9	9
Acetaminophen w/Codeine.....	2,671	2,553	10	10
Ibuprofen (Motrin, Nuprin)....	2,491	1,712	11	18
Amitriptyline (Elavil).....	2,150	2,290	12	11
Methadone.....	1,993	1,832	13	14
O.T.C. Sleep Aids.....	1,850	1,738	14	16
D-Propoxyphene (Darvon).....	1,817	1,876	15	12
Flurazepam (Dalmane).....	1,517	1,776	16	15
Diphenhydramine (Benadryl)....	1,514	1,532	17	19
Hydantoin (Dilantin).....	1,490	1,875	18	13
Oxycodone (Percodan).....	1,484	1,467	19	21
Phenobarbital (Nembutal).....	1,465	1,728	20	17

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C-84-1

Revised April 1988

CAP 18

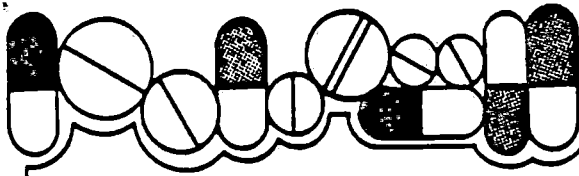
1986 Most Frequently Reported Drugs
From Medical Examiner Reports

<u>Drug Name</u>	<u>Medical Examiner Mentions</u>		<u>Drug Rank</u>	
	<u>1986</u>	<u>1985</u>	<u>1986</u>	<u>1985</u>
Heroin/Morphine.....	1,549	1,315	1	1
Alcohol-in-combination.....	1,463	1,288	2	2
Cocaine.....	1,092	643	3	3
Codeine.....	434	351	4	4
Quinine.....	358	345	5	5
Diazepam (Valium).....	317	315	6	6
Amitriptyline (Elavil).....	263	252	7	7
Acetaminophen (Tylenol, Datril).....	255	197	8	9
D-Propoxyphene (Darvon).....	246	234	9	8
PCP/PCP Combinations.....	245	195	10	10
Phenobarbital (Nembutal).....	161	148	11	11
Desmethyldiazepam.....	158	101	12	18
Diphenhydramine (Benadryl).....	140	114	13	13
Doxepin (Sinequan).....	135	109	14	15
Lidocaine.....	134	91	15	20
Nortriptyline.....	134	109	15	15
Methadone.....	133	131	17	12
Aspirin.....	115	86	18	21
Methamphetamine (Speed).....	114	64	19	24
Benzodiazepine (Lithium).....	100	63	20	25

Source: Drug Abuse Warning Network (1985-1986)

NOTE: Medical Examiner data from New York are not included in this table because of incomplete reporting. Up to 4 drugs may be mentioned in a drug related emergency room visit and up to 6 drugs in a drug related death. Alcohol is reported only when it is used in combination with other drugs.

The DAWN system is a voluntary data collection system through which hospital emergency room (ER) and medical examiner (ME) facilities report information on medical crises and deaths related to the improper use of drugs. During 1986, 744 ER's and 75 ME facilities participated in the system. DAWN affiliated ME's and ER's comprise a non-random sample and the majority are located in 27 metropolitan areas throughout the country. Only drug abuse episodes which have resulted in a medical emergency or death are reported and therefore, DAWN data do not reflect general prevalence levels of drug abuse.



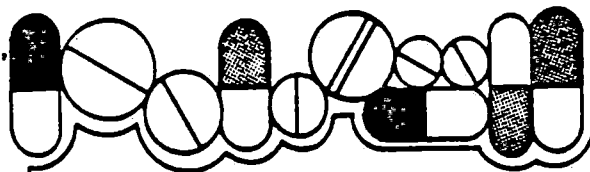
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Highlights of an Attitudes and Knowledge Survey about Illegal Drug Use

On August 25-28, 1,001 Americans age 18 and older were surveyed by telephone about their personal knowledge and beliefs about illegal drugs. The survey, sponsored by NIDA, was conducted by the research firm of Royer Cook Inc. Following are highlights of this survey:

- o Most adult Americans sampled (98%) considered illegal drug use to be an important national problem: 73% described drug use as "one of the most serious problems facing the country" while only 2% considered it not important.
- o Almost half of the adults sampled perceived an increase in cocaine users between 1981 and 1986: 43% reported knowing more people who use cocaine now, 5% reported knowing fewer, 10% reported no change, and 39% said they never knew any cocaine users.
- o The number of marijuana users was not perceived to change much in the last 5 years: 25% never knew any marijuana users, 22% reported that the number was the same, 29% reported knowing more and 24% reported knowing fewer marijuana users now.
- o While most Americans believed that both marijuana and cocaine are more accessible now than 5 years ago, more considered it easier to obtain cocaine: 63% thought it is easier to get cocaine now than in 1981.
- o Most Americans thought that people risk harming themselves by using marijuana, cocaine or crack. Marijuana is perceived as less risky than cocaine and crack is considered the most risky.
- o Occasional use of marijuana was considered a great risk by 49% of the adults and regular use was considered a great risk by 73%.
- o Occasional use of cocaine was considered a great risk by 68% and regular use was considered a great risk by 92%.
- o Any use of crack was viewed as very dangerous by 90% of the adults sampled.



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HIGHLIGHTS OF THE 1985 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE NATIONAL INSTITUTE ON DRUG ABUSE

Trend Analysis:

- o Current use of marijuana (past month use) decreased from 20.0 million in 1982 to 18.2 million in 1985. This represents a decrease in rate of use from 11% of the household population aged 12 and older in 1982 to 10% in 1985.
- o Current use of cocaine (past month use) increased from 4.2 million in 1982 to 5.8 million in 1985. This represents an increase in rate of use from 2% of the household population aged 12 and older in 1982 to 3% in 1985.
- o Compared with 1979 and 1982 levels, the 18-25 year-old-group was most likely to have stabilized or decreased their use of most drugs in 1985. In contrast, the 26+ year-old age group was most likely to have increased their use of most drugs. The increase in this age group is at least partially explained by the aging of individuals who began using drugs in previous years.

1985 Analysis:

- o Overall, 70.4 million Americans age 12 or older (or 37% of the population) have tried marijuana, cocaine or other illicit drugs at least once in their lifetime.
- o Nineteen percent of the of the household population aged 12 years and older (36.8 million people) have tried marijuana, cocaine or other illicit drugs at least once in the past year and 23 million people (12%) at least once during the month prior to being surveyed in the 1985 National Household Survey on Drug Abuse.
- o Twenty-one percent of the cocaine users have used freebase and 8% have used cocaine intravenously. Recent cocaine users are more likely to have ever used freebase: 38% of the past month users compared with 20% of the past year users and 10% of those last using cocaine over a year ago.
- o Among the employed 20-40 year olds, 29% reported use of an illicit drug in the past year and 19% reported some illicit drug use at least once in the past month.
- o Among employed 20-40 year-olds, 16% reported using marijuana and 5% reported using cocaine at least once in the past month.
- o Among 18-34 year-old women (i.e., in the primary childbearing ages), 30% used an illicit drug at least once last year and 18% used an illicit drug at least once in the past month.

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Analysis by Drug

Cocaine

- o The number of current cocaine users increased from 4.2 million in 1982 to 5.8 million in 1985, a percentage increase from 2% to 3%. Furthermore, current and frequent cocaine users were also more likely to report symptoms of dependency on the drug.
- o Lifetime use of cocaine among youth (age 12-17) and young adults (age 18-25) decreased from a high of 6.5% and 28.3% in 1982 to 5.2% and 25.2% respectively in 1985. The percent of older adults (age 26+), who had tried the drug, however, increased by a full percentage point to its highest rate, from 8.5% to 9.5%.
- o Among youth, lifetime and past year prevalence of cocaine is highest for Hispanics (7% and 6%) compared to Whites (6% and 5%) and Blacks (3% and 3%). Among young adults, the rates are highest for Whites (28% and 18%) compared to Hispanics (15% and 12 %) and Blacks (14% and 11%). Among older adults, these rates are highest among Blacks (7% and 4%) as compared to Whites (4% and 1%) and Hispanics (3% and 1%).
- o In 1985, for the first time, data were gathered about the ways cocaine was used. Sniffing cocaine is by far the most popular route of administration: 95% of the cocaine users reported taking cocaine by this route. While overall only 8% of the cocaine users reported ever taking the drug intravenously, the relationship of intravenous drug use to AIDS highlights the need to reduce the use of this route of administration even further. Youth (3%) were least likely and older adults (13%) were most likely to have taken cocaine intravenously.
- o Forty-four percent of youth using cocaine have smoked the drug, as compared to 21% of young adults and 19% of mid-adults (age 26-34). Furthermore, 38% of those who had used cocaine in the past month report having smoked cocaine, as compared to 10% of those who had used cocaine more than a year ago. (These data were collected in 1985 and do not fully reflect the use of crack, which did not appear nationally until late 1985). Because of the rapid and short duration of effects, smoking freebase is dangerous and results in the rapid development of drug dependency.
- o In addition, our survey finds that the more frequently people use cocaine, the more likely they are to freebase. Only 7% of the respondents who had used cocaine one or two times reported that they smoked it, as compared to 34% of those who had used it 10-99 times, and 57% of those who had used cocaine 100 times or more.

Marijuana

- o Almost 62 million Americans (33%) have tried marijuana at least once in their lives, an increase of 2% since 1982. A little over 5 million youth (24%), almost 20 million young adults (60%), and over 37 million older adults (27%), have tried the drug.

(more)

- o Current use of marijuana (past month use) decreased from 11% in 1982 to 10% in 1985 which represents a reduction from 20 million to 18.2 million users.
- o The lifetime rate for youth is 3% lower than 1982; the rate for young adults is 3.6% lower. Although not statistically significant, this continues the downward trend that was first observed in 1982. The increase of 4.2% in lifetime rate among adults 26+, from 23% in 1982 to 27% 1985, is statistically significant. The increase in this age group is partially explained by the aging of individuals who began using drugs in previous years.
- o The lifetime rates for marijuana indicate that more Whites than Blacks or Hispanics have tried marijuana, with the exception of older adults where 21% of Blacks have tried the drug, as compared to 16% of Whites and 12% Hispanics. Current use of marijuana is highest among Blacks in young and older adults, with the exception of youth where the rate is highest for Whites (13%) followed by Hispanics (10%) and Blacks (8%).
- o Many of the people who have tried marijuana have used the drug extensively. Among youth, 23% of males who reported having tried marijuana have used it at least 100 times; the comparable number for females is 10%. Among young adult males, 39% of those who had used marijuana have used it 100 or more times, and the corresponding figure for females is 24%.
- o Current users of marijuana are more likely than persons not currently using marijuana, to be current users of other drugs. For example, among young adults, at least one-fourth (28% for male, 25% for female) of the current marijuana users are also current users of cocaine, as compared with only 2% of current cocaine users who did not use marijuana in the past month.

Hallucinogens

- o Hallucinogens, which first gained prominence during the mid-sixties, include such drugs as LSD, PCP, mescaline, and peyote. In 1985, only 3.2% of the youth have ever tried hallucinogens, as compared to 5.2% in 1982. Declines were also noted for use in the past year (from 3.6% to 2.6%). Similar trends were seen among the other age groups.
- o Experience with hallucinogens is found largely among Whites. For example, 13% of the Whites have ever tried an hallucinogen, compared with 6% of the Hispanics and 3% of the Blacks.

Inhalants

- o While too many youth (9%) have experimented with inhalants, current use is rare: only 4% of youth, 1% of young and mid-adults, and less than 1/2 of 1% of older adults have tried an inhalant in the month prior to the survey.
- o Experience with inhalants is more extensive among Whites than Blacks or Hispanics. However, younger Hispanics are more likely than younger Blacks to have ever used inhalants them in the past year.

Psychotherapeutic Drugs

- o The nonmedical use of psychotherapeutic drugs: sedatives, tranquilizers, stimulants, and analgesics is not common. For sedatives, there was decreased nonmedical use in all age groups, the only two statistically significant changes, however, occurred in the 18-25 age group. First, the percent of 18-25 year-olds who have ever taken a sedative for a nonmedical reason decreased from 19% in 1982 to 11% in 1985. And secondly, there was a significant decline in the nonmedical use of sedatives in the past year, from 8.7% in 1982 to 5.1% in 1985. Nonmedical use of stimulants declined among the two younger age groups but none of the changes were statistically significant.
- o Significant increases occurred with the nonmedical use of tranquilizers and analgesics among older adults. The percent reporting ever having used a tranquilizer nonmedically increased from 3.6% in 1982 to 7.1% in 1985. Use in the past year increased from 1.1% in 1982 to 2.8% in 1985. The percent reporting ever having used an analgesic nonmedically increased from 3.2% to 5.6%. Use in the past year increased from 1% in 1982 to 2.9% in 1985.

Cigarettes and Tobacco Products

- o More than three-quarters of the American population (76%) have tried cigarettes, and almost a third (32%) are current smokers. Current use among youth is 16%; among young adults is 37%; and among older adults is 32%.
- o Supporting the relationship between smoking and the use of other drugs, among youth, 78% of male smokers are also current drinkers, as compared to 25% of nonsmokers; 47% of male smokers use marijuana, as compared to only 7% of nonsmokers; and 10% of male smokers use cocaine, as compared to less than 1/2 of 1% of the nonsmokers.
- o The data in the 1985 survey shows that 11% of both youth and young adults used smokeless tobacco during the past year.
- o Among youth, more male (20%) than females (1%) report use of smokeless tobacco. Among young adults, the comparable figures are 21% for males and 2% for females.

Alcohol

- o Slightly more than half (56%) of the youth have tried an alcoholic beverage at some time in their lives. Use in the past year (52%) is almost as high; and 32% have consumed at least one drink during the past month. Among young adults, the figures are substantially higher: 93% had tried alcohol, 87% had used alcohol in the preceeding year, and 72% had used alcohol during the preceding month.
- o Among male youth, 57% of the current drinkers are also current marijuana users, as compared to only 10% of the nondrinkers. Six percent of current male drinkers also use cocaine, as compared to less than 1/2 of one 1% of the nondrinkers.

NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE, 1985

LIFETIME PREVALENCE OF DRUG USE: 1972-1985

Drug	Youth: age 12-17							Young Adults: age 18-25							Older Adults: age 26 +						
	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85
	Percent							Percent							Percent						
Marijuana & Hashish	14.0	23.0	22.4	28.0	30.9	26.7	23.7	47.9	52.7	52.9	59.9	68.2	64.1	60.5	7.4	9.9	12.9	15.3	19.6	23.0	27.2
Hallucinogens	4.8	6.0	5.1	4.6	7.1	5.2	3.2	—	16.6	17.3	19.8	25.1	21.1	11.5	—	1.3	1.6	2.6	4.5	6.4	6.2
Cocaine	1.5	3.6	3.4	4.0	5.4	6.5	5.2	9.1	12.7	13.4	19.1	27.5	28.3	25.2	1.6	0.9	1.6	2.6	4.3	8.5	9.5
Heroin	0.6	1.0	0.5	1.1	0.5	..	..	4.6	4.5	3.9	3.6	3.5	1.2	1.2	..	0.5	0.5	0.8	1.0	1.1	1.1
Nonmedical Use of:																					
Stimulants	4.0	5.0	4.4	5.2	3.4	6.7	5.5	12.0	17.0	16.6	21.2	16.2	18.0	17.3	3.0	3.0	5.6	4.7	5.6	6.2	7.9
Sedative	3.0	5.0	2.8	3.1	3.2	5.8	4.0	10.0	15.0	11.9	18.4	17.0	16.7	11.0	2.0	2.0	2.4	2.6	3.5	4.6	5.2
Tranquillizers	3.0	3.0	3.3	3.8	4.1	4.9	4.8	7.0	10.0	9.1	13.4	15.6	15.1	12.2	5.0	2.0	2.7	2.6	3.1	3.6	7.1
Analgesics	—	—	—	—	3.2	4.2	5.9	—	—	—	—	11.8	12.1	11.4	—	—	—	—	2.7	3.2	5.6
Alcohol	—	54.0	53.6	52.6	70.3	65.2	55.9	—	61.6	63.6	64.2	95.3	94.6	92.6	—	73.2	74.7	77.9	91.5	88.2	89.3
Cigarettes	—	52.0	45.5	47.3	54.1	49.5	45.3	—	66.8	70.1	67.6	82.6	76.9	76.0	—	65.4	64.5	67.0	83.0	78.7	80.5

— Not Available.

.. Less than one-half of 1 percent.

Source: National Household Survey on Drug Abuse, 1985, National Institute on Drug Abuse, Division of Epidemiology and Statistical Analysis.

(more)

Revised November 1986



ANNUAL DRUG USE: 1972-1985

Drug	Youth: age 12-17							Young Adults: age 18-25							Older Adults: age 26 +						
	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85
	Percent							Percent							Percent						
Marijuana & Hashish	—	18.5	18.4	22.3	24.1	20.6	20.0	—	34.2	35.0	38.7	46.9	40.4	37.0	—	3.8	5.4	6.4	9.0	10.6	9.5
Hallucinogens	3.6	4.3	2.8	3.1	4.7	3.6	2.8	—	6.1	6.0	6.4	9.9	6.9	3.7	—	**	**	**	0.5	0.8	1.0
Cocaine	1.5	2.7	2.3	2.8	4.2	4.1	4.4	—	6.1	7.0	10.2	19.6	18.8	16.4	—	**	0.6	0.9	2.0	3.8	4.2
Heroin	**	**	**	0.6	**	**	**	—	0.8	0.8	1.2	0.8	**	0.6	—	**	**	**	**	**	**
Nonmedical Use of:																					
Stimulants	—	3.0	2.2	3.7	2.9	5.6	4.4	—	8.0	8.8	10.4	10.1	10.6	10.4	—	**	0.8	0.8	1.3	1.7	2.7
Sedatives	—	2.0	1.2	2.0	2.2	3.7	3.1	—	4.2	5.7	8.2	7.3	8.7	5.4	—	**	0.6	**	0.8	1.4	2.0
Tranquillizers	—	2.0	1.8	2.9	2.7	3.3	3.7	—	4.6	6.2	7.8	7.1	5.9	6.7	—	**	1.2	1.1	0.9	1.1	2.9
Analgesics	—	—	—	—	2.2	3.7	4.4	—	—	—	—	5.2	4.4	6.7	—	—	—	—	0.5	1.0	3.1
Alcohol	—	51.5	49.3	47.5	53.6	47.3	52.0	—	77.1	77.9	79.8	86.6	83.4	87.4	—	62.7	64.2	65.8	72.4	68.3	73.6
Cigarettes	—	—	—	—	13.3*	24.8	26.0	—	—	—	—	46.7*	47.2	45.0	—	—	—	—	39.7*	38.2	36.2

— Not Available.

* For 1979, includes only persons who ever smoked at least 5 packs.

** Less than one-half of 1 percent.

Source: National Household Survey on Drug Abuse, 1985, National Institute on Drug Abuse, Division of Epidemiology and Statistical Analysis.

(more)

CURRENT DRUG USE: 1972-1985

Drug	Youth: age 12-17							Young Adults: age 18-25							Older Adults: age 26 +						
	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85
	Percent							Percent							Percent						
Marijuana & Hashish	7.0	12.0	12.3	16.6	16.7	11.5	12.3	27.8	25.2	25.0	27.4	35.4	27.4	21.9	2.5	2.0	3.5	3.3	6.0	6.5	6.2
Hallucinogens	1.4	1.3	0.9	1.6	2.2	1.4	1.1	—	2.5	1.1	2.0	4.4	1.7	1.6	—	..	..	..	..	..	..
Cocaine	0.6	1.0	1.0	0.6	1.4	1.6	1.6	—	3.1	2.0	3.7	9.3	6.6	7.7	—	..	..	..	0.9	1.2	2.1
Heroin	..	..	..	..	..	..	..	—	..	..	..	..	..	..	—	..	..	..	..	..	..
Nonmedical Use of:																					
Stimulants	—	1.0	1.2	1.3	1.2	2.6	1.8	—	3.7	4.7	2.5	3.5	4.7	4.0	—	..	..	0.6	0.5	0.6	0.7
Sedatives	—	1.0	—	0.6	1.1	1.3	1.1	—	1.6	2.3	2.6	2.6	2.6	1.7	—	..	0.5	..	..	..	0.7
Tranquillizers	—	1.0	1.1	0.7	0.6	0.9	0.6	—	1.2	2.6	2.4	2.1	1.6	1.7	—	..	..	..	..	..	1.0
Analgesics	—	—	—	—	0.6	0.7	1.9	—	—	—	—	1.0	1.0	2.1	—	—	—	—	..	..	0.9
Alcohol	—	34.0	32.4	31.2	37.2	26.9	31.5	—	69.3	69.0	70.0	75.9	67.9	71.5	—	54.5	56.0	54.9	61.3	56.7	60.7
Cigarettes	—	25.0	23.4	22.3	12.1*	14.7	15.6	—	48.8	49.4	47.3	42.6*	39.5	37.2	—	39.1	38.4	36.7	36.9*	34.6	32.8

— Not Available.

* For 1979, includes only persons who ever smoked at least 5 packs.

** Less than one-half of 1 percent.

Source: National Household Survey on Drug Abuse, 1985, National Institute on Drug Abuse, Division of Epidemiology and Statistical Analysis.

DRUG ABUSE STATISTICS 1985—Population Estimates **Division of Epidemiology and Statistical Analysis, NIDA**

The following are estimates of the number of people 12 years of age and older who report they have used drugs nonmedically. Drugs used under a physician's care are not included. The estimates are rounded and were developed from the *National Household Survey on Drug Abuse, 1985*, for the National Institute on Drug Abuse by the Institute for Survey Research, Temple University.

	12-17 years (pop. 21,840,000)				18-25 years (pop. 32,490,000)				26+ years ** (pop. 136,660,000)				TOTAL *** (pop. 190,790,000)			
	%	Ever Used	%	Current User	%	Ever Used	%	Current User	%	Ever Used	%	Current User	%	Ever Used	%	Current User
Marijuana & Hashish	24	5,130,000	12	2,660,000	60	19,670,000	22	7,110,000	27	37,130,000	6	8,430,000	33	61,940,000	10	18,190,000
Hallucinogens	3	690,000	1	250,000	12	3,740,000	2	520,000	6	8,440,000	*	—	7	12,880,000	1	960,000
Inhalants	9	1,970,000	4	770,000	13	4,150,000	1	320,000	5	6,820,000	1	850,000	7	12,940,000	1	1,940,000
Cocaine	5	1,120,000	2	390,000	25	8,170,000	8	2,510,000	9	12,950,000	2	2,850,000	12	22,240,000	3	5,750,000
Heroin	*	—	*	—	1	380,000	*	—	1	1,470,000	*	—	1	1,930,000	*	—
Stimulants	6	1,180,000	2	380,000	17	5,610,000	4	1,300,000	8	10,820,000	1	1,010,000	9	17,810,000	1	2,690,000
Sedatives	4	870,000	1	230,000	11	3,580,000	2	550,000	5	7,090,000	1	930,000	6	11,540,000	1	1,710,000
Tranquillizers	5	1,030,000	1	140,000	12	3,960,000	2	560,000	7	9,780,000	1	1,490,000	8	14,750,000	1	2,180,000
Analgesics	6	1,270,000	2	420,000	11	3,700,000	2	690,000	6	7,650,000	1	1,350,000	7	12,620,000	1	2,450,000
Alcohol	57	12,100,000	32	6,820,000	93	30,160,000	72	23,220,000	89	122,100,000	61	83,010,000	86	164,360,000	59	113,070,000
Cigarettes	45	9,790,000	16	3,370,000	76	24,710,000	37	12,080,000	80	110,000,000	33	44,830,000	78	144,510,000	32	60,280,000

* Amounts of less than 0.5% are not listed.

** Population estimates for this age group are weighted averages of the estimates for the 26-34 year old and 35+ year old age groups.

*** Totals may not equal the sum of the three age groups because of rounding.

Terms:

Ever Used: used at least once in a person's lifetime.

Current User: used at least once in the 30 days prior to the survey.

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CURRENT DRUG USE: 1972-1985

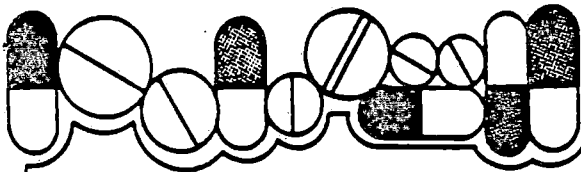
Drug	Youth: age 12-17							Young Adults: age 18-25							Older Adults: age 26 +						
	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85	'72	'74	'76	'77	'79	'82	'85
	Percent							Percent							Percent						
Marijuana & Hashish	7.0	12.0	12.3	16.6	16.7	11.5	12.3	27.8	25.2	25.0	27.4	35.4	27.4	21.9	2.5	2.0	3.5	3.3	6.0	6.5	6.2
Hallucinogens	1.4	1.3	0.9	1.6	2.2	1.4	1.1	—	2.5	1.1	2.0	4.4	1.7	1.6	—	..	..	..	..	..	..
Cocaine	0.6	1.0	1.0	0.6	1.4	1.6	1.6	—	3.1	2.0	3.7	9.3	6.6	7.7	—	..	..	..	0.9	1.2	2.1
Heroin	..	..	..	..	..	..	..	—	..	..	..	..	..	..	—	..	..	..	..	..	..
Nonmedical Use of:																					
Stimulants	—	1.0	1.2	1.3	1.2	2.6	1.6	—	3.7	4.7	2.5	3.5	4.7	4.0	—	..	..	0.6	0.5	0.6	0.7
Sedatives	—	1.0	—	0.6	1.1	1.3	1.1	—	1.6	2.3	2.6	2.6	2.6	1.7	—	..	0.5	..	..	..	0.7
Tranquillizers	—	1.0	1.1	0.7	0.6	0.9	0.6	—	1.2	2.6	2.4	2.1	1.6	1.7	—	..	..	..	..	..	1.0
Analgesics	—	—	—	—	0.6	0.7	1.9	—	—	—	—	1.0	1.0	2.1	—	—	—	—	..	..	0.9
Alcohol	—	34.0	32.4	31.2	37.2	26.9	31.5	—	69.3	69.0	70.0	75.9	67.9	71.5	—	54.5	56.0	54.9	61.3	56.7	60.7
Cigarettes	—	25.0	23.4	22.3	12.1*	14.7	15.6	—	48.6	49.4	47.3	42.6*	39.5	37.2	—	39.1	38.4	36.7	36.9*	34.6	32.8

— Not Available.

* For 1979, includes only persons who ever smoked at least 5 packs.

** Less than one-half of 1 percent.

Source: National Household Survey on Drug Abuse, 1985, National Institute on Drug Abuse, Division of Epidemiology and Statistical Analysis.



NIDA Capsules

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HIGH SCHOOL SENIOR DRUG USE: 1975-1987

The following tables show the percentage of high school seniors from the classes of 1975 through 1987 who have used drugs of abuse. These numbers were gathered in annual nationwide surveys conducted for the National Institute on Drug Abuse by the University of Michigan Institute for Social Research. The 1987 survey involved more than 16,000 high school seniors from public and private schools.

High School Senior Survey
Trends in Lifetime Prevalence
Percent Who Ever Used

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987
Marijuana/Hashish	47.3	52.8	56.4	59.2	60.4	60.3	59.5	58.7	57.0	54.9	54.2	50.9	50.2
Inhalants	NA	10.3	11.1	12.0	12.7	11.9	12.3	12.8	13.6	14.4	15.4	15.9	17.0
<i>Inhalants Adjusted</i>	NA	NA	NA	NA	18.2	17.3	17.2	17.7	18.2	18.0	18.1	20.1	18.6
Amyl & Butyl Nitrites	NA	NA	NA	NA	11.1	11.1	10.1	9.8	8.4	8.1	7.9	8.6	4.7
Hallucinogens	16.3	15.1	13.9	14.3	14.1	13.3	13.3	12.5	11.9	10.7	10.3	9.7	10.3
<i>Hallucinogens Adjusted</i>	NA	NA	NA	NA	17.7	15.6	15.3	14.3	13.6	12.3	12.1	11.9	10.6
LSD	11.3	11.0	9.8	9.7	9.5	9.3	9.8	9.6	8.9	8.0	7.5	7.2	8.4
PCP	NA	NA	NA	NA	12.8	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0
Cocaine	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1	17.3	16.9	15.2
Crack	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.6
Other Cocaine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14.0
Heroin	2.2	1.8	1.8	1.6	1.1	1.1	1.1	1.2	1.2	1.3	1.2	1.1	1.2
Other Opiates*	9.0	9.6	10.3	9.9	10.1	9.8	10.1	9.6	9.4	9.7	10.2	9.0	9.2
Stimulants*	22.3	22.6	23.0	22.9	24.2	26.4	32.2	35.6	35.4	NA	NA	NA	NA
<i>Stimulants Adjusted*</i>	NA	NA	NA	NA	NA	NA	NA	27.9	26.9	27.9	26.2	23.4	21.6
Sedatives*	18.2	17.7	17.4	16.0	14.8	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7
Barbiturates*	16.9	16.2	15.6	13.7	11.8	11.0	11.3	10.3	9.9	9.9	9.2	8.4	7.4
Methaqualones*	8.1	7.8	8.5	7.9	8.3	9.5	10.6	10.7	10.1	8.3	6.7	5.2	4.0
Tranquilizers*	17.0	16.8	18.0	17.0	16.3	15.2	14.7	14.0	13.3	12.4	11.9	10.9	10.9
Alcohol	90.4	91.9	92.5	93.1	93.0	93.2	92.6	92.8	92.6	92.6	92.2	91.3	92.2
Cigarettes	73.6	75.4	75.7	75.3	74.0	71.0	71.0	70.1	70.6	69.7	68.8	67.6	67.2

Inhalants Adjusted for underreporting of amyl and butyl nitrites.

Hallucinogens Adjusted for underreporting of PCP.

Stimulants Adjusted to exclude inappropriate reporting of nonprescription stimulants.

* Only use not under a doctor's orders included.

Terms:

Ever Used: Used at least one time.

Used in Last Year: Used at least once in the 12 months prior to the survey.

Used in Past Month: Used at least once in the 30 days prior to the survey.

Used Daily: Used 20 or more times in the month before the survey.

Source: National Institute on Drug Abuse, Monitoring the Future Study, 1987

C-85-1

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High School Senior Survey Trends in Annual Prevalence Percent Who Used in Last Year

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987
Marijuana/hashish	40.0	44.5	47.6	50.2	50.8	48.8	46.1	44.3	42.3	40.0	40.6	38.8	36.3
inhalants	NA	3.0	3.7	4.1	5.4	4.6	4.1	4.5	4.3	5.1	5.7	6.1	6.9
inhalants adjusted	NA	NA	NA	NA	8.9	7.9	6.1	6.6	6.2	7.2	7.5	8.9	8.1
Amyl & Butyl Nitrites	NA	NA	NA	NA	6.5	5.7	3.7	3.6	3.6	4.0	4.0	4.7	2.6
Hallucinogens	11.2	9.4	8.8	9.6	9.9	9.3	9.0	8.1	7.3	6.5	6.3	6.0	6.4
Hallucinogens adjusted	NA	NA	NA	NA	11.8	10.4	10.1	9.0	8.7	7.7	7.6	7.6	6.7
LSD	7.2	6.4	5.5	6.3	6.6	6.5	6.5	6.1	5.4	4.7	4.4	4.5	5.2
PCP	NA	NA	NA	NA	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3
Cocaine	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3
Crack	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.0
Other Cocaine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	9.8
Heroin	1.0	0.8	0.8	0.8	0.5	0.5	0.5	0.6	0.6	0.5	0.6	0.5	0.5
Other Opicides	5.7	5.7	6.4	6.0	6.2	6.3	5.9	5.3	5.1	5.2	5.9	5.2	5.3
Stimulants	16.2	15.8	16.3	17.1	18.3	20.8	26.0	26.1	24.6	NA	NA	NA	NA
Stimulants adjusted*	NA	NA	NA	NA	NA	NA	NA	20.7	17.9	17.7	15.8	11.4	12.2
Sedatives	11.7	10.7	10.8	9.9	9.9	10.3	10.5	9.1	7.9	6.6	5.8	5.2	4.1
Barbiturates	10.7	9.6	9.3	8.1	7.5	6.8	6.6	5.5	5.2	4.9	4.6	4.2	3.6
Methuquinones	5.1	4.7	5.2	4.9	5.9	7.2	7.6	6.8	5.4	3.8	2.8	2.1	1.5
Tranquilizers	10.6	10.3	10.8	9.9	9.6	8.7	8.0	7.0	6.9	6.1	6.1	5.8	5.5
Alcohol	84.8	85.7	87.0	87.7	88.1	87.9	87.0	86.8	87.3	86.0	85.6	84.5	85.7
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

inhalants adjusted for underreporting of amyl and butyl nitrites

Hallucinogens adjusted for underreporting of PCP

Stimulants adjusted to exclude inappropriate reporting of nonprescription stimulants

* Only use not under a doctor's orders included.

Terms:

Ever Used: Used at least one time.

Used in Last Year: Used at least once in the 12 months prior to the survey.

Used in Past Month: Used at least once in the 30 days prior to the survey.

Used Daily: Used 20 or more times in the month before the survey.

Source: National Institute on Drug Abuse, Monitoring the Future Study, 1987

High School Senior Survey
Trends in 30-Day Prevalence
Percent Who Used in Past Month

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987
Marijuana/Hashish	27.1	32.2	35.4	37.1	36.5	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0
Inhalants	NA	0.9	1.3	1.5	1.7	1.4	1.5	1.5	1.7	1.9	2.2	2.5	2.8
<i>Inhalants Adjusted</i>	NA	NA	NA	NA	2.2	2.7	2.5	2.5	2.5	2.6	3.0	3.2	3.5
Amyl & Butyl Nitrites	NA	NA	NA	NA	2.4	1.8	1.4	1.1	1.4	1.4	1.6	1.3	1.3
Hallucinogens	4.7	3.4	4.1	3.9	4.0	3.7	3.7	3.4	2.8	2.6	2.5	2.5	2.5
<i>Hallucinogens Adjusted</i>	NA	NA	NA	NA	5.3	4.4	4.5	4.1	3.5	3.2	3.8	3.5	2.8
LSD	2.3	1.9	2.1	2.1	2.4	2.3	2.5	2.4	1.9	1.5	1.6	1.7	1.8
PCP	NA	NA	NA	NA	2.4	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6
Cocaine	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3
Crack	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.5
Other Cocaine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1
Heroin	0.4	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.2
Other Opiates*	2.1	2.0	2.8	2.1	2.4	2.4	2.1	1.8	1.8	1.8	2.3	2.0	1.8
Stimulants*	8.5	7.7	8.8	8.7	9.9	12.1	15.8	13.7	12.4	NA	NA	NA	NA
<i>Stimulants Adjusted*</i>	NA	NA	NA	NA	NA	NA	NA	10.7	8.9	8.3	6.8	5.5	5.2
Sedatives*	5.4	4.5	5.1	4.2	4.4	4.8	4.6	3.4	3.0	2.3	2.4	2.2	1.7
Borbiturates*	4.7	3.9	4.3	3.2	3.2	2.9	2.6	2.0	2.1	1.7	2.0	1.8	1.4
Methaqualones*	2.1	1.6	2.3	1.9	2.3	3.3	3.1	2.4	1.8	1.1	1.0	0.8	0.6
Tranquilizers*	4.1	4.0	4.6	3.4	3.7	3.1	2.7	2.4	2.5	2.1	2.1	2.1	2.0
Alcohol	68.2	68.3	71.2	72.1	71.8	72.0	70.7	69.7	69.4	67.2	65.9	65.3	66.4
Cigarettes	36.7	38.8	38.4	36.7	34.4	30.5	29.4	30.0	30.3	29.3	30.1	29.6	29.4

Inhalants Adjusted for underreporting of amyl and butyl nitrites.

Hallucinogens Adjusted for underreporting of PCP.

Stimulants Adjusted to exclude inappropriate reporting of nonprescription stimulants.

* Only use not under a doctor's orders included.

Terms:

Ever Used: Used at least one time.

Used in Last Year: Used at least once in the 12 months prior to the survey.

Used in Past Month: Used at least once in the 30 days prior to the survey;

Used Daily: Used 20 or more times in the month before the survey.

Source: National Institute on Drug Abuse, Monitoring the Future Study, 1987

High School Senior Survey
Trends in Daily Use
Percent Who Used Daily in Last 30 Days

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987
Marijuana/Hashish	6.0	8.2	9.1	10.7	10.3	9.1	7.0	6.3	5.5	5.0	4.9	4.0	3.3
Inhalants	NA	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1
<i>Inhalants Adjusted</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>0.1</i>	<i>0.2</i>	<i>0.2</i>	<i>0.2</i>	<i>0.2</i>	<i>0.2</i>	<i>0.4</i>	<i>0.4</i>	<i>0.4</i>
Amyl & Butyl Nitrites	NA	NA	NA	NA	0.0	0.1	0.1	0.0	0.2	0.1	0.3	0.5	0.3
Hallucinogens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
<i>Hallucinogens Adjusted</i>	NA	NA	NA	NA	<i>0.2</i>	<i>0.2</i>	<i>0.1</i>	<i>0.2</i>	<i>0.2</i>	<i>0.2</i>	<i>0.3</i>	<i>0.3</i>	<i>0.2</i>
LSD	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1
PCP	NA	NA	NA	NA	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3
Cocaine	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.4	0.4	0.3
Crack	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2
Other Cocaine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2
Heroin	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Other Opiates*	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Stimulants*	0.5	0.4	0.5	0.5	0.6	0.7	1.2	1.1	1.1	NA	NA	NA	NA
<i>Stimulants Adjusted*</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>0.7</i>	<i>0.8</i>	<i>0.6</i>	<i>0.4</i>	<i>0.3</i>	<i>0.3</i>
Sedatives*	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1
Barbiturates*	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1
Methaqualones*	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0
Tranquilizers*	0.1	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.1
Alcohol	5.7	5.6	6.1	5.7	6.9	6.0	6.0	5.7	5.5	4.8	5.0	4.8	4.8
Cigarettes	26.9	28.8	28.8	27.5	25.4	21.3	20.3	21.1	21.2	18.7	19.5	18.7	18.7

Inhalants Adjusted for underreporting of amyl and butyl nitrites.

Hallucinogens Adjusted for underreporting of PCP.

Stimulants Adjusted to exclude inappropriate reporting of nonprescription stimulants.

* Only use not under a doctor's orders included.

Terms:

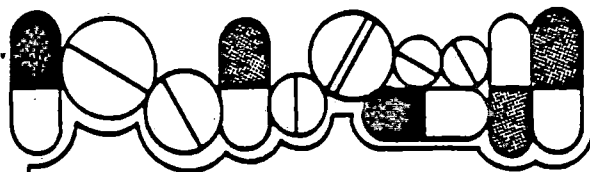
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Used Daily: Used 20 or more times in the month before the survey.

Source: National Institute on Drug Abuse, Monitoring the Future Study, 1987



NIDA Capsules

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FACTS ABOUT DRUGS IN THE WORKPLACE

Drug abuse affects all aspects of American life -- it threatens the workplace as well as the home, the schools, and the community. Business leaders must take a firm stance against illicit drug use. Workplace policies should be based on the rationale that use of drugs, including alcohol in the workplace, is unacceptable since it can adversely affect health, safety, and productivity, as well as public confidence and trust. When drug abuse interferes with an employee's efficient and safe performance of work responsibilities and reduces the employee's dependability, it creates a problem for the whole organization.

PREVALENCE Drug use is most prevalent among young adults - the segment of our society entering the workforce. According to the most recent NIDA National Household Survey, nearly 1 in 4 (24 percent) of employed males 18 - 24 years old and more than 1 in 5 (21 percent) employed 25 - 34 year old males use marijuana at least once a month. Approximately 1 in 11 (9 percent) in this group uses cocaine at least once a month. Clearly, there is significant drug use by members of the American workforce, and such use carries with it a risk of drug dependence and a host of problems related to decreased job performance and productivity.

A recent Gallup survey found that 68 percent of large companies with drug testing programs have had to deal with incidents of employee drug abuse in the past year. When alcohol is included, as reported in surveys by Marquette University, the percentage increases to 95 percent.

COSTS TO SOCIETY While estimates of the direct costs of drug abuse to business have been difficult to obtain, studies suggest that the overall impact of drug abuse on society is substantial. A Government study published in 1984 estimated the overall annual costs to society of drug abuse to be \$60 billion. Of this amount, over \$33 billion was believed to result from unrealized productivity due to drug use. The costs of drug use in the workplace include not only lost productivity, but costs related to absenteeism, accidents, health care, loss of trained personnel, theft, and prevention, treatment, and deterrence programs.

The magnitude of these human and economic costs is difficult to estimate but surely impact upon business in a substantial way. For example, according to a recent study by Blue Cross & Blue Shield of Pennsylvania, when substance abuse occurs in families, both the substance abuser and members of the family have increased rates of hospital utilization compared to other Blue Cross Subscribers. Alcohol abuse results in hospitalization more than any other drug; cocaine abuse is second.

(more)

C-87-2

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EMPLOYEE ASSISTANCE PROGRAMS An Employee Assistance Program (EAP) is a system for motivating and helping employees who have personal problems to seek and accept appropriate help to solve their problems. EAPs are particularly concerned with problems that adversely affect job performance.

These programs can serve as part of a comprehensive approach to combat drug abuse in the workplace. EAPs can provide education of employees about alcohol and other drugs as well as about personal problems that may affect job performance; training for supervisors and other key employees to act as referral agents; case consultation; problem assessment; referrals of employees to counseling or treatment; followup on cases referred; and feedback to management on services rendered. One recent review of evaluation studies suggests that over 70 percent of employees referred to EAPs for alcoholism are able to return to work and perform satisfactorily.

Another reason that employers are becoming more interested in substance abuse programs is that 36 States now mandate that insurers offer substance abuse coverage in their policies. However, currently only about 25 percent of the workforce has access to an EAP.

An effective EAP program will consist of:

Top Management Support--indicating that those in authority agree with the program and are willing to fund it.

Policy Statement--which clarifies the company's current needs; supports management, union leaders, and other key personnel, and includes provisions for administration and organization of EAP services.

Supervisory Training--to educate managers/supervisors to identify job performance problems; to identify, document, confront and refer employees needing assistance to the EAP; to understand confidentiality limits to protect the rights of employees; and to facilitate a positive return to work.

Client Services--through counselors that assess employees, refer them to the appropriate professional help, and provide followup and reintegration into the workforce.

External Linkages--for employee referral, such as with self-help groups, treatment programs, and service organizations.

Employee Education--to increase awareness of the problem and establish norms for a drug-free workplace.

Evaluation--to determine what changes might improve the program, whether objectives are adequately met, and whether staff complies with internal policies and procedures.

(more)

DRUG TESTING A NIDA report issued in 1986 states, "Urine screening can be an effective tool in the early identification of employees with drug problems and should be considered as a useful technique within the overall program."

Urinalysis for drug use is being used to screen job applicants by many of the Nation's largest employers, including major corporations, manufacturers, public utilities and transportation, and many small businesses. In general, most companies have an established policy that they will not hire individuals who present positive urines indicating recent use of illicit substances. However, many of these companies also counsel applicants who fail the drug screening to seek treatment and to reapply.

Many companies (1 in 5 one survey) are testing persons currently on the job, up from 3 percent in 1984. The poll indicates that the majority of firms--83 percent--test their employees only when drug use is suspected. Safety is the reason most often given for testing, followed by productivity improvement and helping affected employees.

Several recent surveys (1986-1988) have collected information on drug testing in industry. These surveys have varied in size, target populations, and focus, but together give a picture of the status of testing in business and industry. Overall, seven surveys have found that from 20-33 percent of companies surveyed have a drug testing program, with significant differences between companies of different types.

In general, the larger the company, the more likely it is to have a drug testing program. One survey found that 15 percent of companies doing under \$15 million worth of business do testing, while 36 percent of companies doing over \$1 billion do some testing. Larger companies are leading in the adoption of drug testing programs. Significant differences also exist by type of industry, with federally regulated industries, such as utilities (91 percent) and transportation (81 percent), being most likely to have drug testing programs.

Implementing drug-testing programs to identify abusers is only part of the process. A testing program needs to be combined with workplace education, changes in attitudes and structures in the organization, and treatment and rehabilitation alternatives available through EAPs for employees who are discovered to have a problem.

NIDA's DRUG-FREE WORKPLACE INITIATIVE In February 1987, NIDA established the Office of Workplace Initiatives (OWI). The OWI develops policies and provides leadership for the implementation and administration of a national program to eliminate illegal drug use in the workplace. Its programs include research, treatment, training, and prevention activities as well as projects related to the development of a comprehensive Drug-Free Workplace program which includes policy development, supervisory training, employee education, employee assistance, and drug testing components.

(more)

OWI has developed Mandatory Guidelines for Federal Workplace Drug Testing Programs which include Scientific and Technical Requirements and Certification Standards for Laboratories Engaged in Urine Drug Testing for Federal Agencies. In addition, OWI is:

- * fostering research to determine the extent and nature of drug abuse in the workplace
- * performing cost-benefit analyses of comprehensive drug-free workplace programs
- * analyzing and recommending EAP policy models for employers
- * developing guidelines for a comprehensive federal EAP program
- * publishing and disseminating a drug abuse curriculum for EAP practitioners
- * filming and distributing a four-part videotape series on drugs at work
- * publishing and disseminating a directory of educational resources in the employee assistance area.

RESOURCES

RESEARCH GRANTS NIDA supports research on the prevalence, impact, and treatment of drug abuse in the workplace through its research grant program. Information on the grant application process can be obtained from the Grants Management Office, NIDA, Room 10-25, 5600 Fishers Lane, Rockville, MD 20857. Information and consultation on specific research topics can be obtained from the Office of Workplace Initiatives, NIDA, Room 10-A-53, 5600 Fishers Lane, Rockville, MD 20857.

NIDA'S WORKPLACE HELPLINE NIDA has established a toll-free "helpline" to provide information to employers. The number is 800-843-4971, and operates Monday through Friday from 9 a.m. to 8 p.m. Eastern Time. Staff members provide consultation to employers about initiating a company policy which covers such efforts as an employee education program, urine testing programs, and establishing an EAP to deal with drug-related problems of employees.

NIDA also operates a toll-free Drug Abuse Information and Treatment Referral Line - 1-800-662-HELP to provide individuals with drug related information, and facilitate the placement of drug users in treatment programs.

VIDEOTAPES "Drugs at Work" is the first program in a four-part videotape series on drug abuse in the workplace, promoting awareness of the important issues involved and providing valuable information for the development of effective workplace programs to address the problem of drug abuse on the job. Policy development, drug testing, employee assistance programs, prevention, and education are discussed.

"Getting Help" is the second program; it addresses the significant role of EAPs in the reduction of drug abuse in the workplace. It describes the responsibility of the workplace to the employee and the key components of an effective EAP, including education, training, referrals, and followup services.

(more)

PUBLICATIONS

Employee Drug Screening: Detection of Drug Use by Urinalysis. An informative booklet in a question and answer format which addresses many of the most asked questions about drug testing in the workplace.

Urine Testing for Drugs of Abuse. This publication (NIDA Research Monograph No. 73) provides technical and scientific information that will assist in the planning and implementation of drug testing programs. Chapters address the methodology used for urinalysis, how to ensure accuracy in such analyses, and the background to help in interpretation of assay results.

Guidelines for the Development and Assessment of a Comprehensive Federal Employee Assistance Program. Presents goals for a comprehensive Federal EAP to strive to achieve and a suggested model for many private sector employees to use as applicable to their workplaces. The Guidelines, which include a monitoring tool, will assist EAPs in verifying data, defining problems, and implementing remedies.

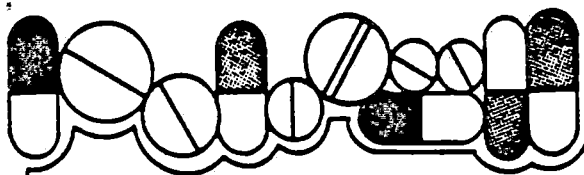
Directory of Academic Institutions and Organizations: Drug, Alcohol, and Employee Assistance Program Educational Resources. A national directory of educational opportunities on subjects relevant to employee assistance, covering academic institutions, national organizations, and State alcohol and drug abuse agencies.

Drug Abuse Curriculum for Employee Assistance Professionals. Designed to assist EAP professionals in understanding and addressing employee drug abuse problems. Its purpose is to upgrade the knowledge and skills of EAP staff regarding the role of the EAP in identification, referral, and treatment of individuals evidencing problems associated with drug use, and to show them how to use organizational initiatives for prevention, education, and training regarding drug abuse.

Strategic Planning for Workplace Drug Abuse Programs. A guide to help employers through the process of planning and organizing anti-drug abuse programs. The guide addresses the needs, rights, and responsibilities of both employees and companies in attacking drug abuse.

Copies of these and other publications on drugs as well as the videotapes may be obtained from the National Clearinghouse for Alcohol and Drug Information, PO Box 2345, Rockville, MD 20852.

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NIDA's DRUG-FREE WORKPLACE HELPLINE 1-800-843-4971

In January 1987, the National Institute on Drug Abuse (NIDA) established a toll-free Drug-Free Workplace Helpline to answer questions and provide technical assistance to business, industry and unions about the development and implementation of a comprehensive drug-free workplace program. Corporate executive officers (CEO's), union representatives and managers responsible for corporate policy are encouraged to call the Helpline for assistance in assessing their needs and to prepare their organizations to deal with current or potential problems caused by drugs in the workplace.

WHAT THE HELPLINE CAN DO FOR YOUR COMPANY

NIDA is in the unique position of communicating with corporate America about workplace drug abuse concerns by providing a national focal point for the dissemination of information. The Helpline provides telephone consultation, resource referrals, networking services, and publications to assist in planning, policy development and program implementation. Helpline information specialists have been trained to give information specific to your organization over the phone. Depending on the needs of the caller, the Helpline staff provides information, publications and referrals on the subjects of how to:

- * Assess drug abuse in an organization
- * Develop and implement a drug abuse policy
- * Choose an employee assistance program (EAP) model that is compatible with their individual organizations
- * Implement employee education and supervisory training
- * Evaluate the effectiveness of a drug abuse program in terms of cost and human factors
- * Understand the technical, legal and employee relations aspects of drug testing
- * Identify signs and symptoms of drug abuse.

When appropriate, they suggest networking with other public and private organizations who can serve as resources and provide additional services. In addition, a variety of written information pertinent to the fight against drugs in the workplace is available from the Helpline staff upon request. There are 26 different publications currently being sent to organizations of all sizes, the latest being Strategic Planning for Workplace Drug Abuse Programs, published by NIDA.

-more-

C-87-01

Revised September, 1988

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WHAT THE CALLS HAVE COVERED SO FAR

The Helpline has received over 9,500 calls as of September 1988. It averages more than 600 calls per month, and 62 percent of these have been from managers and first line supervisors--the decision makers of their organizations. Other callers include employees and professionals from the employee assistance and drug testing fields. Of those calling from the business world, the majority are from companies with less than 250 employees.

While callers have different situations and questions, the most common problems raised are drug testing, employee assistance programs and supervisory training. Often a caller requests information about only one topic, such as drug testing. But the Helpline staff will take the opportunity to talk about related issues like corporate policy, EAPs and supervisory training, so that the caller has a more realistic understanding of a comprehensive program.

HOW ORGANIZATIONS LEARN ABOUT THE HELPLINE

The Workplace Helpline has been advertised extensively in the media so that employers may be aware of the Helpline and what it does. It is being promoted through a national campaign sponsored by the Media-Advertising Partnership for a Drug-Free America. The Partnership aims to reshape social attitudes about illegal drug use; as such, they develop and publish, as a public service, full-page ads urging CEO's, union representatives, and managers to call the Helpline. These ads appear weekly in such publications as the Wall Street Journal and the New York Times.

The Helpline operates from 9:00 a.m. to 8:00 p.m. (Eastern Time), Monday through Friday.

For further information about the Helpline, call the National Institute on Drug Abuse, (301) 443-0802.



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MANDATORY GUIDELINES FOR FEDERAL DRUG TESTING PROGRAMS

Mandatory Guidelines for Federal Drug Testing Programs, which prescribe procedures and standards for conducting drug testing of Federal employees, were published in the Federal Register on April 11, 1988.

The Guidelines establish comprehensive standards and procedures for all aspects of drug testing, including procedures for collecting urine specimens, the drugs employees may be tested for and eligibility standards for certifying laboratories engaged in drug testing for Federal agencies.

The Guidelines were developed in accordance with Executive Order 12564, Drug-Free Federal Workplace, issued by the President on September 15, 1986, and Public Law 100-71, which establish requirements for Federal agencies and employees in order to obtain a drug-free Federal workplace.

The Mandatory Guidelines incorporate the Scientific and Technical Guidelines for Federal Drug Testing Programs (Guidelines) first released by HHS in February 1987 and the proposed Standards for Certification of Laboratories Engaged in Urine Drug Testing (Standards). In response to PL 100-71, the Guidelines and Standards were published in the Federal Register on August 14, 1987. Comments on the proposed Guidelines and Standards were received from approximately 150 individuals, organizations and Federal agencies. The comments were reviewed and considered in developing the final Mandatory Guidelines.

Highlights of the Mandatory Guidelines include:

DRUGS TO BE TESTED -- The Guidelines require Federal drug testing programs to test, at a minimum, for marijuana and cocaine and also authorize testing for opiates, amphetamines and phencyclidine (PCP). When conducting tests based on reasonable suspicion, accident or unsafe practice, an agency may test for any drug listed in Schedule I or II of the Controlled Substances Act.

SPECIMEN COLLECTION PROCEDURES -- The Guidelines specify procedures for collecting urine specimens to ensure privacy of employees, unless the agency has reason to believe that an individual may alter or substitute the specimen to be provided.

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April, 1988

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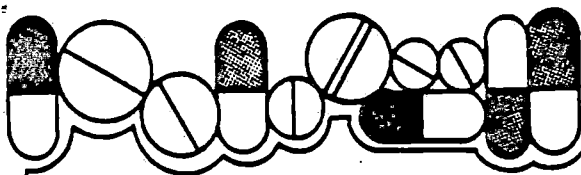
LABORATORY ANALYSIS PROCEDURES -- The Guidelines specify standards which require the use of the best available technology for ensuring the full reliability and accuracy of drug tests and strict procedures governing the chain of custody of specimens collected for drug testing. When an initial screening test shows the presence of illegal drugs, the Guidelines require a confirmatory test of a specimen using gas chromatography/mass spectrometry techniques. Results will be reported as positive only when both the initial and confirmatory tests are positive.

LABORATORY CERTIFICATION -- The Guidelines establish criteria for certification and revocation of certification of laboratories performing drug testing and appropriate standards and procedures for periodic review of laboratories. Certification standards are included to ensure that laboratories engaged in Federal employee drug testing achieve maximum accuracy of test results to protect the rights of the Federal employees being tested.

HANDLING TEST RESULTS -- The Guidelines also require each agency to have a physician with knowledge of substance abuse disorders to serve as a Medical Review Officer (MRO). The MRO will review all positive test results with the employee to determine whether alternative medical factors could account for the result. This review must occur prior to the transmission of results to agency administrative officials. If alternative medical factors are found by the MRO to be the cause of a positive test result, this test would be reported as negative. The Guidelines require that employees with positive test results be referred by the MRO to the Employee Assistance Program.

The Guidelines do not apply to drug testing under any legal authority other than Executive Order 12564 and do not apply to testing of military service personnel or applicants to the military.

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DRUG ABUSE TREATMENT*

Dependence on alcohol or other drugs is a chronic relapsing disease. The 1985 National Household Survey on Drug Abuse shows that about 23 million Americans currently use illicit drugs. Over 6.5 million people are severely dependent on heroin, other opiates, amphetamines, and cocaine. In addition, about 1.2 million people who use intravenous drugs are at risk to HIV infection or transmission through needle-sharing, sexual relations, or perinatally. Those who are severely dependent most often need drug abuse treatment to become healthy again.

To measure the effects of treatment, one must use graded measures of change. It is reasonable to think in terms of remissions rather than cures. Pneumonia can be cured. Successful treatment for arthritis, diabetes, drug dependence and other chronic diseases can be measured by reductions in symptoms, improvement in ability to function, or reductions in costs to society.

There are many different types of drug dependent persons. Patients differ in many ways, not just according to drug of choice. Some important variables include presence or absence of psychiatric disorders such as depression, anxiety or other illnesses. Other dimensions include educational or occupational achievements, family/social support systems, family history (genetics). Correct diagnosis is essential to selecting the right treatment.

A wide range of treatments are available. A partial listing includes:

Drug-Free Treatments

- Therapeutic Community
- Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous and others
- Psychotherapy of various types including supportive-expressive, cognitive/behavioral, family therapy and others
- Behavior Therapy specifically aimed at prevention of relapse

Treatments Aided by Drugs

- Methadone Maintenance
- Naltrexone (nonaddicting narcotic antagonist)
- Antabuse (blocker of alcohol metabolism)
- Psychoactive medication when indicated

* Based on Presentation by Charles P. O'Brien, MD, Ph.D.,
Chief of Psychiatry, Philadelphia Veterans Medical Center,
June 23, 1988, Washington, D.C.

Treatment Effectiveness

Since the 1960's, four major treatment modalities have been developed to treat heroin addiction. These modalities vary from program to program but generally may be described as follows:

Therapeutic Communities: These are full-time, drug free residential programs. Time in treatment often extend well beyond a year. These communities are highly organized and provide, for example, peer support and confrontation, counseling, and residential job functions. The goal of this treatment is to persuade the client to abandon antisocial and self-destructive behavior and pursue a mature and productive way of life.

Methadone Maintenance: This approach involves replacing street heroin with methadone, a synthetic opiate that allows clients to stabilize themselves physiologically such that they can explore alternative ways of functioning. This modality is usually provided on an outpatient basis. Time in treatment varies, although many clients stay in treatment a year or more.

Outpatient Drug Free: This modality provides treatment for abusers of both opioids and nonopioid drugs. Programs vary widely in duration, goals, and content. At one extreme are highly organized programs operated as daytime therapeutic communities, at the other extreme are more relaxed programs that offer group therapy sessions, recreational activities, and help with personal problems.

Detoxification: This may be inpatient or outpatient, but typically is outpatient. It is intended help patients achieve abstinence gradually (using methadone in decreasing doses) without severe symptoms. Since 1974, detoxification programs involving methadone were limited to 21 days (Narcotics Addicts Treatment Act of 1974, P.L. 93-281). New legislation, however, has authorized detoxification regimens lasting up to 180 days to provide an opportunity to engage patients into longer term treatment programs.

A number of studies evaluating the effectiveness of these modalities have been conducted. In general, they confirm that a high percentage of individuals show significantly improved behaviors consequent to leaving treatment. The behavioral criteria used to evaluate treatment effectiveness looks at: diminution in drug use, diminution in criminal activity, and increased productive activity.

Patient Treatment Matching

As with all treatments in medicine and surgery, not all treatments work for all patients. Rather a treatment should be selected based on the needs of the specific patient. Also, combinations of treatment are often necessary. Much more research is needed in this area, although we do have some data. For example, opioid dependent patients with high severity psychiatric disorders should not be treated in drug-free therapeutic communities. They may actually worsen under certain treatments, but they respond well to methadone maintenance with supportive psychotherapy and psychoactive medication as needed. Opioid dependent patients without significant psychiatric disorders do equally well on methadone maintenance with nonprofessional drug counseling as with professional psychotherapy provided by a psychiatrist or psychologist.

Training and Skill of Therapist

Although there is a wide range of effective treatments available, there is a great lack of clinicians with training in the proper diagnosis and treatment of addictive disorders. Also, some treatment programs are understaffed or are staffed by poorly trained individuals. One study showed a ten fold variation in the availability of physicians among methadone programs. It is not surprising that not all methadone programs are equally effective. Good methadone programs have been found to be highly effective because they provide excellent counseling, psychotherapy and other treatments as needed. Poorly staffed methadone programs or those staffed by untrained individuals may be relatively ineffective.

Cost-Effectiveness Studies

The cost of substance abuse to our society is enormous. Treatment studies now often measure the cost of treatment versus the gains in productivity when the former patient returns to the work force. Relatively few studies have been so far completed, but they support the economic benefits of substance abuse treatment. One study conducted within the Veterans Administration has actually shown the increased benefits and reduced cost of treatment (average savings of \$3700 per patient) when patients are matched to the correct treatment.

Conservation of Treatment Resources

Not all patients need expensive inpatient treatment. Some can do just as well with a brief period of inpatient care and then outpatient or day treatment. Others can be treated completely as out patients. It is

important to conserve the available treatment resources for the long term prevention of relapse. Outpatient treatment is seven to ten times less expensive than inpatient care. All patients should be seen for a minimum of six months and preferably for two years or longer. With modern treatment, patients can often return to work quickly and continue rehabilitation or relapse-prevention treatment.

Cocaine Dependence

The widespread inexpensive availability of cocaine is a new phenomenon. Treatment programs have not faced this kind of cocaine dependence before and thus we have no backlog of experience and data to draw from. Our initial results suggest that there are short term methods available to help patients go into a remission from cocaine dependence and achieve a period of abstinence. However, we already know that dependence is very common and sometimes very rapid. Some of the new treatment techniques involve medication which may help to correct some of the new biochemical disturbances produced by heavy cocaine use. But we have no information about long term success rates.

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HIGHLIGHTS OF NATIONAL ADOLESCENT SCHOOL HEALTH SURVEY

DRUG AND ALCOHOL USE

The National Adolescent School Health Survey was conducted in the Fall of 1987 and included approximately 11,000 eighth and tenth grade students from public and private schools. The survey included questions on illicit drug use, cigarette and alcohol use, suicide and depression, violence, AIDS, sexually transmitted diseases and nutrition. The following highlights pertain to findings on illicit drug use, and cigarette and alcohol use.

CIGARETTE USE

- o 51% of 8th grade students and 63% of 10th grade students report having tried cigarettes, and 16% of 8th grade students and 26% of 10th grade students report having smoked a cigarette during the past month.
- o Nearly equal numbers of boys and girls report ever trying cigarettes (girls 58% boys 57%) as well as smoking during the past month (girls 23% boys 20%).
- o 12% of boys and 1% of girls reported having chewed tobacco or used snuff during the past month.
- o Of those students who have tried cigarettes, 72% of the 8th grade students and 41% of the 10th grade students report first use by grade 6 or before.

ALCOHOL USE

- o 77% of 8th grade students have tried alcohol and of these, 55% report first trying it by grade 6. 89% of 10th grade students report having tried an alcoholic beverage; of these, 69% report first use by grade 8.
- o 34% of 8th grade students and 53% of 10th grade students report having had an alcoholic beverage during the past month.
- o 26% of 8th grade students and 38% of 10th grade students report having had five or more drinks on at least one occasion during the past two weeks.
- o 13% of 8th grade students and 18% of 10th grade students report using a combination of alcohol and drugs on one or more occasions during the past month.

MARIJUANA USE

- o 15% of 8th grade students report having tried marijuana and of these, 44% report first use by grade 6. 35% of 10th grade students report having tried marijuana with 56% of them reporting first use by grade 8.
- o 6% of 8th grade students and 15% of 10th grade students report having used marijuana during the past month.
- o Past month marijuana use was reported by 10% of the girls and 12% of the boys.
- o 4% of the students report having used marijuana 6 or more times during the past month.

COCAINE USE

- o 5% of 8th grade students and 9% of 10th grade students report having tried cocaine. 2% of 8th grade students and 3% of 10th grade students report having used cocaine during the past month.
- o Of those who have tried cocaine, approximately one-third have tried crack. 2% of 8th grade students and 3% of 10th graders report having tried the crack form of cocaine.
- o Of those students who have tried cocaine, 62% of the 8th grade students report first trying it in grades 7 or 8, and 76% of the 10th grade students report first trying it in grades 9 or 10.

INHALANT USE

- o 21% of both 8th and 10th grade students report having tried inhalants (glues, gases, sprays). Of those students who have tried inhalants, 61% of the 8th grade students report first use by grade 6 and 78% of the 10th grade students report first use by grade 8.
- o 7% of the 8th grade students and 5% of the 10th grade students report inhalant use during the past month.

PERCEPTION OF RISK

- o 86% of the students perceive a moderate or great risk from smoking cigarettes on a daily basis.
- o 80% of the students perceive a moderate or great risk from the regular use of alcohol.
- o 81% of the students perceive a moderate or great risk from occasional use of marijuana; 88% from cocaine powder; and 77% perceive a moderate or great risk from occasional use of inhalants.

PEER DISAPPROVAL OF DRUG USE

- o 76% of the students report that their close friends would disapprove if they smoked a pack of cigarettes each day.
- o 74% of the students report that their close friends would disapprove if they drank alcohol regularly; however, slightly less than half (43%) think that their close friends would disapprove if they drank alcohol occasionally.
- o 81% of the students report that their close friends would disapprove if they smoked marijuana occasionally and 93% would disapprove if they used cocaine occasionally.

OTHER FINDINGS

- o 86% of the students report that it would be fairly or very easy for them to get cigarettes, 84% for alcohol; 57% for marijuana; and 27% report that it would be easy for them to get cocaine.
- o 79% of the 8th grade students and 88% of the 10th grade students report having received instruction in school on the effects of drugs and alcohol.

Lifetime Prevalence for Selected Drugs Among 8th, 10th, and 12th Grade Students* 1987

	Percent Who Ever Used		
	<u>8th graders</u>	<u>10th graders</u>	<u>12th graders</u>
Alcohol	77	89	92
Cigarette	51	63	67
Marijuana	15	35	50
Cocaine	5	9	15
Crack**	2	3	6
Inhalants	21	21	17

* Data on 8th and 10th grade students is from the National Adolescent Student Health Survey. Data on 12th graders is from the High School Senior Survey.

** Reflects a subset of any use of cocaine.

NIDA



NATIONAL INSTITUTE
ON DRUG ABUSE

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DRUG ABUSE IN THE WORKPLACE

VIDEOTAPE SERIES

Drugs At Work, Getting Help, and Drug Testing: Handle With Care, are three videotapes in a series on drug abuse in the workplace.

Drugs At Work is a 23 minute educational documentary which describes costs of drug use for the workplace, the individual, and the public; and examines action being taken by government and private companies. It provides information for developing effective drug abuse workplace programs through policy development, drug testing, employee assistance programs, prevention, and education. Interviews with drug users who have sought treatment and with experts on drugs in the workplace are included; and government and industry representatives describe federal and corporate programs currently underway. Drugs At Work is an important program for all levels in the workplace, from top management to line staff.

Getting Help presents detailed information about the use of Employee Assistance Programs (EAPs) in addressing drug use in the workplace. The film describes the value of EAPs to employees and employers through comments by business, labor, and government leaders, and EAP professionals; presentation of three model programs; and EAP client interviews. It encourages employers to consider EAPs as a tool in combatting drugs at work, and provides employees with reassuring information about the confidentiality and effectiveness of an EAP program.

Drug Testing: Handle With Care describes the options available in designing a drug testing component as part of a comprehensive drug-free workplace program. Procedures addressing the needs of both the employer and the employee, to ensure the accuracy and reliability of test results, for specimen collection and laboratory analysis, and a discussion of the critical role of the Medical Review Officer (MRO) are highlighted. Case studies of public/private, unionized/nonunionized work environments with testing components are presented.

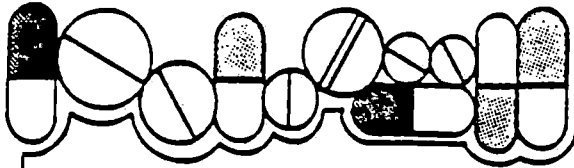
Available in both employer and employee versions, the videotapes are designed to be part of a comprehensive workplace drug abuse program. The fourth in the series, drug abuse prevention and employee education, is expected to be available this summer.

The videotapes are available on free loan from Modern Talking Picture Service Scheduling Center, 5000 Park Street, North, St. Petersburg, FL 33709, (813) 541-5763. They are available for purchase from National Audio Visual Center, Customer Service Section, 8700 Edgeworth Drive, Capital Heights, MD 20743-3701, (301) 763-1896.

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SUBSTANCE ABUSE AMONG HISPANIC AMERICANS

- Nearly 3.7 million Hispanics have used an illicit drug at least once in their lifetimes. (Source: Household Survey)
- Hispanic teenagers aged 12-17 years are more likely than white or black youth to have used cocaine at least once during their lifetimes, during the past year, or during the past month. (Source: Household Survey)
- Drug abuse is an important factor associated with the high rate of school dropouts among Hispanics. Hispanics who are high school dropouts are more likely to use illicit drugs than those who are high school graduates. (Source: Current Research)
- AIDS is a severe problem among Hispanics due to intravenous drug use. While 7% of the total U.S. population is Hispanic, 15% of all adult AIDS cases and 23% of the pediatric AIDS cases are Hispanic. (Source: CDC)
- Data on treatment admissions from 15 States show that in 1985, 30% of the clients admitted to drug abuse treatment programs in 15 States were Hispanic; 44% of the primary PCP clients were Hispanic. (Source: CODAP)
- Hispanics who seek treatment are most likely to report problems with heroin, marijuana, and cocaine. (Source: CODAP)
- Hispanics accounted for 22% of emergency room episodes due to inhalants--a significant over-representation of that ethnic group compared with their numbers in the total population. (Source: DAWN)
- "Speedballing" (combining heroin and cocaine) and other drug combinations are a problem among Hispanics. (Source: DAWN)
- Cross-cultural comparisons of drug use have shown that Mexican Americans and Puerto Ricans are equally more likely than Cuban Americans to have ever used marijuana, cocaine, and inhalants. (Source: HHANES)

NIDA's toll free Hispanic Hotline number for drug abuse treatment referral is 1-800-66-AYUDA.

Household Survey: 1985 National Household Survey on Drug Abuse, NIDA.
HHANES: Hispanic Health and Nutrition Examination Survey (1982-4), NIDA, 1987.
Current Research: Drug Abuse Among Hispanic Youth (unpublished, 1989).
CDC: Centers for Disease Control, AIDS Surveillance Report (Feb. 20, 1989).
CODAP: Client Oriented Data Acquisition Process, 1985.
DAWN: Drug Abuse Warning Network, 1987.

C-89-02

FAVOR VOLTEAR PAGINA
PARA TRADUCCION EN ESPANOL

March 1989

Cap 30

ABUSO DE DROGAS ILICITAS EN LA POBLACION HISPANA

- Aproximadamente 3.7 millones de Hispanos han usado sustancias ilicitas por lo menos una vez en sus vida. (Fuente: Household Survey)
- El uso de la cocaína por lo menos una vez en la vida, durante el ultimo año o mes es mas frecuente entre los jovenes Hispanos de 12 a 17 años de edad que entre los jovenes americanos blancos y negros. (Fuente: Household Survey)
- Se ha determinado que el abuso de drogas esta relacionado con el alto porcentaje de estudiantes Hispanos que abandona sus estudios. Hispanos que deserta sus estudios consume drogas mas frecuentemente que aquellos que termina sus estudios. (Fuente: investigación en progreso)
- El SIDA es un problema severo entre la población Hispana debido a la autoadministración de drogas por via endovenosa. Aunque el 7% de la población estadounidense es Hispana, el 15% de los adultos y el 23% de los niños diagnosticado con el SIDA son Hispanos. (Fuente: CDC)
- Información sobre el número de admisiones a programas de tratamiento de drogas en 15 estados de los Estados Unidos en 1985 indica que el 30% de los clientes eran Hispanos. Además el 44% de los clientes admitidos a programas de tratamiento por el abuso de PCP eran Hispanos. (Fuente: CODAP)
- La mayoría de los Hispanos admitidos a programas de tratamiento de drogas son consumidores de heroína, cocaína y marijuana. (Fuente: CODAP)
- Hispanos representaron el 22% de admisiones a salas de emergencias en hospitales debido al consumo de inhalables - un porcentaje mas alto que el promedio de la población Hispana en los Estados Unidos. (Fuente: DAWN)
- El uso multiple de drogas como "Speedballing" (uso de heroína y cocaína en combinación) es un problema entre la población Hispana en los Estados Unidos. (Fuente: DAWN)
- Estudios sobre el uso de drogas en la población Hispana en los Estados Unidos han determinado que personas de origen Mejicano o Puerto Riqueño usa la marijuana, cocaína y los inhalables con mas frecuencia que la población Cubana. (Fuente: HHANES)

Para información sobre referencias a programas de tratamiento del abuso de drogas favor llamar gratuitamente al teléfono 1-800-AYUDA del NIDA.

Household Survey: 1985 National Household Survey on Drug Abuse, NIDA.

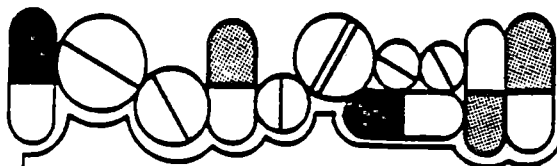
HHANES: Hispanic Health and Nutrition Examination Survey (1982-4), NIDA, 1987.

Investigación en progreso: Drug Abuse Among Hispanic Youth (unpublished, 1989).

CDC: Centers for Disease Control, AIDS Surveillance Report (Feb. 20, 1989).

CODAP: Client Oriented Data Acquisition Process, 1985.

DAWN: Drug Abuse Warning Network, 1987.



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DRUG ABUSE WARNING NETWORK

Emergency Room Cocaine Mentions

The following table lists the frequency of cocaine-related emergency room admissions and the percentage that involved smoking as the route of administering cocaine in 1988 compared with 1985. This data is collected by the National Institute on Drug Abuse (NIDA), through the Drug Abuse Warning Network (DAWN), a voluntary data collection system through which hospital emergency room (ER) and medical examiner (ME) facilities report information on medical crises and deaths related to improper use of drugs. Cocaine-related ER admissions listed below were reported from hospitals in 21 metropolitan areas throughout the country.

	<u>1988</u>		<u>1985</u>	
	Total Cocaine Mentions	Percent Involving Smoked Cocaine	Total Cocaine Mentions	Percent Involving Smoked Cocaine
Atlanta	596	23	172	6
Baltimore	1018	7	248	1
Boston	1173	18	323	4
Buffalo	419	24	43	0
Chicago	4019	23	757	10
Dallas	1152	23	158	1
Denver	641	16	243	2
Detroit	3309	54	1088	16
Los Angeles	2956	29	1640	35
Miami	519	31	1038	16
Minneapolis	378	28	136	4
Newark	1339	30	346	6
New Orleans	2827	41	512	2
New York City	7457	40	3347	4
Philadelphia	5831	31	717	6
Phoenix	981	8	123	5
San Diego	219	17	172	6
San Francisco	719	33	411	7
Seattle	952	19	244	9
St. Louis	534	25	78	6
Washington, D.C.	4467	39	894	4

C-89-01

February 1989

Cap 31

Capsules

Overcoming Barriers to Drug Abuse Treatment In The Community

The cocaine addiction crisis of the last few years and the spread of AIDS among intravenous drug users have focused attention on the increasing need for drug abuse treatment services in the local community. But responding to this need is not always easy even if financial resources are available. Communities often resist the building of new drug abuse treatment facilities despite the fact that many individuals in those communities need local, affordable treatment for themselves or a loved one.

The goal of this NIDA project is to develop a flexible education model for use by communities who have funding and want to establish drug treatment facilities. Local drug treatment personnel will receive NIDA-sponsored training to learn techniques that will help encourage support for and acceptance of drug treatment programs in their communities. This model will be used in communities to educate local people about drug treatment with the goal of countering resistance to the establishment of new treatment facilities.

The community education model program, which is to undergo a pilot test in late summer, will have 4 key elements:

- Critical theme--The model will be built on a critical theme and supporting messages concerning drug treatment and siting of facilities that are cohesive, well-documented, and scientifically sound.
- Flexible strategies--Drug treatment personnel will be able to choose appropriate strategies for conveying messages to people in their own communities about the need and importance of drug abuse treatment. The model will include specific techniques and background information on how to effectively implement the model.
- Media materials--A videotape documentary as well as radio, TV, and print ads and brochures will help drug treatment personnel educate community people about treatment.
- Training and technical assistance--NIDA will provide training to help communities use the model and its accompanying materials effectively. In 1989, the model will be evaluated after it undergoes a pilot test in four sites. During the next two years, NIDA will deliver training and technical assistance to implement the model in 20 sites.

Research has been conducted to obtain extensive input from experts and practitioners in Federal, State, and local government; the private sector; academia; and community-based programs and groups involved with drug treatment; public affairs and media relations; community organizing; and related fields. Specifically, the project has conducted:

- Interviews with all 55 Single State Agency directors for drug abuse;
- Interviews with 50 treatment programs across the country;
- Discussions with State mental health directors;
- Discussions with a wide variety of organizations active in the field;
- Extensive literature review and analysis;
- 20 focus groups in five cities around the country with serious drug problems;
- A 1 1/2 day meeting with practicing treatment experts to get recommendations on the model.

All of these research tracks pointed to the same key findings about why communities resist drug abuse treatment centers. The two biggest fears related to:

- Security--fear or concern that crime in the community will rise as a result of an influx of drug users;
- Property values--fear or concern that as a result of the treatment facility, property values will decline.

ON THE POSITIVE SIDE, the research showed that when people learn about drug abuse treatment and believe it works, they find centers more acceptable.

As this publication goes to press (May 1989), the project is starting to develop media materials that will be used as part of the community education model. These materials are focused on the theme that "drug treatment benefits the community" and will include:

- Videotape documentary;
- Television public service announcements;
- Radio public service announcements;
- Print advertisements;
- Brochures.

When the community education model is implemented, communities will be given training and technical assistance to learn how to: conduct a needs assessment; build networks and coalitions; work with community people and groups; develop a public relations strategy, including techniques for working with the press, and how to most effectively use the media materials.

For further information about the project, contact:

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Capsules

DRUG ABUSE AND PREGNANCY

Increasing numbers of women are abusing drugs during pregnancy and thus endangering the well-being and lives of their children as well as themselves. The spreading abuse of phencyclidine (PCP), cocaine, and its potent form "crack," added to the more well-known addictive narcotics such as heroin, has intensified concerns about the implications of maternal drug use for unborn children.

Some harmful effects are generally recognized. Cocaine use, for example, increases risk of hemorrhage and premature delivery, threatening the lives of mother and child. Babies exposed to narcotics in the womb are frequently born addicted, and the misery they suffer from withdrawal makes them difficult to care for, creating special demands on mothers who are often unable to take care of their children adequately. Other effects are less certain. Head size is often smaller in infants exposed to narcotics. While growth erases some of the physical differences, there may be subtle, long-term deficits in mental or neurological functioning in infants exposed to drugs in the womb.

Scientists are just beginning to explore how various drugs may affect the development of physical coordination, language, and emotional interactions. NIDA, through its clinical, epidemiological, and basic research programs, is increasing knowledge of immediate and long-term effects of drug use during pregnancy. NIDA grantees and others are designing and evaluating therapeutic programs to help these mothers and their children overcome the harm caused by drugs.

SCOPE OF THE PROBLEM

Evidence of increasing drug use among pregnant women comes from many parts of the country. NIDA estimates that of the women of childbearing age (15-44 years of age), 15 percent are current substance abusers. Approximately 34 million consume alcoholic beverages, more than 18 million are current cigarette smokers, and more than 6 million are current users of an illicit drug, of which 44 percent tried marijuana and 14 percent tried cocaine at least once.

A 1988 survey conducted by the National Association for Perinatal Addiction Research and Education, of 36 hospitals from across the country and representing approximately 155,000 pregnancies annually, found that on average, 11 percent of pregnant women used heroin, methadone, amphetamines, PCP, marijuana, and most commonly, cocaine. The researchers estimate that each year, as many as 375,000 infants may be affected by their mother's drug use.

C-89-04

June 1989

Cap 33

Dr. Barry Zuckerman and his colleagues at Boston University School of Medicine and Boston City Hospital conducted a study of 1,226 women who gave birth at the hospital between 1986 and 1988. Of this group, 27 percent of the women had smoked marijuana and 18 percent used cocaine. They found that marijuana users gave birth to babies who are three ounces lighter and one-fifth of an inch shorter than babies born to women who did not use marijuana, while the cocaine use was associated with still shorter and lighter infants.

Dr. Loretta P. Finnegan, director of the Family Center of Jefferson Medical College of Thomas Jefferson University in Philadelphia reports that in 1985, 7 percent of women at the center were found to have cocaine in their urine, and now urine screens show that 58 percent are using the substance.

EFFECTS ON THE PREGNANT MOTHER AND THE FETUS

Until relatively recently, NIDA's research on the effects of maternal drug use on fetal and infant development has focused on narcotics and drugs like methadone that is used in the treatment of narcotic addiction. As the abuse of cocaine, PCP, and other drugs grew, NIDA expanded this research program to non-narcotic drugs. NIDA's research in this area is intended to estimate incidence, prevalence, and patterns of use of illicit drugs among pregnant women, to identify the consequences of maternal drug use on the newborn, to identify the mechanisms underlying organic and behavioral effects resulting from exposure to drugs, and to develop strategies and procedures to prevent, ameliorate, or reverse these toxic effects and their developmental consequences.

A NIDA-supported study by Dr. Ira J. Chasnoff and his colleagues at Northwestern University's Perinatal Center for Chemical Dependence found that women injecting cocaine intravenously during pregnancy immediately experienced complications, including premature separation of the placenta from the womb, which causes hemorrhaging that threatens the lives of both mother and fetus. Another study found that cocaine-addicted women were twice as likely to suffer premature separation of the placenta as women dependent on other drugs and four times as likely as drug-free women to experience this complication. However, this risk is reduced if the pregnant woman discontinues cocaine use early in pregnancy. Isolated cases of birth defects have been associated with cocaine use during pregnancy; however, additional studies are needed to confirm these observations.

Cocaine can also precipitate miscarriage or premature delivery because it raises blood pressure and increases contractions of the uterus. Maternal cocaine use also endangers the fetus directly. Studies show that the drug constricts arteries leading to the womb. This constriction diminishes the amount of blood, and hence oxygen that reach the fetus. In one extreme case, cocaine apparently caused fetal stroke.

EFFECTS ON INFANTS

Knowledge of drug effects during the early months of life comes largely from studies of children born to women dependent on narcotics. Infants exposed to these drugs in the womb are often born addicted and undergo a characteristic withdrawal sequence called the Neonatal Abstinence Syndrome (NAS). Newborns with NAS show increased sensitivity to noise, irritability, poor coordination, excessive sneezing and yawning, and uncoordinated sucking and swallowing reflexes. If these symptoms persist, they require medication. NIDA-funded researchers are testing carefully controlled doses of phenobarbital, tincture of opium, and other substances to help infants withdraw from narcotics.

Research using ultrasound measurements also raises questions about the rate of brain growth in narcotic-exposed babies. The head circumference tends to be slightly smaller, although this difference soon disappears. By the time infants are six months old, there is little difference between drug-exposed babies and others in brain measurement. But concerns remain, since prenatal harm to these areas of the brain could affect mental functioning, such as memory, in later childhood. Some researchers find, moreover, that certain differences between drug-exposed and other infants persist, adding to concerns about long-term effects.

Other findings include increased risk for Sudden Infant Death Syndrome in which incidence among cocaine exposed infants in the Chicago study was 17 percent as compared to 1.6 percent in the general population and four percent in infants of mothers maintained on methadone. Assessment at four months of age indicate that the cocaine-exposed infants are at considerable risk for motor dysfunction. Data on 30 full-term cocaine-exposed infants and 50 full-term non-drug exposed infants indicate a significant difference in mean total risk scores with 72 percent of the control group infants in the "no risk" category, while 43 percent of the cocaine-exposed infants, were designated "high risk" for motor developmental dysfunction. The infants will be followed to three years of age.

LONG-TERM EFFECTS

The epidemic of drug abuse among pregnant women is recent enough that investigators are only now having the opportunity to follow groups of children over several years and thus generalize about more far-reaching effects. Some of the preliminary findings are encouraging. Children at age two to five born to methadone-maintained women seem comparable in intelligence to youngsters of drug-free mothers. However, despite scoring in the normal range for overall intelligence, these children seem to run increased risk of learning disabilities and delayed motor, speech, and language development.

Effective drug intervention programs for drug-dependent mothers and their children may be essential to promoting the youngster's emotional and intellectual well-being. Dr. Judy Howard at the University of California, Los

Angeles, is assessing the benefits of a program using a pediatrician, a public health nurse, and a social worker to contact homes regularly to offer information, advice, and referrals to medical and other services. In addition, an infant development specialist works with the children on development skills while a specialist helps mothers and foster parents become sensitive to the child's level of stress and state of well-being.

The increasing use of drugs by women of childbearing age, the greater numbers of children being born to drug-abusing women, and the environment in which these infants are reared all lend added urgency to conduct additional research in these critical areas.

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DATE 9-2

TO Jim Burke

FAX NUMBER (516) 537-3456

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COMMENTS I hope you like this draft
and I'm anxious for your comments.
Have a great weekend. Thanks! Cmm

FROM Christina Martin

FAX NUMBER 202-456-6218

OFFICE NUMBER 202-456-7750

Christina

08/31/89 14:02:22

SPEECHWRITING AND RESEARCH OFFICES
DAILY PRESIDENTIAL SPEECH SCHEDULE

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EVENT/LOCATION	DATE	PROJ.OFFICER	WRITER/RESEARCH	C.W. DRAFT	STAFFING	TO POTUS
Drug Speech	09/05/89 Tuesday		Davis Martin	08/25/89 Friday	08/28/89 Monday	08/28/89 Monday
American Legion 71st Conven. Baltimore, M.D.	09/07/89 Thursday		Smith Blessey	08/24/89 Thursday	08/25/89 Friday	08/28/89 Monday
National Baptist Convention New Orleans, Louisiana	09/08/89 Friday		Davis Martin	08/25/89 Friday	08/29/89 Tuesday	08/30/89 Wednesday
U.S. Hispanic C of C	09/08/89 Friday		Smith Blessey	09/05/89 Tuesday	09/06/89 Wednesday	09/07/89 Thursday
Treasury Depart. 200th Anniv. Treasury Building	09/11/89 Monday		McGroarty Dooley	09/05/89 Tuesday	09/07/89 Thursday	09/08/89 Friday
United Way Video	09/11/89 Monday		McGroarty Dooley	09/07/89 Thursday	09/08/89 Friday	09/08/89 Friday
Vocational Education Event Rose Garden	09/11/89 Monday	S.Siv	Grant Simon	09/05/89 Tuesday	09/06/89 Wednesday	09/07/89 Thursday
Schools Speech	09/12/89 Tuesday		Lange TBD	09/05/89 Tuesday	09/07/89 Thursday	09/08/89 Friday
D.A.R.E. Event	09/13/89 Wednesday		Davis Martin	09/06/89 Wednesday	09/08/89 Friday	09/11/89 Monday

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SPEECHWRITING AND RESEARCH OFFICES
DAILY PRESIDENTIAL SPEECH SCHEDULE

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EVENT/LOCATION	DATE	PROJ.OFFICER	WRITER/RESEARCH	C.W. DRAFT	STAFFING	TO POTUS
King Fahd of Saudi Arabia	09/14/89 Thursday	B. Scowcroft	Smith Blessey	09/07/89 Thursday	09/11/89 Monday	09/12/89 Tuesday
Presidential S.E.S. Awards Constitution Hall	09/14/89 Thursday	D. Bates	McNally Simon	09/07/89 Thursday	09/11/89 Monday	09/12/89 Tuesday
A. Sioux Falls Centennial Sioux Falls, South Dakota	09/18/89 Monday		McNally Simon	09/11/89 Monday	09/13/89 Wednesday	09/14/89 Thursday
B. Montana Centennial	09/18/89 Monday		McGroarty Dooley	09/11/89 Monday	09/13/89 Wednesday	09/14/89 Thursday
Spokane Washington	09/19/89 Tuesday		Lange TBD	09/12/89 Tuesday	09/14/89 Thursday	09/15/89 Friday
Young America Medals Rose Garden	09/21/89 Thursday		Davis Martin	09/14/89 Thursday	09/18/89 Monday	09/19/89 Tuesday
200th Anniv. Attorney General Department of Justice	09/22/89 Friday		McNally Simon	09/11/89 Monday	09/13/89 Wednesday	09/14/89 Thursday
Courter Fundraiser New Jersey	09/22/89 Friday		Smith Blessey	09/15/89 Friday	09/18/89 Monday	09/20/89 Wednesday

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SPEECHWRITING AND RESEARCH OFFICES
DAILY PRESIDENTIAL SPEECH SCHEDULE

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EVENT/LOCATION	DATE	PROJ.OFFICER	WRITER/RESEARCH	C.W. DRAFT	STAFFING	TO POTUS
Red Mass Luncheon Boston, Mass.	09/23/89 Saturday		Grant Martin	09/15/89 Friday	09/18/89 Monday	09/20/89 Wednesday
U.N. General Assembly New York City	09/25/89 Monday		McGroarty Dooley	09/06/89 Wednesday	09/18/89 Monday	09/20/89 Wednesday
Amer. Film Institute Pension Building	09/26/89 Tuesday	Studdert/Demare	Smith Blessey	09/19/89 Tuesday	09/21/89 Thursday	09/22/89 Friday
Governors Educational Summit TBD	09/27/89 Wednesday		Davis Martin	09/13/89 Wednesday	09/14/89 Thursday	09/15/89 Friday
World Bank/Intern. Monetary Fund Annual Meeting Sheraton Washington Hotel	09/27/89 Wednesday	D.Bates	McNally Simon	09/20/89 Wednesday	09/22/89 Friday	09/25/89 Monday
Retirement Adm. Crowe	09/29/89 Friday		McGroarty Dooley	09/22/89 Friday	09/25/89 Monday	09/26/89 Tuesday
Midland Community Award	10/00/89 TBD		TBD TBD			
NRSC Inner Circle Gala Union Station	10/02/89 Monday	Andy Card		09/25/89 Monday	09/27/89 Wednesday	09/28/89 Thursday

08/31/89 14:02:33

SPEECHWRITING AND RESEARCH OFFICES
DAILY PRESIDENTIAL SPEECH SCHEDULE

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EVENT/LOCATION	DATE	PROJ.OFFICER	WRITER/RESEARCH	C.W. DRAFT	STAFFING	TO POTUS
Salinas State Dinner	10/03/89 Tuesday	B. Scowcroft	Smith Blessey	09/26/89 Tuesday	09/28/89 Thursday	09/29/89 Friday
Coleman Fundraiser N. Virginia	10/04/89 Wednesday		Smith Blessey	09/27/89 Wednesday	09/29/89 Friday	10/02/89 Monday
Cossiga State Visit	10/11/89 Wednesday		McGroarty Dooley	10/04/89 Wednesday	10/06/89 Friday	10/09/89 Monday
Italian Society Dinner	10/14/89 Saturday		McGroarty Dooley	10/06/89 Friday	10/10/89 Tuesday	10/11/89 Wednesday
RGA President's Dinner TBD	10/17/89 Tuesday	A.Card		10/10/89 Tuesday	10/12/89 Thursday	10/13/89 Friday
International Drug Conference Costa Rica	10/27/89 Friday		McNally Simon	10/20/89 Friday	10/24/89 Tuesday	10/25/89 Wednesday
Governor Martinez Funder Tampa, Florida	12/01/89 Friday	Andy Card		11/24/89 Friday	11/28/89 Tuesday	11/29/89 Wednesday
NAACP Fundraising Gala New York City, New York	12/15/89 Friday			12/08/89 Friday	12/12/89 Tuesday	12/13/89 Wednesday

08/31/89 14:02:37

SPEECHWRITING AND RESEARCH OFFICES
DAILY PRESIDENTIAL SPEECH SCHEDULE

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EVENT/LOCATION

DATE

PROJ.OFFICER

WRITER/RESEARCH

C.W. DRAFT

STAFFING

TO POTUS

President D. Eisenhower B-day 10/14/90