Originally Processed With FOIA(s): **FOIA Number:**
S

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the George Bush Presidential Library Staff.

Record Group/Collection: George H.W. Bush Presidential Records
Collection/Office of Origin: Speechwriting, White House Office of
Series: Davis, Mark, Files
Subseries: Subject File, 1989-1991

OA/ID Number: 13873
Folder ID Number: 13873-007

Folder Title:
National Conference of State Legislators, 3/10/89[1]

Stack:	Row:	Section:	Shelf:	Position:
G	19	2	6	6

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

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

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

EMBARGOED FOR RELEASE AT 10 A.M. EST
Tuesday, February 28, 1989

CONTACT: Mona Whittaker
(301) 443-6245

Dr. Frederick K. Goodwin, administrator of the Alcohol, Drug Abuse and Mental Health Administration, today released results of the national survey of drug abuse among the high school senior class of 1988, which show drug use in this population at its lowest level since the survey began in 1975, including significant decreases in cocaine use for the second year in a row.

From 1987 to 1988, the proportion of seniors who have used cocaine at least once in their lifetime dropped by one-fifth, from 15 percent in 1987 to 12 percent in 1988. "Current use" of cocaine (at least once in the last 30 days) also declined from 4.3 percent in 1987 to 3.4 percent in 1988.

"This news about the decrease in cocaine use is encouraging," Dr. Goodwin said, "but the survey found that 40 percent of seniors who tried cocaine also have used crack, a smokeable and highly addictive form of cocaine. Fortunately, crack use may also be moving in the right direction. Those reporting using it at least once decreased from 6 percent in 1987 to 5 percent in 1988."

Dr. Charles R. Schuster, director of the National Institute on Drug Abuse, a component of ADAMHA and sponsor of the survey, said, "We can safely say that these decreases suggest that high school seniors, a very important population to the future of our country, are hearing the messages about cocaine's dangers and are avoiding drug use in general. While crack cocaine is very available, seniors appear to be concerned about its addictive qualities and are less likely to try or continue use."

(more)

This is the 14th in a series of national surveys conducted annually since 1975 by the University of Michigan Institute for Social Research under grants from NIDA.

In addition to cocaine, the 1988 survey found a decrease in the proportion of seniors who said they had "ever used" each of the other 18 drugs included in the survey. Furthermore, there was a significant reduction in those reporting current use of any illicit drug, from 25 percent in 1987 to 21 percent in 1988. Dr. Schuster noted, however, that 54 percent of seniors had tried an illicit drug by the time they graduated from high school. And large percentages of young people are still experimenting and using many illicit drugs, including marijuana, stimulants and inhalants, he said.

Marijuana use decreased significantly between 1987 and 1988, yet the rate "remains unacceptably high, especially in light of recent data on its harmful effects on brain functioning," Dr. Schuster said. In the class of 1988, 47 percent of seniors reported use at least once, 33 percent reported use in the past year and 18 percent reported use in the past 30 days. The 1988 survey also reports 20 percent of seniors used stimulants and 18 percent used inhalants at least once.

Despite a steady decline in drug use among high school seniors, there are still large subgroups in the general population whose drug use patterns are becoming more compulsive and more damaging. Dr. Schuster said, "We're very concerned about these subgroups, especially adolescents who are dropping out of school and becoming involved with drugs. We have heard of major metropolitan areas reporting dropout rates as high as 40 to 50 percent. These young people are more likely to become involved with the criminal justice system and experience problems with drugs."

Data from NIDA's Drug Abuse Warning Network (DAWN), which collects information on negative health consequences and deaths due to drug abuse, show over 46,000 emergency room cases involving cocaine in 1987, up from 25,000 in 1986. Cocaine-related emergency room cases involving smoking crack or other forms of cocaine increased from 21 percent in 1986 to 30 percent in 1987.

The high school senior survey found increases in seniors concerned about the negative effects of marijuana, PCP and cocaine. Almost 32 percent of seniors saw "great risk" from even occasionally smoking marijuana and 77 percent felt that smoking marijuana regularly is harmful. The study also showed increases in the percent of seniors who disapproved of people over 18 smoking marijuana and a significant increase in seniors saying their close friends would disapprove if they were to use drugs even once or twice. Survey director Dr. Lloyd Johnston pointed to newly emerging concerns among seniors about drugs and their effects as important factors accounting for decreases in experimentation and use.

The survey found overall rates for alcohol use decreased, yet still remain high -- 92 percent of seniors tried alcohol at least once and 35 percent reported having five or more drinks in a row in the last two weeks. Cigarette smoking by seniors also remains a problem, with 66 percent having tried smoking at least once and 18 percent smoking daily.

###

STATEMENT OF FREDERICK K. GOODWIN, M.D.

ADMINISTRATOR

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Press Conference

National High School Senior Survey 1988

February 28, 1989

I am pleased to present to you this morning findings from one of the most well-known research projects sponsored by the National Institute on Drug Abuse, "Monitoring the Future," also known as the National High School Senior Survey. NIDA, as one of three Institutes of the Alcohol, Drug Abuse, and Mental Health Administration, is devoted to research in the biomedical and behavioral aspects of drug abuse and addiction. This survey is conducted by Dr. Lloyd Johnston and his associates at the University of Michigan Institute for Social Research. As the name implies, this survey has monitored the patterns of drug use among young people and provided guidance to our national drug abuse demand reduction efforts since 1975.

Drug abuse has consistently and appropriately been at the top of the concerns of the American public over the past several years. During the recent election, most political polls found that drug abuse was the number one social problem of greatest concern to Americans. The most recent Gallup Youth Survey, released in 1988, found that 55% of teenagers named drug abuse as the biggest problem facing their generation, more than double the 27 percent

found in 1977, when the survey was first conducted. But at one time--and not too long ago-- many adults considered drug experimentation as a "rite of passage" for young people. They often had a very benign view of the effects of drug use -- it was only a stage in a teenagers' life. Today, we know far too well that the consequences of even first time drug use, especially among youngsters, are cause for serious concern.

In light of this concern, I am especially pleased to report that this 1988 survey shows drug use among high school seniors at its lowest level since the survey began in 1975, including significant decreases in cocaine use by the seniors for the second year in a row.

From 1987-1988, the proportion of seniors who have used cocaine at least once dropped by one-fifth, from 15 percent in 1987 to 12 percent in 1988. "Current use"--that is, use within the last 30 days--of cocaine also declined, from 4.3 percent in 1987 to 3.4 percent in 1988, a drop of nearly one-fourth. This news about the decrease in cocaine use is encouraging, but the survey also found that 42% of seniors who tried cocaine also have used crack, a smokeable and highly addictive form of cocaine. Fortunately, crack use may also be moving in the right direction among this group: it decreased from 6 percent who used at least once in their life in 1987 to 5 percent in 1988.

In addition to the drop in cocaine use, the 1988 survey found decreases in the proportions of seniors who said they had "ever used" each of the other 17 drugs included in the survey. Furthermore, there was a significant reduction in those reporting current use of <u>any</u> illicit drug, from 25 percent in 1987 to 21 percent in 1988, a 16 percent decline.

In general, these trends reflect results from a wide range of local and national efforts to stem the drug abuse tide. For example, our Office for Substance Abuse Prevention (OSAP) is sponsoring over 130 grants to community organizations all over the country. These youth projects provide the basis for intervening with young people who are most vulnerable to the effects of drugs--particularly, children of substance abusers; those with psychiatric disorders, such as depression; school dropouts; and abused or neglected children.

I have directed that ADAMHA research also give increased attention to "co-morbidity"--that is, substance abusers with co-existing mental disorders. Young people with "co-morbidity" are 2 1/2 times more likely to start with a treatable psychiatric disorder and go on to substance abuse than the other way around. Thus, the early recognition and effective treatment of psychiatric disorders should be able to prevent a sizable portion of the drug problem among the young. It is especially important that we recognize this in the case of pre-existing depression, for once it is properly diagnosed, it can be effectively treated.

From our basic animal and clinical research, we have learned that there are biological "time bombs" ticking in those who have inherited a predisposition or vulnerability to alcohol or drug abuse. For such kids, even a first use of alcohol or an illicit drug may be an irrevocable step, leading to serious substance abuse problems. We are vigorously pursuing a program of research to expand out knowledge about such vulnerabilities. One of the highest priorities of ADAMHA research is the development of new pharmacologic agents to treat cocaine craving, an area where we already have some exciting leads from animal studies.

The high school survey provides trend data on use of many drugs, as I have indicated. Drs. Schuster, Johnston and Adams will discuss these findings with you But I would like to address changes in alcohol use among seniors. For the first time in several years, we are seeing a small decline in alcohol use. The proportion of seniors who can be categorized as "current drinkers" (had one or more drinks in the last 30 days) declined from 66 percent in 1987 to 64 in 1988--a small but statistically significant decrease. Binge drinking (seniors having 5 or more drinks in a row) during the prior two weeks also showed a modest but significant drop, from 38 to 35 percent.

While this news about alcohol use is encouraging, we must remember that for most of the country, the legal drinking age has been raised. Alcohol use in this age group, i.e., 17-19 year olds, is now illegal in most states. With 66 percent of high school seniors still drinking regularly, we cannot afford to be complacent. Not only can alcohol be a serious problem in its own right, but its regular use increases the likelihood of going on to use of cocaine and other illicit drugs..

Now I would like to introduce Dr. Charles Schuster, Director of the National Institute on Drug Abuse, who will discuss some of the more specific findings of the survey.

###

STATEMENT OF CHARLES R. SCHUSTER, PH.D

DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Press Conference

National High School Senior Survey 1988

February 28, 1989

Thank you Dr. Goodwin. As most of you know, the National High School Senior Survey has been one of the major contributors to our knowledge of student drug abuse for 14 years. It warned us of the tremendous increase in illicit drug use in the late 1970's and the peak in cocaine use by seniors in 1985. This kind of research is critical to target our resource allocations wisely and develop new relevant prevention and treatment programs.

Today, we are encouraged by the downward trend in the use of all illicit drugs, including the use of cocaine which has declined for the second year in a row. We can safely say that this decrease suggests that high school seniors, a very important population to the future of our country, are hearing the messages about cocaine's dangers and are avoiding drug use in general. While crack cocaine is readily available, seniors appear to be concerned about its addictive qualities and are less likely to try or continue use.

Although these downward trends in illicit drug use are encouraging, drug abuse in our youth still remains a major public health problem. We can see that one of every eight high school seniors, or 12 percent, have tried cocaine before they graduate high school. We cannot be sure how many of them will continue to use the drug. Further, others will initiate cocaine use after they leave

high school. Dr. Johnston's findings show that among those who have graduated high school, 14 percent have used cocaine in the past year, as compared to only 8 percent as high school seniors.

Tragically, some of those exposed to cocaine will become addicted and will experience some of the severe medical consequences of use, for example, paranoia, convulsions, and cardiovascular toxicity and death. We can see from one of our other research projects, the Drug Abuse Warning Network (DAWN), that over 46,000 people sought help in emergency rooms for cocaine or cocaine-related medical problems in 1987, up from 25,000 in 1986. Cases involving smoking crack or other forms of cocaine increased from 21 percent in 1986 to 30 percent in 1987.

The High School Senior Survey also found a significant reduction in those reporting current use of any illicit drug, from 25 percent in 1987 to 21 percent in 1988. A similar decline was seen in lifetime prevalence of illicit drugs where the trend went from 57 to 54 percent in the past year. But we must be cautious in interpreting these encouraging trends. These figures indicate that <u>one out of every two</u> students have tried an illicit drug before they graduated high school. And those are the graduates. What does this mean for those who do not make it through high school. Certain large metropolitan areas are reporting high school dropout rates of up to 40 to 50 percent. These young people are more likely to become involved with the criminal justice system and experience problems with drugs.

NIDA research based on the National Household Survey on Drug Abuse of 1985 found that the rate of illicit drug use among 19-21 year old high school dropouts was 67% higher than for high school graduates of the same age. A

second study funded by NIDA of men ages 19-27 conducted at Columbia University in New York found that dropouts used 50% more cocaine and 80% more marijuana than those high school graduates.

We also must be concerned because large percentages of young people are still experimenting with and using many illicit drugs, including marijuana, stimulants and inhalants. This CHART illustrates what I'm saying. As I said previously, over half of those who graduate high school have tried marijuana or another illicit drug. Twenty percent have tried stimulants like methamphetamine and other amphetamine derivatives; almost as many (18 percent) have tried inhalants, which other NIDA research has shown to be a particular problem among young ethnic minority children, especially Hispanics and Native Americans. And, of course, any experimentation with cocaine is dangerous, and can presage serious consequences for a teenager.

All measures of marijuana use decreased significantly between 1987 and 1988, yet the rate "remains unacceptably high." In the class of 1988, 47 percent of seniors reported use at least once, 33 percent reported use in the past year, and 18 percent used in the past thirty days. Each of these measures dropped by three percentage points from 1987 to 1988.

It is important to note that these declines in drug use accompany an increase in the number of seniors who report in the survey that drugs are "easy to get." If young people want a drug, they know they can get it. These results emphasize the importance of demand reduction, which encompasses drug abuse prevention, research and treatment activities, and demonstrate that reductions in use can be achieved in spite of continued availability of drugs.

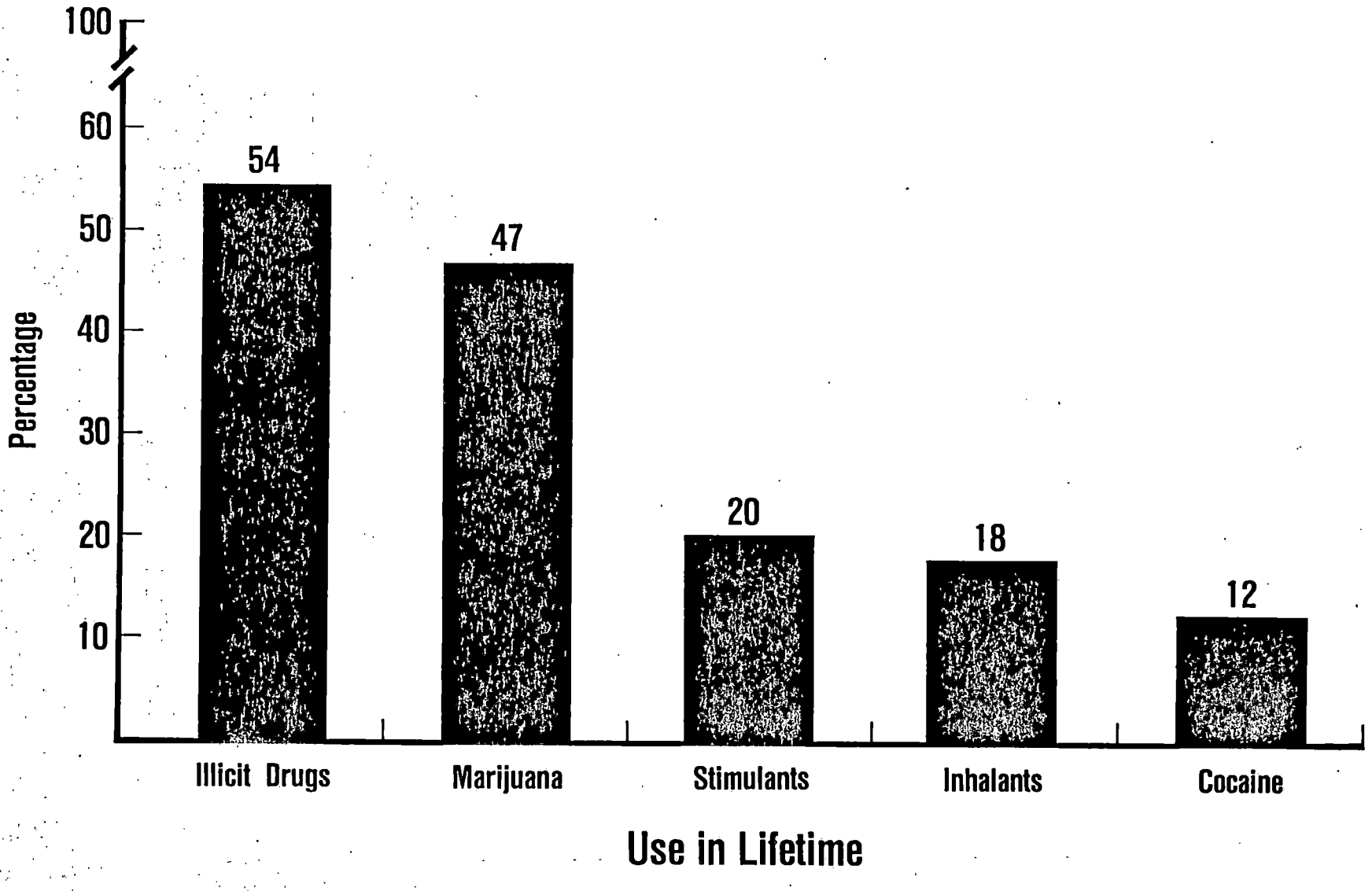
Increased concern about the harmful effects of drugs, coupled with increased disapproval of drug use are making it "uncool, unacceptable, and unwise" to use drugs. As you can see in this CHART, as the perceptions of harmfulness of marijuana and cocaine have increased over time, the use of marijuana and cocaine have declined. We are seeing similar trends in many of the other illicit drugs. Dr. Johnston will discuss the relationships of these two measured in greater detail in his statement.

Changing attitudes and norms is difficult. It requires research to provide sound, credible information on the psychological and physical consequences of illicit drug use. Further, it requires a continuing commitment and contribution from all segments of society, including government, business, community groups, schools, and certainly the media, to get this information across. The results of this survey are showing that these efforts are paying off. More and more young people are heeding the messages; they're making good decisions about their lives; and they're staying away from drugs.

Now I would like to introduce Dr. Lloyd Johnston, the principal investigator of "Monitoring the Future," from the University of Michigan Institute for Social Research.

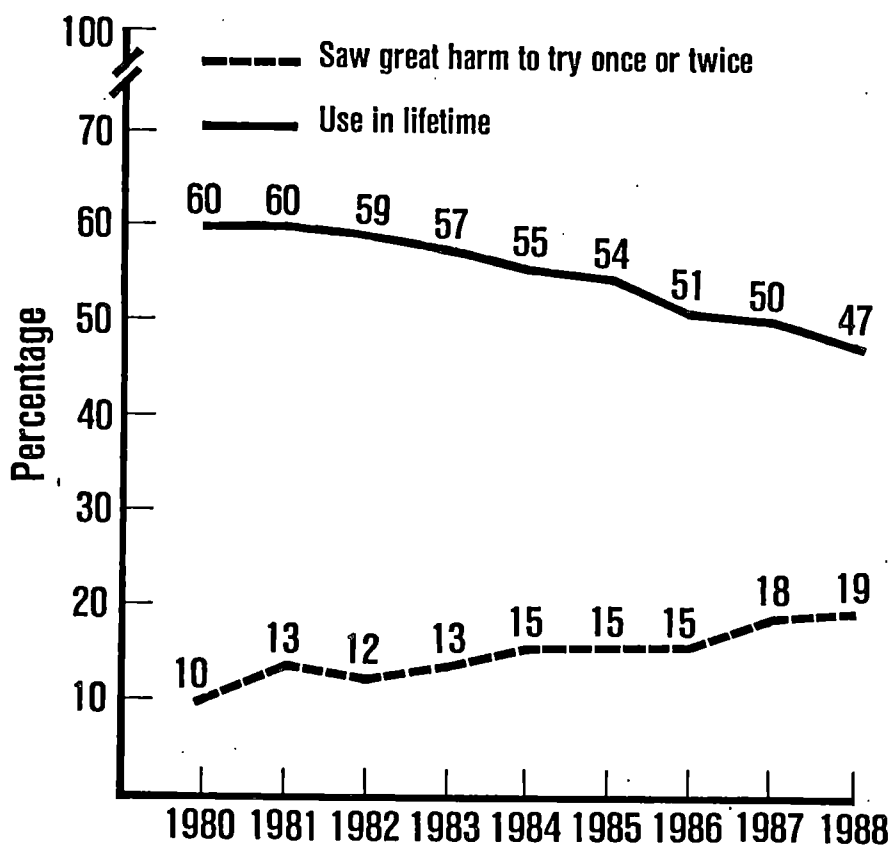
###

National Institute on Drug Abuse
High School Senior Survey
Seniors' Experience with Illicit Drugs 1988

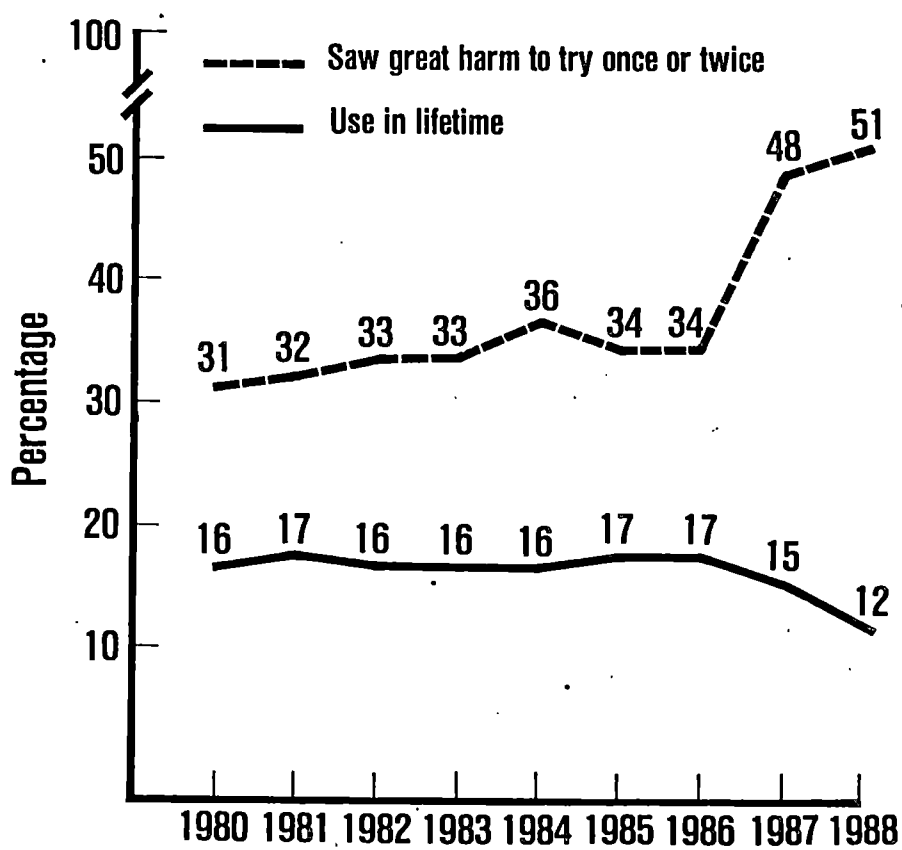


National Institute on Drug Abuse
High School Senior Survey

Correlation Between Marijuana Use and Perceived Harmfulness of Marijuana



Correlation Between Cocaine Use and Perceived Harmfulness of Cocaine



THE HIGH SCHOOL SENIOR SURVEY (MONITORING THE FUTURE STUDY)

The 1988 survey on drug use and related attitudes of America's high school seniors is the fourteenth in an annual series begun in 1975. These surveys are conducted through an ongoing national research and reporting program entitled Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth. The program is conducted by the University of Michigan's Institute for Social Research and is funded by NIDA. The study is sometimes referred to as the High School Senior Survey, since each year a representative sample of seniors in public and private high schools in the coterminous United States is surveyed. However, the study also includes representative samples of young adults from previous graduating classes. NIDA's annual support for the Monitoring the Future program is approximately $1.5 million.

Procedures and Content

Data from high school seniors are collected during the spring of each year. Data collection takes place in approximately 130 public and private high schools selected to provide an accurate cross section of high school seniors throughout the United States, except in Alaska and Hawaii. Approximately 16,000 seniors have been surveyed each year since 1975. Although most questions, such as those concerning drug use, are asked of all participants, some questions dealing with attitudes, beliefs, and perceptions are asked of only about one-fifth of the respondents. A representative sample of 2,400 individuals is chosen from each class for ongoing followup via a mailed questionnaire once every two years (half the group receives a questionnaire each year).

Two major topics in the reports of these surveys are the current prevalence of drug use among American high school seniors and trends in use since 1975. Sixteen classes and subclasses of drugs are covered, including alcohol and cigarettes (illicit for minors) and nonprescription stimulants as well as illicit drugs. Also included are data on grade of first use, trends in use at earlier grade levels, intensity of drug use, attitudes and beliefs among seniors concerning various types of drug use, and their perceptions of certain relevant aspects of the social environment.

~~CONFIDENTIAL~~ NOT FOR QUOTATION OR CITATION WITHOUT THE PERMISSION OF THE PRINCIPAL INVESTIGATORS

Determined To Be an Administrative
Marking Per E.O. 12356 Sec. 1.1 (a)

1988 Survey Results

from

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

January, 1989

TABLE 8
Trends in Lifetime Prevalence of Eighteen Types of Drugs

	Percent 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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	47.2	−3.0ss
Inhalants[a]	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	16.7	−0.3
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*18.2*	*17.3*	*17.2*	*17.7*	*18.2*	*18.0*	*18.1*	*20.1*	*18.6*	*17.5*	*−1.1*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	11.1	11.1	10.1	9.8	8.4	8.1	7.9	8.6	4.7	3.2	−1.5s
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	8.9	−1.4s
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*17.7*	*15.6*	*15.3*	*14.3*	*13.6*	*12.3*	*12.1*	*11.9*	*10.6*	*9.2*	*−1.4s*
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	7.7	−0.7
PCP[c,h]	NA	NA	NA	NA	12.8	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0	2.9	−0.1
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	12.1	−3.1sss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.6	4.8	−0.8
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14.0	12.1	−1.9
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	1.1	−0.1
Other opiates[e]	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	8.6	−0.6
Stimulants[e]	22.3	22.6	23.0	22.9	24.2	26.4	32.2	35.6	35.4	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*27.9*	*26.9*	*27.9*	*26.2*	*23.4*	*21.6*	*19.8*	*−1.8s*
Sedatives[e]	18.2	17.7	17.4	16.0	14.6	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7	7.8	−0.9
Barbiturates[e]	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	6.7	−0.7
Methaqualone[e]	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	3.3	−0.7
Tranquilizers[e]	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	9.4	−1.5s
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	92.0	−0.2
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	66.4	−0.8

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

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-fifth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

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

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

[g] Data based on two questionnaire forms. N is two-fifths of N indicated.

[h] Question text changed slightly in 1987.

TABLE 9
Trends in Annual Prevalence of Eighteen Types of Drugs

	Percent who used in last twelve months														
	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	Class of 1988	'87 – '88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	33.1	−3.2ss
Inhalants[a]	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	6.5	−0.4
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*8.9*	*7.9*	*6.1*	*6.6*	*6.2*	*7.2*	*7.5*	*8.9*	*8.1*	*7.1*	*−1.0*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	6.5	5.7	3.7	3.6	3.6	4.0	4.0	4.7	2.6	1.7	−0.9s
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	5.5	−0.9s
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*11.8*	*10.4*	*10.1*	*9.0*	*8.3*	*7.3*	*7.6*	*7.6*	*6.7*	*5.8*	*−0.9*
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	4.8	−0.4
PCP[c,h]	NA	NA	NA	NA	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3	1.2	−0.1
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	7.9	−2.4sss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	4.0	3.1	−0.9s
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	9.8	7.4	−2.4ss
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	0.5	0.0
Other opiates[e]	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	4.6	−0.7s
Stimulants[e]	16.2	15.8	16.3	17.1	18.3	20.8	26.0	26.1	24.6	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*20.3*	*17.9*	*17.7*	*15.8*	*13.4*	*12.2*	*10.9*	*−1.3s*
Sedatives[e]	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	3.7	−0.4
Barbiturates[e]	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	3.2	−0.4
Methaqualone[e]	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	1.3	−0.2
Tranquilizers[e]	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	4.8	−0.7
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	85.3	−0.4
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.
[a] Data based on four questionnaire forms. N is four-fifths of N indicated.
[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.
[c] Data based on a single questionnaire form. N is one-fifth of N indicated.
[d] Adjusted for underreporting of PCP. See text for details.
[e] Only drug use which was not under a doctor's orders is included here.
[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
[g] Data based on a single questionnaire form in 1986 (N is one-fifth of N indicated), and on two questionnaire forms in 1987 (N is two-fifths of N indicated).
[h] Question text changed slightly in 1987.

TABLE 10
Trends in Thirty-Day Prevalence of Eighteen Types of Drugs

	Percent who used in last thirty 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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	18.0	−3.0ss
Inhalants[a]	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	2.6	−0.2
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*3.2*	*2.7*	*2.5*	*2.5*	*2.5*	*2.6*	*3.0*	*3.2*	*3.5*	*3.0*	*−0.5*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	2.4	1.8	1.4	1.1	1.4	1.4	1.6	1.3	1.3	0.6	−0.7s
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	2.2	−0.3
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*5.3*	*4.4*	*4.5*	*4.1*	*3.5*	*3.2*	*3.8*	*3.5*	*2.8*	*2.3*	*−0.5*
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	1.8	0.0
PCP[c,h]	NA	NA	NA	NA	2.4	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6	0.3	−0.3
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	3.4	−0.9ss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.5	1.6	+0.1
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	3.2	−0.9
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	0.2	0.0
Other opiates[e]	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	1.6	−0.2
Stimulants[e]	8.5	7.7	8.8	8.7	9.9	12.1	15.8	13.7	12.4	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*10.7*	*8.9*	*8.3*	*6.8*	*5.5*	*5.2*	*4.6*	*−0.6*
Sedatives[e]	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	1.4	−0.3
Barbiturates[e]	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	1.2	−0.2
Methaqualone[e]	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	0.5	−0.1
Tranquilizers[e]	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	1.5	−0.5s
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	63.9	−2.5s
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	28.7	−0.7

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

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-fifth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

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

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

[g] Data based on two questionnaire forms. N is two-fifths of N indicated.

[h] Question text changed slightly in 1987.

TABLE 11
Trends in Thirty-Day Prevalence of Daily Use of Eighteen Types of Drugs

	Percent who used daily in last thirty 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	Class of 1988	'87–'88 change[g]
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	2.7	−0.6s
Inhalants[a]	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	0.2	+0.1
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*0.1*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.4*	*0.4*	*0.4*	*0.3*	*−0.1*
Amyl & Butyl Nitrites[c,i]	NA	NA	NA	NA	0.0	0.1	0.1	0.0	0.2	0.1	0.3	0.5	0.3	0.1	−0.2
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	0.0	−0.1
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*0.2*	*0.2*	*0.1*	*0.2*	*0.2*	*0.2*	*0.3*	*0.3*	*0.2*	*0.0*	*−0.2s*
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	0.0	0.0[g]
PCP[c,i]	NA	NA	NA	NA	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3	0.1	−0.2[g]
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	0.2	−0.1
"Crack"[h]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	0.1	−0.1
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	0.2	0.0
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	0.0	0.0
Other opiates[e]	0.1	0.1	0.2	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Stimulants[e]	0.5	0.4	0.5	0.5	0.6	0.7	1.2	1.1	1.1	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*0.7*	*0.8*	*0.6*	*0.4*	*0.3*	*0.3*	*0.3*	*0.0*
Sedatives[e]	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	0.1	0.0
Barbiturates[e]	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	0.0	0.0[g]
Methaqualone[e]	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	0.1	0.0[g]
Tranquilizers[e]	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	0.0	0.0[g]
Alcohol															
Daily	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	4.2	−0.6
5+ drinks in a row/ last 2 weeks	36.8	37.1	39.4	40.3	41.2	41.2	41.4	40.5	40.8	38.7	36.7	36.8	37.5	34.7	−2.8s
Cigarettes															
Daily	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	18.1	−0.6
Half-pack or more per day	17.9	19.2	19.4	18.8	16.5	14.3	13.5	14.2	13.8	12.3	12.5	11.4	11.4	10.6	−0.8

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

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.
[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.
[c] Data based on a single questionnaire form. N is one-fifth of N indicated.
[d] Adjusted for underreporting of PCP. See text for details.
[e] Only drug use which was not under a doctor's orders is included here.
[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
[g] Any apparent inconsistency between the change estimate and the prevalence estimates for the two most recent classes is due to rounding error.
[h] Data based on two questionnaire forms. N is two-fifths of N indicated.
[i] Question text changed slightly in 1987.

TABLE 12

Trends in Lifetime, Annual, and Thirty-Day Prevalence in an Index of Illicit Drug Use

(Based on Original and Adjusted Amphetamine Questions)[a]

	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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
Percent reporting use in lifetime															
Marijuana Only	19.0	22.9	25.8	27.6	27.7	26.7	22.8	20.8	19.7	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	23.3	22.5	21.3	20.9	19.9	20.8	21.4	+0.6
Any Illicit Drug Other Than Marijuana[b]	36.2	35.4	35.8	36.5	37.4	38.7	42.8	45.0	44.4	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	41.1	40.4	40.3	39.7	37.7	35.8	32.5	−3.3sss
Total: Any Illicit Drug Use	55.2	58.3	61.6	64.1	65.1	65.4	65.6	65.8	64.1	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	64.4	62.9	61.6	60.6	57.6	56.6	53.9	−2.7ss
Percent reporting use in last twelve months															
Marijuana Only	18.8	22.7	25.1	26.7	26.0	22.7	18.1	17.0	16.6	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	19.3	19.0	17.8	18.9	18.4	17.6	17.4	−0.2
Any Illicit Drug Other Than Marijuana[b]	26.2	25.4	26.0	27.1	28.2	30.4	34.0	33.8	32.5	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	30.1	28.4	28.0	27.4	25.9	24.1	21.1	−3.0sss
Total: Any Illicit Drug Use	45.0	48.1	51.1	53.8	54.2	53.1	52.1	50.8	49.1	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	49.4	47.4	45.8	46.3	44.3	41.7	38.5	−3.2sss
Percent reporting use in last thirty days															
Marijuana Only	15.3	20.3	22.4	23.8	22.2	18.8	15.2	14.3	14.0	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	15.5	15.1	14.1	14.8	13.9	13.1	11.3	−1.8s
Any Illicit Drug Other Than Marijuana[b]	15.4	13.9	15.2	15.1	16.8	18.4	21.7	19.2	18.4	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	17.0	15.4	15.1	14.9	13.2	11.6	10.0	−1.6ss
Total: Any Illicit Drug Use	30.7	34.2	37.6	38.9	38.9	37.2	36.9	33.5	32.4	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	32.5	30.5	29.2	29.7	27.1	24.7	21.3	−3.4sss

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.

[a] Adjusted questions about stimulant use were introduced in 1982 to exclude more completely the inappropriate reporting of non-prescription stimulants.

[b] Use of "other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

TABLE 4

Lifetime Prevalence of Use of Eighteen Types of Drugs by Subgroups, Class of 1988

(Entries are percentages)

	MJ	INH[a]	NIT	HAL[a]	LSD	PCP	COKE[b]	CRCK[b]	OtCo[b]	HER	OP	STM[c]	SED	BARB	QUA	TRN	ALC	CIG
All Seniors	47.2	16.7	3.2	8.9	7.7	2.9	12.1	4.8	12.1	1.1	8.6	19.8	7.8	6.7	3.3	9.4	92.0	66.4
Sex:																		
Male	49.8	19.5	3.9	10.8	9.6	3.4	13.6	6.0	13.7	1.4	9.2	18.4	8.0	6.8	3.9	9.0	92.1	65.4
Female	44.5	14.0	2.6	6.8	5.6	2.6	10.4	3.4	10.1	0.9	7.9	20.9	7.5	6.6	2.6	9.6	92.0	67.1
College Plans:																		
None or under 4 yrs	53.6	19.4	3.1	10.9	9.9	3.8	15.8	6.5	12.3	1.7	10.1	25.9	10.5	9.1	4.8	11.0	92.2	73.7
Complete 4 yrs	44.0	15.7	3.3	7.5	6.4	2.6	10.0	3.7	10.7	0.8	7.9	17.2	6.4	5.5	2.4	8.6	92.2	62.7
Region:																		
Northeast	49.6	15.3	2.1	9.3	7.0	3.5	13.2	3.8	11.8	1.0	7.2	16.5	7.7	6.1	3.7	9.5	93.9	66.6
North Central	48.0	16.8	2.7	8.2	7.4	1.5	9.4	3.4	9.4	0.8	8.5	22.1	6.6	5.9	2.5	7.4	93.8	69.4
South	42.4	17.0	4.4	8.0	7.3	3.1	9.7	4.2	10.2	1.1	8.4	19.4	9.1	8.0	3.6	10.8	89.3	64.6
West	52.0	17.5	2.6	10.9	9.4	4.1	19.0	8.6	19.7	1.7	10.7	20.8	7.3	6.4	3.3	9.3	92.5	65.2
Population Density:																		
Large SMSA	47.8	16.8	3.5	10.2	8.2	5.3	14.3	5.8	13.7	1.0	8.1	16.7	7.9	6.3	3.6	9.4	92.2	63.3
Other SMSA	49.7	16.1	3.2	9.8	8.8	2.6	12.8	5.1	13.1	1.2	9.3	21.3	8.0	7.0	3.3	9.4	92.3	66.9
Non-SMSA	41.9	17.8	2.9	5.8	5.2	1.2	8.6	3.2	9.0	1.2	7.9	20.3	7.5	6.6	2.9	9.3	91.3	68.7

[a]Unadjusted for known underreporting of certain drugs. See text for details.

[b]Cocaine data based on five questionnaire forms, "crack" data based on two questionnaire forms, and other cocaine data based on one questionnaire form.

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

TABLE 5

Annual Prevalence of Use of Eighteen Types of Drugs by Subgroups, Class of 1988

(Entries are percentages)

	MJ	INH[a]	NIT	HAL[a]	LSD	PCP	COKE[b]	CRK[b]	OtCo[b]	HER	OP	STM[c]	SED	BARB	QUA	TRN	ALC	CIG[d]
All Seniors	33.1	6.5	1.7	5.5	4.8	1.2	7.9	3.1	7.4	0.5	4.6	10.9	3.7	3.2	1.3	4.8	85.3	–
Sex:																		
Male	35.8	8.2	2.0	7.2	6.5	1.7	9.1	4.0	8.0	0.7	5.1	10.8	3.9	3.4	1.5	4.7	85.7	–
Female	30.3	4.9	1.5	3.7	3.0	0.6	6.5	2.0	6.2	0.3	4.1	10.9	3.4	3.0	1.0	4.8	85.0	–
College Plans:																		
None or under 4 yrs	36.2	8.1	1.3	6.4	5.7	1.8	9.7	4.2	6.0	0.8	4.8	13.9	4.7	4.1	1.7	5.1	85.5	–
Complete 4 yrs	31.3	6.0	1.9	4.7	4.1	0.9	6.7	2.3	6.7	0.3	4.6	9.5	3.1	2.7	1.0	4.6	85.7	–
Region:																		
Northeast	36.7	6.0	0.4	5.8	4.7	1.4	9.1	2.3	7.0	0.5	3.7	8.4	3.3	2.5	1.6	4.5	88.0	–
North Central	34.3	7.2	1.8	5.3	4.7	0.7	6.1	2.4	5.6	0.3	4.4	12.2	2.9	2.5	1.1	3.7	88.1	–
South	28.7	6.8	2.6	5.2	4.7	1.5	6.2	2.7	5.8	0.5	4.7	10.8	4.6	4.1	1.4	6.0	80.9	–
West	35.6	5.6	1.3	6.0	5.2	1.0	12.1	5.6	13.4	0.7	5.7	11.8	3.4	3.2	1.2	4.4	86.5	–
Population Density:																		
Large SMSA	34.3	6.5	1.9	6.5	5.2	2.8	9.3	3.9	9.8	0.4	4.0	8.8	3.6	2.8	1.5	4.7	86.1	–
Other SMSA	34.7	6.0	1.4	6.0	5.6	0.6	8.5	3.3	7.8	0.5	5.2	11.9	3.8	3.4	1.2	5.0	85.7	–
Non-SMSA	29.0	7.5	2.1	3.5	3.1	0.5	5.3	2.0	4.5	0.5	4.4	11.3	3.5	3.2	1.2	4.5	83.9	–

[a]Unadjusted for known underreporting of certain drugs. See text for details.

[b]Cocaine data based on five questionnaire forms, "crack" data based on two questionnaire forms, and other cocaine data based on one questionnaire form.

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

[d]Annual prevalence is not available.

TABLE 6

Thirty-Day Prevalence of Use of Eighteen Types of Drugs by Subgroups, Class of 1988

(Entries are percentages)

	MJ	INH[a]	NIT	HAL[a]	LSD	PCP	COKE[b]	CRCK[b]	OtCo[b]	HER	OP	STM[c]	SED	BARB	QUA	TRN	ALC	CIG
All Seniors	18.0	2.6	0.6	2.2	1.8	0.3	3.4	1.6	3.2	0.2	1.6	4.6	1.4	1.2	0.5	1.5	63.9	28.7
Sex:																		
Male	20.7	3.2	0.9	3.2	2.7	0.4	4.2	2.1	3.4	0.3	1.8	4.5	1.6	1.3	0.6	1.4	68.0	28.0
Female	15.2	2.0	0.4	1.2	0.9	0.2	2.6	0.9	2.9	0.1	1.4	4.6	1.2	1.1	0.3	1.5	59.9	28.9
College Plans:																		
None or under 4 yrs	20.4	3.2	0.6	2.5	2.0	0.5	4.6	2.4	3.1	0.4	1.8	6.3	2.0	1.7	0.8	1.6	65.0	37.5
Complete 4 yrs	16.4	2.2	0.6	1.9	1.6	0.2	2.8	1.1	2.7	0.1	1.5	3.7	1.1	1.0	0.3	1.4	63.6	24.4
Region:																		
Northeast	20.2	2.5	0.0	2.1	1.7	0.3	3.8	1.2	3.4	0.3	1.1	3.2	1.2	1.1	0.4	1.3	66.7	31.2
North Central	18.6	3.2	1.0	2.1	1.9	0.1	2.5	1.1	2.6	0.1	1.3	5.1	1.1	1.0	0.3	1.2	67.9	31.1
South	15.8	2.3	0.9	2.2	1.7	0.4	3.0	1.5	3.1	0.2	1.8	4.3	1.9	1.5	0.7	2.0	58.6	28.0
West	18.9	2.1	0.2	2.5	1.9	0.5	5.2	2.8	4.3	0.3	2.1	5.7	1.3	1.2	0.5	1.3	65.0	23.9
Population Density:																		
Large SMSA	19.4	2.0	0.7	2.2	1.6	0.5	4.2	1.9	3.7	0.1	1.2	3.5	1.0	0.9	0.2	1.3	63.8	26.9
Other SMSA	19.3	2.4	0.5	2.6	2.3	0.3	3.8	1.7	3.5	0.2	1.8	5.1	1.6	1.4	0.5	1.7	64.1	28.3
Non-SMSA	14.3	3.4	0.9	1.4	1.2	0.1	2.1	1.1	2.2	0.2	1.6	4.8	1.5	1.3	0.7	1.4	63.8	31.4

[a] Unadjusted for known underreporting of certain drugs. See text for details.

[b] Cocaine data based on five questionnaire forms, "crack" data based on two questionnaire forms, and other cocaine data based on one questionnaire form.

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

TABLE 16

Trends in Harmfulness of Drugs as Perceived by Seniors

Percentage saying "great risk"[a]

Q. How much do you think people risk harming themselves (physically or in other ways), if they . . .	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	Class of 1988	'87–'88 change
Try marijuana once or twice	15.1	11.4	9.5	8.1	9.4	10.0	13.0	11.5	12.7	14.7	14.8	15.1	18.4	19.0	+0.6
Smoke marijuana occasionally	18.1	15.0	13.4	12.4	13.5	14.7	19.1	18.3	20.6	22.6	24.5	25.0	30.4	31.7	+1.3
Smoke marijuana regularly	43.3	38.6	36.4	34.9	42.0	50.4	57.6	60.4	62.8	66.9	70.4	71.3	73.5	77.0	+3.5ss
Try LSD once or twice	49.4	45.7	43.2	42.7	41.6	43.9	45.5	44.9	44.7	45.4	43.5	42.0	44.9	45.7	+0.8
Take LSD regularly	81.4	80.8	79.1	81.1	82.4	83.0	83.5	83.5	83.2	83.8	82.9	82.6	83.8	84.2	+0.4
Try PCP once or twice	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	55.6	58.8	+3.2s
Try cocaine once or twice	42.6	39.1	35.6	33.2	31.5	31.3	32.1	32.8	33.0	35.7	34.0	33.5	47.9	51.2	+3.3s
Take cocaine occasionally	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	54.2	66.8	69.2	+2.4
Take cocaine regularly	73.1	72.3	68.2	68.2	69.5	69.2	71.2	73.0	74.3	78.8	79.0	82.2	88.5	89.2	+0.7
Try heroin once or twice	60.1	58.9	55.8	52.9	50.4	52.1	52.9	51.1	50.8	49.8	47.3	45.8	53.6	54.0	+0.4
Take heroin occasionally	75.6	75.6	71.9	71.4	70.9	70.9	72.2	69.8	71.8	70.7	69.8	68.2	74.6	73.8	−0.8
Take heroin regularly	87.2	88.6	86.1	86.6	87.5	86.2	87.5	86.0	86.1	87.2	86.0	87.1	88.7	88.8	+0.1
Try amphetamines once or twice	35.4	33.4	30.8	29.9	29.7	29.7	26.4	25.3	24.7	25.4	25.2	25.1	29.1	29.6	+0.5
Take amphetamines regularly	69.0	67.3	66.6	67.1	69.9	69.1	66.1	64.7	64.8	67.1	67.2	67.3	69.4	69.8	+0.4
Try barbiturates once or twice	34.8	32.5	31.2	31.3	30.7	30.9	28.4	27.5	27.0	27.4	26.1	25.4	30.9	29.7	−1.2
Take barbiturates regularly	69.1	67.7	68.6	68.4	71.6	72.2	69.9	67.6	67.7	68.5	68.3	67.2	69.4	69.6	+0.2
Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	5.3	4.8	4.1	3.4	4.1	3.8	4.6	3.5	4.2	4.6	5.0	4.6	6.2	6.0	−0.2
Take one or two drinks nearly every day	21.5	21.2	18.5	19.6	22.6	20.3	21.6	21.6	21.6	23.0	24.4	25.1	26.2	27.3	+1.1
Take four or five drinks nearly every day	63.5	61.0	62.9	63.1	66.2	65.7	64.5	65.5	66.8	68.4	69.8	66.5	69.7	68.5	−1.2
Have five or more drinks once or twice each weekend	37.8	37.0	34.7	34.5	34.9	35.9	36.3	36.0	38.6	41.7	43.0	39.1	41.9	42.6	+0.7
Smoke one or more packs of cigarettes per day	51.3	56.4	58.4	59.0	63.0	63.7	63.3	60.5	61.2	63.8	66.5	66.0	68.6	68.0	−0.6
Approx. N =	(2804)	(2918)	(3052)	(3770)	(3250)	(3234)	(3604)	(3557)	(3305)	(3262)	(3250)	(3020)	(3315)	(3276)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.
[a]Answer alternatives were: (1) No risk, (2) Slight risk, (3) Moderate risk, (4) Great risk, and (5) Can't say, drug unfamiliar.

TABLE 17
Trends in Proportions of Seniors Disapproving of Drug Use

Q. Do you disapprove of people (who are 18 or older) doing each of the following?[b]	Percentage "disapproving"[a]														
	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	Class of 1988	'87 – '88 change
Try marijuana once or twice	47.0	38.4	33.4	33.4	34.2	39.0	40.0	45.5	46.3	49.3	51.4	54.6	56.6	60.8	+4.2ss
Smoke marijuana occasionally	54.8	47.8	44.3	43.5	45.3	49.7	52.6	59.1	60.7	63.5	65.8	69.0	71.6	74.0	+2.4
Smoke marijuana regularly	71.9	69.5	65.5	67.5	69.2	74.6	77.4	80.6	82.5	84.7	85.5	86.6	89.2	89.3	+0.1
Try LSD once or twice	82.8	84.6	83.9	85.4	86.6	87.3	86.4	88.8	89.1	88.9	89.5	89.2	91.6	89.8	−1.8s
Take LSD regularly	94.1	95.3	95.8	96.4	96.9	96.7	96.8	96.7	97.0	96.8	97.0	96.6	97.8	96.4	−1.4ss
Try cocaine once or twice	81.3	82.4	79.1	77.0	74.7	76.3	74.6	76.6	77.0	79.7	79.3	80.2	87.3	89.1	+1.8
Take cocaine regularly	93.3	93.9	92.1	91.9	90.8	91.1	90.7	91.5	93.2	94.5	93.8	94.3	96.7	96.2	−0.5
Try heroin once or twice	91.5	92.6	92.5	92.0	93.4	93.5	93.5	94.6	94.3	94.0	94.0	93.3	96.2	95.0	−1.2
Take heroin occasionally	94.8	96.0	96.0	96.4	96.8	96.7	97.2	96.9	96.9	97.1	96.8	96.6	97.9	96.9	−1.0s
Take heroin regularly	96.7	97.5	97.2	97.8	97.9	97.6	97.8	97.5	97.7	98.0	97.6	97.6	98.1	97.2	−0.9s
Try amphetamines once or twice	74.8	75.1	74.2	74.8	75.1	75.4	71.1	72.6	72.3	72.8	74.9	76.5	80.7	82.5	+1.8
Take amphetamines regularly	92.1	92.8	92.5	93.5	94.4	93.0	91.7	92.0	92.6	93.6	93.3	93.5	95.4	94.2	−1.2
Try barbiturates once or twice	77.7	81.3	81.1	82.4	84.0	83.9	82.4	84.4	83.1	84.1	84.9	86.8	89.6	89.4	−0.2
Take barbiturates regularly	93.3	93.6	93.0	94.3	95.2	95.4	94.2	94.4	95.1	95.1	95.5	94.9	96.4	95.3	−1.1
Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	21.6	18.2	15.6	15.6	15.8	16.0	17.2	18.2	18.4	17.4	20.3	20.9	21.4	22.6	+1.2
Take one or two drinks nearly every day	67.6	68.9	66.8	67.7	68.3	69.0	69.1	69.9	68.9	72.9	70.9	72.8	74.2	75.0	+0.8
Take four or five drinks nearly every day	88.7	90.7	88.4	90.2	91.7	90.8	91.8	90.9	90.0	91.0	92.0	91.4	92.2	92.8	+0.6
Have five or more drinks once or twice each weekend	60.3	58.6	57.4	56.2	56.7	55.6	55.5	58.8	56.6	59.6	60.4	62.4	62.0	65.3	+3.3s
Smoke one or more packs of cigarettes per day	67.5	65.9	66.4	67.0	70.3	70.8	69.9	69.4	70.8	73.0	72.3	75.4	74.3	73.1	−1.2
Approx. N =	(2677)	(2957)	(3085)	(3686)	(3221)	(3261)	(3610)	(3651)	(3341)	(3254)	(3265)	(3113)	(3302)	(3311)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.
[a]Answer alternatives were: (1) Don't disapprove, (2) Disapprove, and (3) Strongly disapprove. Percentages are shown for categories (2) and (3) combined.
[b]The 1975 question asked about people who are "20 or older."

TABLE 20

Trends in Proportion of Friends Disapproving of Drug Use

All Seniors

Q. How do you think your close friends feel (or would feel) about you . . .	Adjustment Factor	Percentage saying friends disapprove[a] Class of 1975[b]	Class of 1976	Class of 1977[b]	Class of 1978	Class of 1979[b]	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	'87–'88 change
Trying marijuana once or twice	*(−0.5)*	*44.3*	NA	*41.8*	NA	*40.9*	42.6	46.4	50.3	52.0	54.1	54.7	56.7	58.0	62.9	+4.9ss
Smoking marijuana occasionally	*(+0.8)*	*54.8*	NA	*49.0*	NA	*48.2*	50.6	55.9	57.4	59.9	62.9	64.2	64.4	67.0	72.1	+5.1ss
Smoking marijuana regularly	*(+4.6)*	*75.0*	NA	*69.1*	NA	*70.2*	72.0	75.0	74.7	77.6	79.2	81.0	82.3	82.9	85.5	+2.6s
Trying LSD once or twice	*(+2.0)*	*85.6*	NA	*86.6*	NA	*87.6*	87.4	86.5	87.8	87.8	87.6	88.6	89.0	87.9	89.5	+1.6
Trying cocaine once or twice		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	79.6	83.9	88.1	+4.2sss
Taking cocaine occasionally		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	87.3	89.7	92.1	+2.4s
Trying an amphetamine once or twice	*(+2.2)*	*78.8*	NA	*80.3*	NA	*81.0*	78.9	74.4	75.7	76.8	77.0	77.0	79.4	80.0	82.3	+2.3
Taking one or two drinks nearly every day	*(+7.8)*	*67.2*	NA	*71.0*	NA	*71.0*	70.5	69.5	71.9	71.7	73.6	75.4	75.9	71.8	74.9	+3.1s
Taking four or five drinks every day	*(+9.3)*	*89.2*	NA	*88.1*	NA	*88.5*	87.9	86.4	86.6	86.0	86.1	88.2	87.4	85.6	87.1	+1.5
Having five or more drinks once or twice every weekend	*(+4.7)*	*55.0*	NA	*53.4*	NA	*51.3*	50.6	50.3	51.2	50.6	51.3	55.9	54.9	52.4	54.0	+1.6
Smoking one or more packs of cigarettes per day	*(+8.3)*	*63.6*	NA	*68.3*	NA	*73.4*	74.4	73.8	70.3	72.2	73.9	73.7	76.2	74.2	76.4	+2.2
Approx. N =		(2488)	(NA)	(2615)	(NA)	(2716)	(2766)	(3120)	(3024)	(2722)	(2721)	(2688)	(2639)	(2815)	(2778)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Answer alternatives were: (1) Don't disapprove, (2) Disapprove, and (3) Strongly disapprove. Percentages are shown for categories (2) and (3) combined.

[b] These figures have been adjusted by the factors reported in the first column to correct for a lack of comparability of question-context among administrations. (See text for discussion.)

TABLE 23

Trends in Perceived Availability of Drugs, All Seniors

Q. How difficult do you think it would be for you to get each of the following types of drugs, if you wanted some?	Percentage saying drug would be "Fairly easy" or "Very easy" for them to get[a]														
	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	Class of 1988	'87 – '88 change
Marijuana	87.8	87.4	87.9	87.8	90.1	89.0	89.2	88.5	86.2	84.6	85.5	85.2	84.8	85.0	+0.2
Amyl & Butyl Nitrites	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	23.9	25.9	+2.0
LSD	46.2	37.4	34.5	32.2	34.2	35.3	35.0	34.2	30.9	30.6	30.5	28.5	31.4	33.3	+1.9
PCP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	22.8	24.9	+2.1
Some other psychedelic	47.8	35.7	33.8	33.8	34.6	35.0	32.7	30.6	26.6	26.6	26.1	24.9	25.0	26.2	+1.2
Cocaine	37.0	34.0	33.0	37.8	45.5	47.9	47.5	47.4	43.1	45.0	48.9	51.5	54.2	55.0	+0.8
"Crack"	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	41.1	42.1	+1.0
Cocaine powder	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	52.9	50.3	−2.6
Heroin	24.2	18.4	17.9	16.4	18.9	21.2	19.2	20.8	19.3	19.9	21.0	22.0	23.7	28.0	+4.3ss
Some other narcotic (including methadone)	34.5	26.9	27.8	26.1	28.7	29.4	29.6	30.4	30.0	32.1	33.1	32.2	33.0	35.8	+2.8
Amphetamines	67.8	61.8	58.1	58.5	59.9	61.3	69.5	70.8	68.5	68.2	66.4	64.3	64.5	63.9	−0.6
Barbiturates	60.0	54.4	52.4	50.6	49.8	49.1	54.9	55.2	52.5	51.9	51.3	48.3	48.2	47.8	−0.4
Tranquilizers	71.8	65.5	64.9	64.3	61.4	59.1	60.8	58.9	55.3	54.5	54.7	51.2	48.6	49.1	+0.5
Approx. N =	(2627)	(2865)	(3065)	(3598)	(3172)	(3240)	(3578)	(3602)	(3385)	(3269)	(3274)	(3077)	(3271)	(3231)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a]Answer alternatives were: (1) Probably impossible, (2) Very difficult, (3) Fairly difficult, (4) Fairly easy, and (5) Very easy.

TABLE 28

Trends in Annual Prevalence of Fourteen Types of Drugs
Among Follow-Up Respondents 1–11 Years Beyond High School

	Percent who used in last twelve months		
	1987	1988	'87–'88 change
Approx. Wtd. N =	(7450)	(7320)	
Marijuana	34.3	31.3	−3.0sss
Inhalants[b]	2.0	1.7	−0.3
LSD	2.8	2.8	0.0
Cocaine	15.6	13.8	−1.8ss
"Crack"[c]	3.0	3.1	+0.1
Heroin	0.3	0.2	−0.1
Other Opiates[a]	3.0	2.6	−0.4
Stimulants, Adjusted[a,d]	8.5	7.1	−1.4ss
Sedatives[a]	2.5	2.1	−0.4
Barbiturates[a]	2.0	1.9	−0.1
Methaqualone[a]	0.9	0.5	−0.4sS
Tranquilizers[a]	5.1	4.3	−0.8s
Alcohol	89.1	88.5	−0.6
Cigarettes	39.9	37.5	−2.4ss

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .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 two of the five questionnaire forms. 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.

TABLE 29

Trends in Thirty-Day Prevalence of Fourteen Types of Drugs

Among Follow-Up Respondents 1–11 Years Beyond High School

	Percent who used in last thirty days		
	1987	1988	'87–'88 change
Approx. Wtd. N =	(7450)	(7320)	
Marijuana	20.7	17.7	−3.0sss
Inhalants[b]	0.6	0.6	0.0
LSD	0.8	0.8	0.0
Cocaine	6.0	5.7	−0.3
"Crack"[c]	0.9	1.3	+0.4
Heroin	0.1	0.1	0.0
Other Opiates[a]	0.9	0.6	−0.3s
Stimulants, Adjusted[a,d]	3.3	2.7	−0.6s
Sedatives[a]	0.8	0.7	−0.1
Barbiturates[a]	0.7	0.7	0.0
Methaqualone[a]	0.2	0.1	−0.1
Tranquilizers[a]	1.6	1.4	−0.2
Alcohol	75.0	74.0	−1.0
Cigarettes	30.8	28.9	−1.9s

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.

[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 two of the five questionnaire forms. 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.

TABLE 43

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									
	1980	1981	1982	1983	1984	1985	1986	1987	1988	'87–'88 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(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	4.6	6.3	4.3	3.7	2.2	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	−3.7ss
"Crack"[c]	NA	NA	NA	NA	NA	NA	1.3	2.0	1.4	−0.6
Heroin	0.4	0.2	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	2.6	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	91.6	90.0	92.0	91.5	90.9	89.6	−1.3
Cigarettes	36.2	37.6	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, sss = .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.

TABLE 44

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									
	1980	1981	1982	1983	1984	1985	1986	1987	1988	'87–'88 change
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	4.6	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	0.6	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.

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

[b]This question was asked in four of the five questionnaire forms. N is four-fifths of N indicated.

[c]This question was asked in two of the five questionnaire forms. 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.

The University of Michigan

News and Information Services

412 Maynard
Ann Arbor, Michigan
48109-1399

February 24, 1989 (19)
Contact: Terry Gallagher
Phone: (313) 747-1847

Teen drug use continues decline,
according to U-M survey.
Cocaine down for second straight year;
crack begins decline in 1988.

FOR RELEASE 10:00 A.M. EST, TUESDAY, FEBRUARY 28, 1989

EDITORS: Results of the 1988 National High School Senior Survey will be presented at 10 a.m. Tuesday (Feb. 28) in the auditorium of the Hubert Humphrey Bldg., headquarters of the Department of Health and Human Services in Washington, D.C. U-M Research Scientist Dr. Lloyd Johnston will be joined by Dr. Frederick K. Goodwin, Administrator of the Alcohol, Drug Abuse and Mental Health Administration, and Dr. Charles R. Schuster, Director of the National Institute on Drug Abuse. For further information about the study findings, contact Johnston, Program Director at the U-M's Institute for Social Research, (313) 763-5043.

ANN ARBOR---Drug use among American young people in high school and college continued to decline in 1988, according to the most recent national survey by The University of Michigan's Institute for Social Research. Of particular importance, the downturn in cocaine use, which began in 1987, continued in 1988. And among high school seniors at least, crack use---which leveled in 1987---also began to decline in 1988.

These are among the central findings of the 14th national survey in the series titled "Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth." (It is also sometimes referred to as the National High School Senior Survey.)

"Nearly all of the changes revealed by the 1988 survey about illicit drug use are good news, particularly those relating to cocaine and crack. There is also some encouraging indication of a decline in alcohol consumption, but unfortunately not much improvement in the smoking rates," said U-M social psychologists Lloyd Johnston, Jerald Bachman, and Patrick O'Malley, who direct the study.

(more)

Each year since 1975, some 16,000 to 17,000 seniors in 135 high schools nationwide have been surveyed in the study, which has been funded through a series of research grants from the National Institute on Drug Abuse. Self-completed confidential questionnaires are administered to seniors in their classrooms by U-M research personnel.

Also, each year since 1977, some participants from all previously graduated classes have been followed through the use of mailed, self-administered questionnaires. These follow-up surveys have yielded a representative sample of about 1,200 American college students (one to four years past high school) each year since 1980, and presently yield a national sample of about 11,000 young adults one to eleven years beyond high school.

Among the findings reported from the 1988 survey are the following:

Marijuana: Marijuana use continued its long-term, gradual decline among high school seniors in 1988. In the peak year of use, 1979, half of all seniors reported some use in the year prior to the survey (that is, annual prevalence was 51 percent), but by 1988 that statistic has fallen to one-third. Current daily marijuana use has fallen even more in proportional terms---from 10.7 percent in 1978 to 2.7 percent in 1988.

"We think this important decline in marijuana use has been occurring, and continues to occur, largely because of changes in the risks which young people associate with the use of this drug," stated Johnston. "In 1978, the peak year for daily use, only 35 percent of seniors thought there was a 'great risk' associated with regular marijuana use. Today that number stands at 77 percent and is still rising."

Cocaine: "We predicted such a decline in cocaine use would occur once young people began to see its use---particularly experimental and occasional use---as more risky; and that's what now seems to be happening," Johnston said. The proportion of seniors reporting any cocaine use in the prior 12 months dropped between 1986 and 1988 from 13 percent to 8 percent, following a six-year period in which use remained fairly level. Over those same two years (1986 to 1988) the proportion of seniors who said there was great risk associated with even experimenting with cocaine rose from 34 percent to 51 percent, and the proportion who saw great risk associated with occasional cocaine use rose from 54 percent to 69 percent.

Similar changes in cocaine use are occurring among American college students, where the annual prevalence rate for cocaine fell from 17 percent to 10 percent between 1986 and 1988. Cocaine use also fell among all young adults aged 19 to 28 who are high school graduates---from 20 percent annual prevalence in 1986 to 14 percent in 1988. These older age groups are also coming to see cocaine use as more dangerous than in the past.

Disapproval of cocaine use has also been rising among these age groups during the same interval. Fully 89 percent of the 1988 seniors said they personally disapprove of even experimenting with cocaine, up from 80 percent in 1986.

(more)

Crack: "One of the most important findings from the 1988 survey," Johnston added, "is that the use of crack cocaine declined among high school seniors for the first time, and for much the same reason. That is, an increasing number of young people have come to believe that even experimentation with crack is dangerous." Lifetime prevalence of crack use fell from 5.6 percent to 4.8 percent of all seniors between 1987 and 1988, while annual prevalence fell from 4.0 percent to 3.1 percent, after having leveled off between 1986 and 1987.

Between 1987 and 1988 the proportion of seniors who said they believe that experimentation with crack involves great risk rose from 57 percent to 62 percent, while the percent saying it was readily available rose slightly. Among the young adults, there also was a significant increase in the perceived dangers of crack use, and at the same time a substantial increase in perceived availability.

"We really can't say with much certainty whether a similar decline in crack use is occurring among the high school dropout segment of the population, which constitutes about 15 percent of the age group," stated Johnston. "Without question the crack problem is particularly concentrated in this population, especially in the inner cities. However, among the majority still in high school we do not find any evidence that the improvement is concentrated in the upper socioeconomic groups, or among the most academically able, or among those with the best attendance records. This suggests that the incidence of new use may be down even among the dropouts.

"The annual prevalence of crack use showed a decline in 1988 among college students, as well, though not a statistically significant one (from 2.0 percent to 1.4 percent), but there was little change among the 19-29 year olds (from 3.0 percent to 3.1 percent)."

National Strategy: "These important changes in young people's beliefs and attitudes about these drugs, and the declines in use which have accompanied them, tell us a great deal which is relevant to our national strategy in the overall war on drugs," Johnston commented. "The declines in use have occurred in spite of a continuing increase in the availability of cocaine and crack, as reported by seniors, and a fairly constant level of availability for marijuana. In other words, these important successes have been achieved not through supply reduction: they are due almost entirely to a reduction in demand. These results say to me that demand reduction can work, has worked, and has the potential to accomplish a great deal more."

Johnston cautioned, however, "I do not think that use among the already addicted population is likely to be affected nearly as much by an increased recognition of the dangers of crack. Changing use in that segment of the population is going to take longer and will depend heavily on our ability to provide adequate treatment capacity, attract people into treatment, and offer effective treatment. The addicted are going to require the pound of cure, not the ounce of prevention, and that's one reason why it's so very important to prevent use in the first place."

(more)

Other Illicit Drugs: In addition to marijuana, cocaine, and crack, there also was some decline observed in the use of nearly all other illicit drugs in 1988. The use of hallucinogens, stimulants, tranquilizers, opiates other than heroin, and the nitrite inhalants all fell by statistically significant amounts among the nation's high school seniors. Methaqualone and barbiturate sedatives also continued their longer term declines, though their changes in 1988 did not reach statistical significance. The lifetime prevalence for heroin remained at 0.5 percent, where it has hovered for the past nine years, following an earlier period of decline.

Among American college students the story is much the same.

Overall, the proportion of seniors using any illicit drug during the prior year fell from 42 percent in 1987 to 39 percent in 1988. (This compares with 54 percent in 1979, the peak year.) The proportion using any illicit drug other than marijuana in the prior year fell from 24 percent to 21 percent between 1987 and 1988 (which compares with a high point of about 30 percent in 1982.)

Johnston noted, "There's no question this is good news for the country, but what we cannot lose sight of is that there still remains a troublesome amount of illicit drug use among our young people, especially among the segments of the population not well covered by the surveys. Of particular concern is the number who still are willing to experiment with drugs as dangerous as cocaine or crack. And, of course, the one thing that's certain is that there are new drugs yet to come along, which will test the resolve we have inculcated in our young people. That means that prevention must be an ongoing and long-term process."

Alcohol: The 1988 survey also yielded some important results concerning alcohol use among high school students. For the first time in several years, the proportion of seniors who can be categorized as "current drinkers" (had one or more drinks in the past 30 days) declined significantly (from 66 percent to 64 percent). More important, the proportion reporting having five or more drinks in a row during the prior two weeks also declined significantly (from 38 percent to 35 percent, down from a high point of 41 percent in 1983).

Johnston said, "Just as we found no evidence during the onset of the drug epidemic for any displacement of alcohol by the illicit drugs, during this decline phase we have seen no evidence of a displacement from illicit drugs back to alcohol use. In general, these behaviors have tended to move more in parallel, but with alcohol use showing much less overall change, no doubt reflecting its enculturated status in American society.

"This modest decline in alcohol consumption does not seem to be explained by young people seeing such drinking as more dangerous. But we are seeing some change in their own normative attitudes, with an increasing number of seniors saying they personally disapprove of heavy weekend drinking." Among college students, however, and young adults generally, there has been only a slight change in the drinking rates.

(more)

Cigarette Smoking: "Clearly the most disappointing results this year relate to cigarette smoking," according to Johnston, "though that comes as little surprise, since they have been disappointing for the last four years." Neither the number of current smokers, nor the number of current daily smokers, is down significantly from where it was in the class of 1984. "That means that the initiation rate for smoking in this society has pretty well stabilized, and stabilized at a level that is still going to cut short the lives of a lot of our young people. I'm afraid this stabilization has tended to get overshadowed by the overall improvement in adult smoking rates, which results from more people quitting."

The proportion of seniors who are current smokers stands at 29 percent in 1988, with 18 percent of all seniors smoking daily. Johnston pointed out that a number of the current light smokers will graduate to heavy smoking in the years after high school, based on the patterns observed in all previous graduating classes. Cigarette smoking rates among American college students (who are far less likely to smoke than other young adults) are also unchanged since about 1984.

"Clearly the importance of these initiation rates has been underemphasized, in part because of the long delay between the onset of the addiction and the extraordinary amount of death and disease which eventually will result from it," Johnston said. "If the number of young people who eventually will die from this addiction did so in just a year or two after starting, the public outcry for action would be deafening. But the 30- or 40-year delay means that the tragic consequences of adolescent smoking are less recognized. I think it's about time we took the issue of our youngsters smoking a lot more seriously."

#########

EDITORS: The detailed findings from the 1988 survey will be published later this year by the National Institute on Drug Abuse as a research monograph, authored by Johnston, O'Malley, and Bachman, and tentatively titled "Drug Use, Drinking, and Smoking: National Survey Results from High School, College, and Young Adult Populations, 1975-1988."

(ISR;Johnston;Bachman;O'Malley)(R1-3;ISR;Ed1-3;X1a,2a,9;RTspA,B)[3628]

TABLE 1
Trends in Lifetime Prevalence of Eighteen Types of Drugs

	Percent 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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	47.2	−3.0ss
Inhalants[a]	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	16.7	−0.3
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*18.2*	*17.3*	*17.2*	*17.7*	*18.2*	*18.0*	*18.1*	*20.1*	*18.6*	*17.5*	*−1.1*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	11.1	11.1	10.1	9.8	8.4	8.1	7.9	8.6	4.7	3.2	−1.5s
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	8.9	−1.4s
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*17.7*	*15.6*	*15.3*	*14.3*	*13.6*	*12.3*	*12.1*	*11.9*	*10.6*	*9.2*	*−1.4s*
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	7.7	−0.7
PCP[c,h]	NA	NA	NA	NA	12.8	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0	2.9	−0.1
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	12.1	−3.1sss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.6	4.8	−0.8
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14.0	12.1	−1.9
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	1.1	−0.1
Other opiates[e]	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	8.6	−0.6
Stimulants[e]	22.3	22.6	23.0	22.9	24.2	26.4	32.2	35.6	35.4	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*27.9*	*26.9*	*27.9*	*26.2*	*23.4*	*21.6*	*19.8*	*−1.8s*
Sedatives[e]	18.2	17.7	17.4	16.0	14.6	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7	7.8	−0.9
Barbiturates[e]	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	6.7	−0.7
Methaqualone[e]	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	3.3	−0.7
Tranquilizers[e]	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	9.4	−1.5s
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	92.0	−0.2
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	66.4	−0.8

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.
[a] Data based on four questionnaire forms. N is four-fifths of N indicated.
[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.
[c] Data based on a single questionnaire form. N is one-fifth of N indicated.
[d] Adjusted for underreporting of PCP. See text for details.
[e] Only drug use which was not under a doctor's orders is included here.
[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
[g] Data based on two questionnaire forms. N is two-fifths of N indicated.
[h] Question text changed slightly in 1987.

TABLE 2
Trends in Annual Prevalence of Eighteen Types of Drugs

	Percent who used in last twelve months														
	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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	33.1	−3.2ss
Inhalants[a]	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	6.5	−0.4
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*8.9*	*7.9*	*6.1*	*6.6*	*6.2*	*7.2*	*7.5*	*8.9*	*8.1*	*7.1*	*−1.0*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	6.5	5.7	3.7	3.6	3.6	4.0	4.0	4.7	2.6	1.7	−0.9s
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	5.5	−0.9s
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*11.8*	*10.4*	*10.1*	*9.0*	*8.3*	*7.3*	*7.6*	*7.6*	*6.7*	*5.8*	*−0.9*
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	4.8	−0.4
PCP[c,h]	NA	NA	NA	NA	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3	1.2	−0.1
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	7.9	−2.4sss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	4.0	3.1	−0.9s
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	9.8	7.4	−2.4ss
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	0.5	0.0
Other opiates[e]	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	4.6	−0.7s
Stimulants[e]	16.2	15.8	16.3	17.1	18.3	20.8	26.0	26.1	24.6	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*20.3*	*17.9*	*17.7*	*15.8*	*13.4*	*12.2*	*10.9*	*−1.3s*
Sedatives[e]	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	3.7	−0.4
Barbiturates[e]	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	3.2	−0.4
Methaqualone[e]	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	1.3	−0.2
Tranquilizers[e]	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	4.8	−0.7
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	85.3	−0.4
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.
[a] Data based on four questionnaire forms. N is four-fifths of N indicated.
[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.
[c] Data based on a single questionnaire form. N is one-fifth of N indicated.
[d] Adjusted for underreporting of PCP. See text for details.
[e] Only drug use which was not under a doctor's orders is included here.
[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
[g] Data based on a single questionnaire form in 1986 (N is one-fifth of N indicated), and on two questionnaire forms in 1987 (N is two-fifths of N indicated).
[h] Question text changed slightly in 1987.

TABLE 3
Trends in Thirty-Day Prevalence of Eighteen Types of Drugs

	Percent who used in last thirty 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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	18.0	−3.0ss
Inhalants[a]	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	2.6	−0.2
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*3.2*	*2.7*	*2.5*	*2.5*	*2.5*	*2.6*	*3.0*	*3.2*	*3.5*	*3.0*	*−0.5*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	2.4	1.8	1.4	1.1	1.4	1.4	1.6	1.3	1.3	0.6	−0.7s
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	2.2	−0.3
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*5.3*	*4.4*	*4.5*	*4.1*	*3.5*	*3.2*	*3.8*	*3.5*	*2.8*	*2.3*	*−0.5*
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	1.8	0.0
PCP[c,h]	NA	NA	NA	NA	2.4	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6	0.3	−0.3
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	3.4	−0.9ss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.5	1.6	+0.1
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	3.2	−0.9
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	0.2	0.0
Other opiates[e]	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	1.6	−0.2
Stimulants[e]	8.5	7.7	8.8	8.7	9.9	12.1	15.8	13.7	12.4	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*10.7*	*8.9*	*8.3*	*6.8*	*5.5*	*5.2*	*4.6*	*−0.6*
Sedatives[e]	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	1.4	−0.3
Barbiturates[e]	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	1.2	−0.2
Methaqualone[e]	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	0.5	−0.1
Tranquilizers[e]	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	1.5	−0.5s
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	63.9	−2.5s
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	28.7	−0.7

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.
[a] Data based on four questionnaire forms. N is four-fifths of N indicated.
[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.
[c] Data based on a single questionnaire form. N is one-fifth of N indicated.
[d] Adjusted for underreporting of PCP. See text for details.
[e] Only drug use which was not under a doctor's orders is included here.
[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
[g] Data based on two questionnaire forms. N is two-fifths of N indicated.
[h] Question text changed slightly in 1987.

TABLE 4
Trends in Thirty-Day Prevalence of Daily Use of Eighteen Types of Drugs

	Percent who used daily in last thirty 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	Class of 1988	'87–'88 change[g]
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
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	2.7	−0.6s
Inhalants[a]	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	0.2	+0.1
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*0.1*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.4*	*0.4*	*0.4*	*0.3*	*−0.1*
Amyl & Butyl Nitrites[c,i]	NA	NA	NA	NA	0.0	0.1	0.1	0.0	0.2	0.1	0.3	0.5	0.3	0.1	−0.2
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	0.0	−0.1
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*0.2*	*0.2*	*0.1*	*0.2*	*0.2*	*0.2*	*0.3*	*0.3*	*0.2*	*0.0*	*−0.2s*
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	0.0	0.0[g]
PCP[c,i]	NA	NA	NA	NA	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3	0.1	−0.2
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	0.2	−0.1
"Crack"[h]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	0.1	−0.1
Other cocaine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	0.2	0.0
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	0.0	0.0
Other opiates[e]	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	0.1	0.0
Stimulants[e]	0.5	0.4	0.5	0.5	0.6	0.7	1.2	1.1	1.1	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*0.7*	*0.8*	*0.6*	*0.4*	*0.3*	*0.3*	*0.3*	*0.0*
Sedatives[e]	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	0.1	0.0
Barbiturates[e]	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	0.0	0.0[g]
Methaqualone[e]	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	0.1	0.0[g]
Tranquilizers[e]	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	0.0	0.0[g]
Alcohol															
Daily	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	4.2	−0.6
5+ drinks in a row/ last 2 weeks	36.8	37.1	39.4	40.3	41.2	41.2	41.4	40.5	40.8	38.7	36.7	36.8	37.5	34.7	−2.8s
Cigarettes															
Daily	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	18.1	−0.6
Half-pack or more per day	17.9	19.2	19.4	18.8	16.5	14.3	13.5	14.2	13.8	12.3	12.5	11.4	11.4	10.6	−0.8

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.
[a] Data based on four questionnaire forms. N is four-fifths of N indicated.
[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.
[c] Data based on a single questionnaire form. N is one-fifth of N indicated.
[d] Adjusted for underreporting of PCP. See text for details.
[e] Only drug use which was not under a doctor's orders is included here.
[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
[g] Any apparent inconsistency between the change estimate and the prevalence estimates for the two most recent classes is due to rounding error.
[h] Data based on two questionnaire forms. N is two-fifths of N indicated.
[i] Question text changed slightly in 1987.

TABLE 5

Trends in Lifetime, Annual, and Thirty-Day Prevalence in an Index of Illicit Drug Use

(Based on Original and Adjusted Amphetamine Questions)[a]

	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	Class of 1988	'87–'88 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	
Percent reporting use in lifetime															
Marijuana Only	19.0	22.9	25.8	27.6	27.7	26.7	22.8	20.8	19.7	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	23.3	22.5	21.3	20.9	19.9	20.8	21.4	+0.6
Any Illicit Drug Other Than Marijuana[b]	36.2	35.4	35.8	36.5	37.4	38.7	42.8	45.0	44.4	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	41.1	40.4	40.3	39.7	37.7	35.8	32.5	−3.3sss
Total: Any Illicit Drug Use	55.2	58.3	61.6	64.1	65.1	65.4	65.6	65.8	64.1	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	64.4	62.9	61.6	60.6	57.6	56.6	53.9	−2.7ss
Percent reporting use in last twelve months															
Marijuana Only	18.8	22.7	25.1	26.7	26.0	22.7	18.1	17.0	16.6	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	19.3	19.0	17.8	18.9	18.4	17.6	17.4	−0.2
Any Illicit Drug Other Than Marijuana[b]	26.2	25.4	26.0	27.1	28.2	30.4	34.0	33.8	32.5	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	30.1	28.4	28.0	27.4	25.9	24.1	21.1	−3.0sss
Total: Any Illicit Drug Use	45.0	48.1	51.1	53.8	54.2	53.1	52.1	50.8	49.1	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	49.4	47.4	45.8	46.3	44.3	41.7	38.5	−3.2sss
Percent reporting use in last thirty days															
Marijuana Only	15.3	20.3	22.4	23.8	22.2	18.8	15.2	14.3	14.0	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	15.5	15.1	14.1	14.8	13.9	13.1	11.3	−1.8s
Any Illicit Drug Other Than Marijuana[b]	15.4	13.9	15.2	15.1	16.8	18.4	21.7	19.2	18.4	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	17.0	15.4	15.1	14.9	13.2	11.6	10.0	−1.6ss
Total: Any Illicit Drug Use	30.7	34.2	37.6	38.9	38.9	37.2	36.9	33.5	32.4	–	–	–	–	–	
Adjusted Version	–	–	–	–	–	–	–	32.5	30.5	29.2	29.7	27.1	24.7	21.3	−3.4sss

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.

[a] Adjusted questions about stimulant use were introduced in 1982 to exclude more completely the inappropriate reporting of non-prescription stimulants.

[b] Use of "other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

TABLE 6

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									
	1980	1981	1982	1983	1984	1985	1986	1987	1988	'87–'88 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(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	4.6	6.3	4.3	3.7	2.2	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	–3.7ss
"Crack"[c]	NA	NA	NA	NA	NA	NA	1.3	2.0	1.4	–0.6
Heroin	0.4	0.2	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	2.6	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	91.6	90.0	92.0	91.5	90.9	89.6	–1.3
Cigarettes	36.2	37.6	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, sss = .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.

TABLE 7

Trends in Annual Prevalence of Fourteen Types of Drugs
Among Follow-Up Respondents 1–11 Years Beyond High School

	Percent who used in last twelve months		
	1987	1988	'87–'88 change
Approx. Wtd. N =	(7450)	(7320)	
Marijuana	34.3	31.3	–3.0sss
Inhalants[b]	2.0	1.7	–0.3
LSD	2.8	2.8	0.0
Cocaine	15.6	13.8	–1.8ss
"Crack"[c]	3.0	3.1	+0.1
Heroin	0.3	0.2	–0.1
Other Opiates[a]	3.0	2.6	–0.4
Stimulants, Adjusted[a,d]	8.5	7.1	–1.4ss
Sedatives[a]	2.5	2.1	–0.4
Barbiturates[a]	2.0	1.9	–0.1
Methaqualone[a]	0.9	0.5	–0.4ss
Tranquilizers[a]	5.1	4.3	–0.8s
Alcohol	89.1	88.5	–0.6
Cigarettes	39.9	37.5	–2.4ss

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

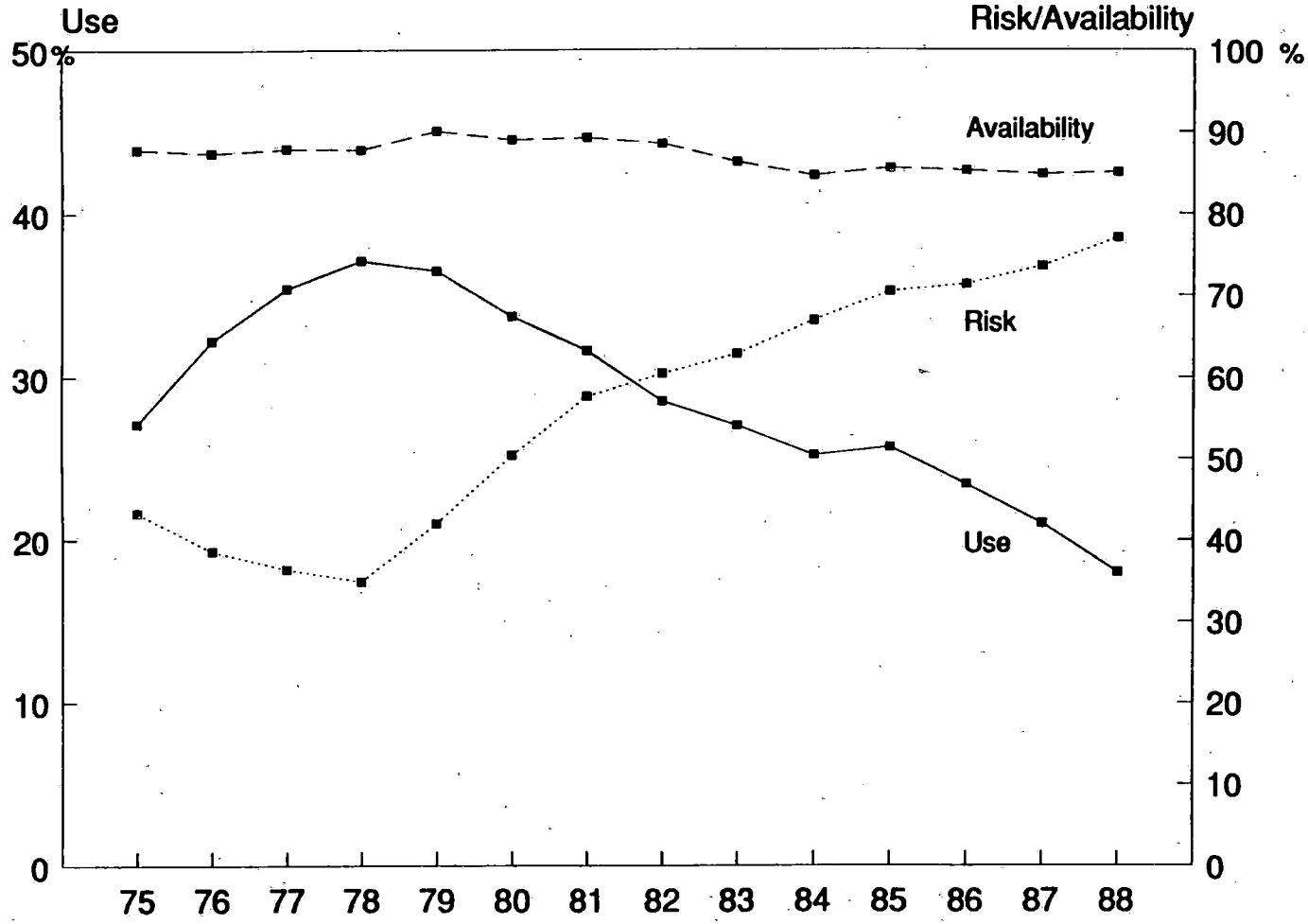
[a] Only drug use which was not under a doctor's orders is included here.

[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 two of the five questionnaire forms. 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.

FIGURE 1
Trends in Marijuana Availability,
Perceived Risk of Regular Use, and Use in Past 30 Days
High School Seniors

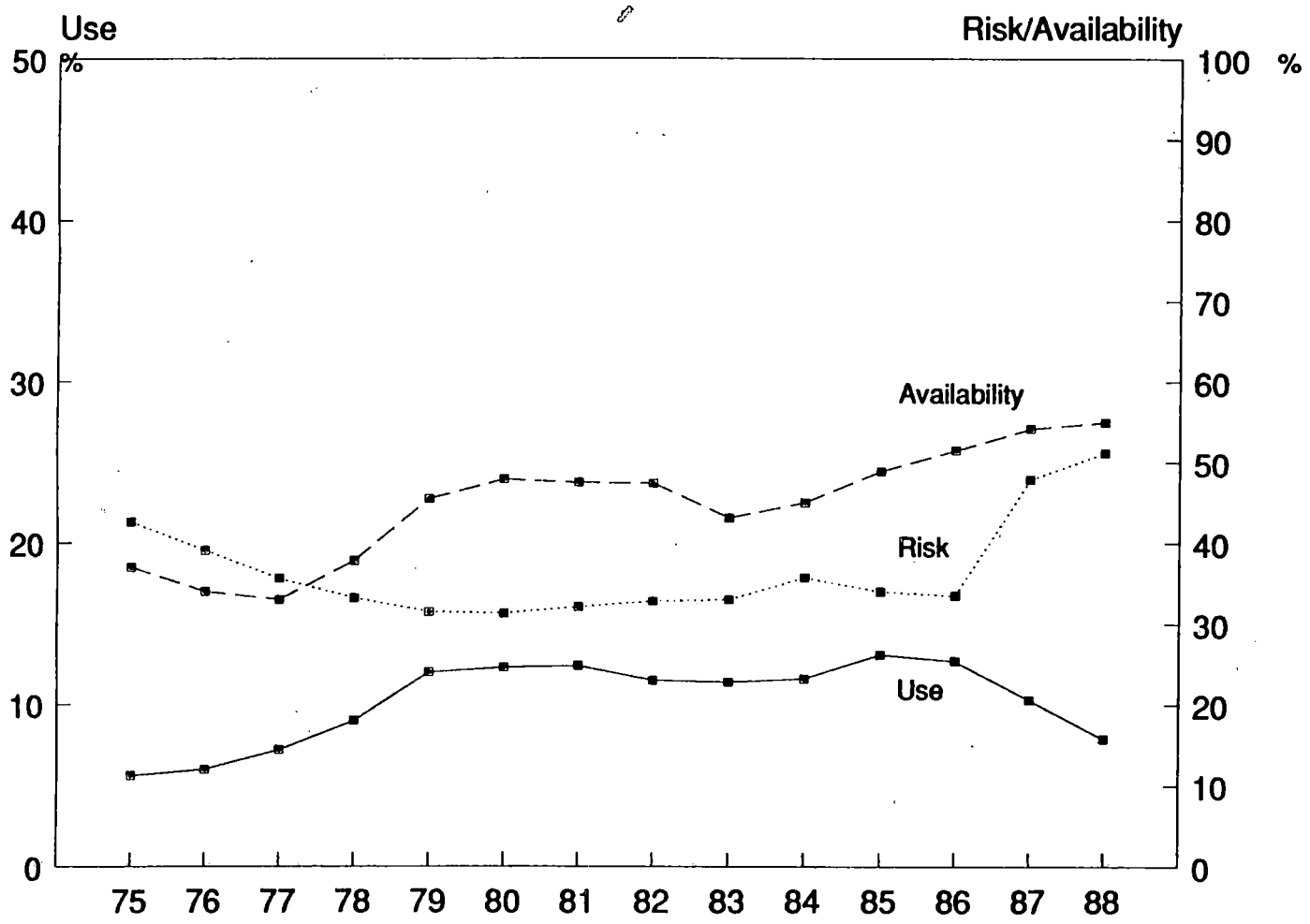


Use: % using once or more in past 30 days

Risk: % saying great risk of harm in regular use

Availability: % saying fairly easy or very easy to get

FIGURE 2
Trends in Cocaine Availability,
Perceived Risk of Trying, and Use in Past Year
High School Seniors



Use: % using once or more in past 12 months

Risk: % saying great risk of harm in using once or twice

Availability: % saying fairly easy or very easy to get

SPEAKERS

Press Conference

on

1988 NATIONAL HIGH SCHOOL SENIOR DRUG ABUSE SURVEY

February 28, 1989
U.S. Department of Health and Human Services

Frederick K. Goodwin, M.D., Administrator of the Alcohol, Drug Abuse and Mental Health Administration, DHHS

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

Lloyd D. Johnston, Ph.D., Institute for Social Research, University of Michigan, Principal Investigator

Susan B. Lachter, Director of the Office for Research Communications, NIDA, Moderator

RESOURCE CONTACTS

1988 NATIONAL HIGH SCHOOL SENIOR DRUG ABUSE SURVEY

Lloyd D. Johnston, Ph.D., Jerald G. Bachman, Ph.D., and
Patrick M. O'Malley, Ph.D., Principal Investigators
Institute for Social Research, University of Michigan,
Ann Arbor, MI (313) 763-5043

Charles R. Schuster, Ph.D., Director, National Institute on
Drug Abuse (NIDA), (301) 443-6245

Edgar H. Adams, Sc.D., Director, Division of Epidemiology and
Statistical Analysis (DESA), NIDA, (301) 443-6504

Beatrice A. Rouse, Ph.D., Chief, Epidemiology Research Branch,
DESA, NIDA, and Project Officer, National High School Senior
Drug Abuse Survey, (301) 443-2974

Susan B. Lachter, Director, Office for Research Communications,
NIDA, (301) 443-1124

Mona Whittaker, Press Officer, NIDA, (301) 443-6245

NIDA Capsules

Issued by the Press Office of the National Institute on Drug Abuse
5600 Fishers Lane, Rockville, Maryland 20857
(301) 443-6245

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

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.

###

NIDA Capsules

Issued by the Press Office of the National Institute on Drug Abuse
5600 Fisners Lane, Rockville, Maryland 20857
(301) 443-6245

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 eight 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

- 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.
- 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%).
- 12% of boys and 1% of girls reported having chewed tobacco or used snuff during the past month.
- 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

- 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.
- 34% of 8th grade students and 53% of 10th grade students report having had an alcoholic beverage during the past month.
- 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.
- 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.

August 1988

C-88-04

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Alcohol, Drug Abuse, and Mental Health Administration

NIDA Capsules

Issued by the Press Office of the National Institute on Drug Abuse
5600 Fishers Lane, Rockville, Maryland 20857
(301) 443-6245

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/ethicity, 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.

(more)

C-83-07a

Revised April, 1988

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.

###

NIDA Capsules

Issued by the Press Office of the National Institute on Drug Abuse
5600 Fishers Lane, Rockville, Maryland 20857
(301) 443-6245

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.

	1988		1985	
	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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Drug Abuse

Overview of Selected Drug Trends

Division of Epidemiology and Statistical Analysis
National Institute on Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857

OVERVIEW OF SELECTED DRUG TRENDS

Edgar H. Adams*
Ann J. Blanken*
Joseph C. Gfroerer*
Lorraine D. Ferguson*

The National Institute on Drug Abuse (NIDA) is the lead Federal agency responsible for supporting research directed at improving our understanding of the bio-medical and bio-behavioral bases of drug use and the development of improved drug abuse prevention and treatment techniques.

Since the 1960s, illicit drug use has become pervasive in American society. Evidence gathered through two major national surveys conducted by NIDA showed increasing drug use from the early 1970s through 1979. Following that peak year, through the early 1980s, these surveys generally showed a reversal of the upward trend. The most recent National Household Survey on Drug Abuse shows that among 18-25 year olds, the age group with the highest prevalence of illicit drug use, the prevalence of nonmedical use of most licit and illicit drugs continued to decrease or level off in 1985. Increasing prevalence levels were found for persons age 26 and older, a reflection of the aging of drug using individuals. The decline between in drug use among America's high school seniors continued with the class of 1987, following a brief interruption in the downward trend for the class of 1985. Although the national surveys indicate that cocaine use is an exception to the general the pattern of decline, there was a significant decline between 1985 and 1987 in percentage of seniors that reported using cocaine during the past month, the past year or sometime in their lifetime.

While the general trends are encouraging, it is widely believed by many experts in the field that the level of drug use in the United States is higher than that in any other industrial nation. More than one half of American youth try an illicit drug before they finish high school. An estimated 23 million Americans used a drug illicitly in the month prior to being surveyed in the 1985 National Household Survey on Drug Abuse. The number of people admitted to emergency rooms following cocaine use, as reported by the Drug Abuse Warning Network (DAWN), increased more than fivefold over the past five 12-month periods. Further, the number of people who died following cocaine use, as reported by DAWN, increased almost fourfold during the same time period. Drug use in the United States clearly remains a major public health problem; it is pervasive in extent, diverse in its manifestations, and constantly changing.

The changes in drug usage patterns since the early 1960s have increased concern about the adverse health effects associated with drug use. In addition to medical emergencies and deaths related to drug abuse, other short- and long-term effects resulting from chronic drug use have been identified for

---

*The Division of Epidemiology and Statistical Analysis, National Institute on Drug Abuse, prepared December 1988.

further research. These include automobile accidents, accidents in the workplace, learning disabilities, interference with normal reproductive function, adverse effects on developing fetuses, and long-term damage to the heart, lungs, and other organs.

Data presented in this paper are extracted from the 1985 National Household Survey on Drug Abuse, the 1987 High School Senior Survey, the Drug Abuse Warning Network through June 1988, and the Client Oriented Data Acquisition Process (CODAP) through 1985. It should be noted that the Omnibus Reconciliation Act of 1981, which enacted the Block Grant funding program, deleted various State reporting requirements (e.g., CODAP). Accordingly, the treatment data presented here are not national, but reflect reporting by 15 States which continued to share data with NIDA on a voluntary basis. It should be noted that California is one of the 15 States reporting to CODAP, and data from that State account for approximately one-half of the treatment admissions. The DAWN data are derived from a nonrandom sample of participating emergency room and medical examiner facilities located primarily in 27 metropolitan areas. The medical examiner data for the most recent year are incomplete due to a lag in reporting, thus caution should be exercised when analyzing the apparent increases or decreases. The New York City medical examiner office is again participating in the DAWN system as of January 1988. That data will continue to be shown separately from the total ME mentions for the next five years, when full data will be available. Both the Household and the High School Senior surveys, however, are based on national probability samples and, accordingly, provide national estimates of the surveyed populations. Summaries of the data from these studies regarding heroin, cocaine, marijuana, and PCP follow.

Heroin/Morphine Trends

The number of heroin mentions in DAWN emergency rooms in all metropolitan areas increased over the five 12-month periods ending June 1984 through June 1988 from 11,288 to 15,037. Analysis of nine metropolitan areas whose data represent 81 percent of all the heroin mentions in the five 12-month periods shows increases between the 12-month periods ending June 1987 and June 1988 in all metropolitan areas except Detroit. The New York area reported almost twice as many heroin mentions (3,364 mentions) than were reported by the second ranked city, Washington D.C. with 1,859 mentions. In the Philadelphia area, the number of heroin related emergencies increased considerably from 420 to 868 and in New Orleans from 219 to 564 between the last two 12-month periods.

Data on the number of heroin related deaths as reported to DAWN from all metropolitan areas shows some fluctuation between the 12-month period ending June 1984 and the 12-month period ending June 1987, 907 deaths to 1,352 deaths, respectively. Provisional data show 1,411 deaths reported thus far in the 12-month period ending June 1988. In the seven metropolitan areas which make up 81 percent of the data on the number of heroin related deaths, increases in the last two 12-month periods were noted in all but two of the metropolitan areas (Los Angeles and Detroit). A large drop in deaths in the Detroit area was reported, from 239 in the 12-month period ending June 1987 to 133 thus far in the 12-month period ending June 1988.

Demographics

Eighty-one percent of the emergency room episodes in 1987 involving heroin occurred among individuals 20-39 years old; 69 percent were male. Fifty percent were black, 31 percent were white, and 13 percent were Hispanic. Although similar distributions were noted among DAWN deaths involving heroin by sex and age, i.e., the majority were male (80%) and 20-39 years of age (75%); the representation by race was similar for blacks and whites (44 percent were white, 42 percent were black, and 12 percent were Hispanic).

In 1985, 64 percent of the clients admitted to drug abuse treatment programs in 15 States for a primary heroin problem were male; 47 percent were white, 22 percent were black and 30 percent were Hispanic. Over half of the clients with a primary heroin problem (55%) were between 30-44 years of age.

Trends in Hospital Emergency Room (ER) and Medical Examiner (ME) Mentions of Heroin/Morphine

Total DAWN System and Metropolitan Areas	July 1983 thru June 1984	July 1984 thru June 1985	July 1985 thru June 1986	July 1986 thru June 1987	July 1987 thru June 1988
Total ER Mentions*	11,288	11,092	12,452	12,970	15,037
of which:					
New York	3,723	2,732	3,003	3,243	3,364
Washington, D.C.	1,054	1,514	1,077	1,213	1,859
Detroit	2,885	1,990	1,797	1,937	1,602
Los Angeles	1,057	898	1,788	1,407	1,434
Chicago	398	532	675	857	1,109
Philadelphia	292	370	382	420	868
Baltimore	233	361	377	592	827
New Orleans	219	246	123	219	564
Seattle	146	222	400	393	547
Total ME mentions** (less Newark and New York City)	907	1,165	1,645	1,352	1,411**
of which:					
Los Angeles	252	290	560	353	326
Washington, D.C.	147	214	148	172	243
Philadelphia	63	77	117	98	172
Detroit	138	212	207	239	133
San Francisco	69	82	169	117	123
San Diego	56	59	91	64	78
Baltimore	35	55	25	57	69
New York City	--	--	--	--	14
Newark	33	68	48	68	68

*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 at least 81 percent of the mentions in the 12-month period ending June 1988.

**Provisional data due to lag in reporting.

--Data not available

Source: NIDA, Drug Abuse Warning Network (DAWN) September 1988 data file.

Heroin and Cocaine Trends

As "speedballing," or the combined use of cocaine and heroin has become increasingly more common, so have the health consequences associated with using this combination of drugs. It should be noted that mentions of both cocaine and heroin for a single DAWN case does not necessarily mean that the two drugs were used in combination, only that they were both used and related to the case at hand.

The number of mentions of both heroin and cocaine in the same DAWN emergency room episode in all the metropolitan areas, for instance, nearly tripled from 1,837 mentions in the 12-month period ending June 1984 to 5,301 mentions in the 12-month period ending June 1988. The New York area accounted for 23 percent of the total mentions in the 12-month period ending June 1988, showing an increase from 966 mentions to 1,233 mentions in the last two 12-month periods. Among the eight metropolitan areas which made up over 80 percent of the mentions in the 12-month period ending June 1988, all reported increases in heroin and cocaine mentions between the last two 12-month periods. The largest increase was reported in Philadelphia with 124 mentions in the 12-month period ending June 1987 increasing to 331 mentions in the 12-month period ending June 1988. Other metropolitan areas reporting significant increases were New Orleans, Baltimore, Chicago, Los Angeles and Washington, D.C.

In all the metropolitan areas, DAWN deaths associated with the use of both heroin and cocaine increased notably from 109 deaths in the 12-month period ending June 1984 to 404 deaths in the 12-month period ending June 1987, and provisional data show that 531 heroin and cocaine related deaths were reported thus far for the 12-month period ending June 1988. Of the five metropolitan areas examined, Boston, Washington, D.C. and Philadelphia showed increases in mentions between the last two 12-month periods, with an especially high increase in Philadelphia from 23 mentions to 89 mentions in those two years.

Data from a panel of 596 consistently-reporting treatment programs in 15 States showed that the number of clients admitted who had problems with both heroin and cocaine increased from 8,883 in 1979 to 13,494 in 1984.

Demographics

As reported in a special study of this combination of drugs, in more than 50 percent of the emergency room episodes in 1986 involving cocaine and heroin the patients were black (54%); 28 percent were white. Seventy percent were male and 74 percent were 25-39 years of age. Among heroin and cocaine drug related deaths, 47 percent of the decedents were black and 35 percent were white; 79 percent were male, and 71 percent were 25-39 years of age.

Again in a special study, 69 percent of the clients reporting a problem with cocaine and heroin at admission to treatment in 1984 were male; 35 percent were white, 51 percent were black, and 13 percent were Hispanic. The average age of heroin and cocaine clients at admission was 31.0 years.

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

Total DAWN System and Metropolitan Areas	July 1983 thru June 1984	July 1984 thru June 1985	July 1985 thru June 1986	July 1986 thru June 1987	July 1987 thru June 1988
Total ER Mentions*	1,837	2,065	2,453	3,536	5,301
of which:					
New York	975	813	917	966	1,233
Chicago	86	131	253	491	648
Washington, D.C.	101	194	170	303	638
Los Angeles	92	99	201	260	403
Detroit	195	140	216	336	354
New Orleans	98	152	65	139	339
Philadelphia	42	79	125	124	331
Baltimore	25	44	59	150	272
Total ME Mentions** (Less Newark and New York City)	109	193	334	404	531**
of which:					
Washington, D.C.	20	49	43	73	104
Los Angeles	29	50	97	102	97
Philadelphia	4	5	14	23	89
Detroit	7	14	42	74	52
Boston	0	8	21	20	38
New York City	--	--	--	--	7
Newark	10	27	18	37	50

*Based on consistently reportings 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 at least 80 percent of the mentions in the 12-month reporting period ending June 1988.

**Provisional data due to lag in reporting.

--Data not available

Source: NIDA, Drug Abuse Warning Network (DAWN) September 1988 data file.

Cocaine Trends

The most recent National Household Survey on Drug Abuse shows that in 1985 an estimated 22 million persons in the continental United States had at least tried cocaine. Of these, approximately 12 million had used it at least once in the past year and approximately 6 million at least once in the month prior to the survey. Past year use of cocaine increased from 1982 to 1985 among youth age 12-17 years and adults age 26 and above, while a decrease was reported for the 18-25 year-old age group. Past month use of cocaine increased from 1982 to 1985 in each of these three age categories. The most recent data from the High School Senior Survey show that for the first time since 1981, the percent of high school seniors reporting use of cocaine declined. Past year use dropped significantly between 1986 and 1987 from 12.7 percent to 10.3 percent and past month use dropped from 6.2 percent to 4.3 percent. The proportion of seniors who had ever used cocaine also dropped between 1986 and 1987 from 16.9 percent to 15.2 percent.

Data from the DAWN system continue to show increases in adverse health consequences associated with the use of cocaine. Over the past five 12-month periods, the number of hospital emergencies associated with the use of the drug increased from 7,155 in the 12-month period ending June 1984 to 39,657 in the 12-month period ending June 1988. Between the last two 12-month periods, the total cocaine mentions increased 57 percent from 25,308 mentions to 39,657 mentions. This increase in the number of cocaine related emergency room visits appears to be distributed across most of the major metropolitan areas of the United States that report to DAWN. The ten metropolitan areas shown in the table account for 80 percent of all cocaine mentions; three of these metropolitan areas, which more than doubled the number of cocaine related mentions between the two most recent 12-month periods are Washington, D.C. from 1,944 mentions to 4,516 mentions; Philadelphia from 1,704 mentions to 4,171 mentions; and New Orleans from 1,078 mentions to 2,670 mentions. Three other metropolitan areas that nearly doubled the number of cocaine related mentions betweeen the two most recent 12-month periods were Dallas, Baltimore and Seattle.

The number of cocaine related deaths reported by all metropolitan areas also increased almost fourfold from 470 in the 12-month period ending June 1984 to 1,582 (provisional data) in the 12-month period ending June 1988. Provisional DAWN mortality data indicate that the largest increases over the past two 12-month periods occurred in the Philadelphia area where cocaine related deaths increased from 93 mentions to 222 mentions and Washington, D.C. where deaths increased from 113 to 182 mentions. A large decrease in cocaine related deaths were reported from the Los Angeles area, from 398 mentions in the 12-month period ending June 1987 to 338 mentions (provisional data) in the 12-month period ending June 1988.

Factors, such as a trend towards more dangerous routes of administration, may be related to the observed cocaine trends in emergency room and medical examiner data. In the past, cocaine was, for the most part, sniffed or snorted. In recent years, smoking or "freebasing" cocaine has become a more

common occurrence. This practice is much more serious than snorting since smoking cocaine increases the pharmocological effects of the drug resulting in an enormous craving for the drug. The trend toward increased smoking of cocaine appears to have accelerated in some parts of the country following the street marketing introduction of the base form of cocaine called "crack." Data from the 1985 National Household Survey on Drug Abuse show that 21 percent of the people who have ever used cocaine have used freebase and 8 percent have used cocaine intravenously. Recent cocaine users are more likely to have ever used freebase: 38 percent of the past month users compared with 20 percent of the past year users and 10 percent of those last using cocaine over a year ago. Among high school seniors in the class of 1987, 5.6 percent reported having tried crack while 4 percent used it in the past year.

The percent of clients admitted to treatment for a primary problem of cocaine abuse, who reported smoking cocaine as their primary route of administration increased from 1.4 percent in 1979 to 18.7 percent in 1984, based on a panel of facilities from 15 States. Between 1984 and 1986, the proportion of cocaine-related hospital emergency room episodes involving smoking as the route of administrative increased from approximately 1 in 15 patients to 1 in 5.

Demographics

The 1985 National Household Survey on Drug Abuse indicates that among youth (age 12-17), 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 (age 18-25), the rates are highest for whites (28% and 18%) compared to Hispanics (15% and 12%) and blacks (14% and 11%). Among older adults (over age 25), these rates are highest among blacks (7% and 3%) as compared to whites (4% and 1%) and Hispanics (3% and 1%).

Demographic data for cocaine related emergency room patients from the DAWN system in 1987 suggest a predominance of males (66%) and adult patients in their 20s and 30s (85% were 20-39 years of age). Fewer whites than blacks were seen in emergency rooms for cocaine emergencies (28% and 55%, respectively).

Demographic data on cocaine related deaths in 1987 are similar to data shown for cocaine emergencies except that the numbers of whites and blacks were quite similar (39 percent and 47 percent respectively), while 11 percent were Hispanic. Eighty percent were male and 79 percent were 20-39 years of age.

Treatment data show that in 1985 the majority of cocaine clients were male (72%); 51 percent were white, 38 percent were black and 10 percent were Hispanic. The majority of the clients were between 20-29 years of age (60%).

Trends in Past Year and Past Month Use of Cocaine
by Age Category
1972-1985

	Estimated Percent of the Population						
	1972	1974	1976	1977	1979	1982	1985
Age 12-17							
Used in Past Year	1.5	2.7	2.3	2.6	4.2	4.1	4.4
Used in Past Month	.6	1.0	1.0	.8	1.4	1.6	1.8
Age 18-25							
Used in Past Year	NA	8.1	7.0	10.2	19.6	18.8	16.4
Used in Past Month	NA	3.1	2.0	3.7	9.3	6.8	7.7
Age 26 and Above							
Used in Past Year	NA	*	.6	.9	2.0	3.8	4.2
Used in Past Month	NA	*	*	*	.9	1.2	2.1

*less than 0.5%

Source: National Household Survey on Drug Abuse, 1972-1985.

Trends in Lifetime, Past Year, Past Month and Daily Use[1]/
of Cocaine by High School Seniors
1980-1987

	Class of							
	1980	1981	1982	1983	1984	1985	1986	1987
Ever Used	15.7	16.5	16.0	16.2	16.1	17.3	16.9	15.2
Used in Past Year	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3
Used in Past Month	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3
Used Daily/Past Month	.2	.3	.2	.2	.2	0.4	0.4	0.3

1/Daily use is defined as use 20 or more times in the past month.

Source: Monitoring the Future Study, 1980-1987.

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

Total DAWN System and Metropolitan Areas	July 1983 thru June 1984	July 1984 thru June 1985	July 1985 thru June 1986	July 1986 thru June 1987	July 1987 thru June 1988
Total ER Mentions*	7,155	9,032	13,247	25,308	39,657
of which:					
New York	2,447	2,371	3,240	5,140	6,393
Washington, D.C.	417	648	981	1,944	4,516
Detroit	576	673	1,432	3,387	4,434
Philadelphia	249	439	865	1,704	4,171
Chicago	376	575	1,079	2,232	3,446
New Orleans	356	556	365	1,078	2,670
Los Angeles	900	1,273	1,814	2,399	2,642
Dallas	41	116	296	688	1,199
Baltimore	87	148	245	639	1,155
Seattle	209	193	315	598	1,129
Total ME Mentions (less Newark and New York City)	470	606	930	1,265	1,582**
of which:					
Los Angeles	126	163	267	398	338
Philadelphia	13	32	51	93	222
Washington, D.C.	41	69	67	113	182
San Francisco	59	64	70	128	147
Detroit	13	27	71	129	119
Boston	7	31	72	70	70
San Diego	24	28	38	28	69
New York City	--	--	--	--	142
Newark	24	53	50	88	122

*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 at least 72 percent of the mentions in the 12-month period ending June 1988.

**Provisional data due to lag in reporting.

--Data not available

Source: NIDA, Drug Abuse Warning Network (DAWN) September 1988 data file.

Marijuana/Hashish Trends

According to the 1985 National Household Survey on Drug Abuse, an estimated 62 million persons had tried marijuana/hashish at least once in their lifetime; 18 million had used it at least once in the past month. Of the youth age 12-17, 24 percent reported ever having tried marijuana/hashish, a percent which is slightly lower than was reported for their counterparts in 1982 (27%). This decrease in the lifetime prevalence rate is in contrast to the trends of the 1970s when successive youth cohorts typically reported greater experience with marijuana/hashish in each survey year. Lifetime prevalence of marijuana use among young adults (ages 18-25) followed a similar pattern, decreasing from 64 percent in 1982 to 60 percent in 1985. Trends in annual and current (use in the past month) prevalence exhibited similar downturns among older adults and young adults. However, current prevalence increased slightly among youth 12-17. The pattern of decreasing marijuana/hashish use among high school seniors continued with the class of 1987, following a leveling of this trend in 1985.

This report includes marijuana and hashish mentions for emergency rooms and medical examiners, and considerably higher counts were noted in the medical examiner data. After investigation, it was discovered that medical examiners cannot distinguish between marijuana and hashish in their testing, and usually reported hashish. Although adjustments were made for this report, care should be exercised if comparisons are made to previous overview reports. Marijuana and hashish are combined in the Household and High School Senior surveys.

The number of DAWN marijuana/hashish emergency room mentions in all metropolitan areas increased over the past five 12-month periods from 3,490 in the 12-month period ending June 1984 to 7,934 in the 12-month period ending June 1988. An analysis of nine metropolitan areas, representing 75 percent of the emergencies in the 12-month period ending June 1988, shows increases between the past two 12-month periods in all areas. A substantial increase in marijuana/hashish mentions, from 114 mentions in the 12-month period ending June 1987 to 287 mentions in the 12-month period ending June 1988, was noted in the Phoenix area. Another area showing a substantial increase is Washington, D.C., reporting 237 mentions in the 12-month period ending June 1984, increasing to 1,378 mentions in the 12-month period ending June 1988.

Interpreting the trend of marijuana emergencies is problematic since marijuana is often used in conjunction with other substances, such as PCP, alcohol, or heroin. In fact, in 1987, 83 percent of all marijuana emergency room mentions were in combination with another substance. Also, because of the recent increases in marijuana mentions, an informal study was performed using the most current unpublished data to determine if there has been a change in reporting patterns. The conclusions are that mentions of marijuana used alone have increased slightly but marijuana mentions in combination with other drugs have increased more substantially.

Demographics

The 1985 National Household Survey on Drug Abuse indicates that more whites than blacks or Hispanics have tried marijuana/hashish at least once in their lifetime, with the exception of adults 26 years of age and older where 21 percent of blacks have tried the drug, as compared to 16 percent of whites and 12 percent Hispanics. Except for youth aged 12-17 where the rate is highest for whites (13%) followed by Hispanics (10%) and blacks (8%), current use of marijuana/hashish is highest among blacks.

In DAWN emergency rooms in 1987, 73 percent of marijuana/hashish patients were under the age of 30. The majority were male (72%) and 40 percent were white, 46 percent black, and 7 percent Hispanic.

Clients admitted to treatment in 1985 for marijuana/hashish use were primarily male (80%) and were primarily white (69%). Most (72%) of primary marijuana/hashish admission clients were under 26 years of age.

Trends in Past Year and Past Month Use of Marijuana
by Age Category
1972-1985

	Estimated Percent of the Population						
	1972	1974	1976	1977	1979	1982	1985
Age 12-17							
Used in Past Year	NA	18.5	18.4	22.3	24.1	20.6	20.0
Used in Past Month	7.0	12.0	12.3	16.6	16.7	11.5	12.3
Age 18-25							
Used in Past Year	NA	34.2	35.0	38.7	46.9	40.4	37.0
Used in Past Month	27.8	25.2	25.0	27.4	35.4	27.4	21.9
Age 26 and Above							
Used in Past Year	NA	3.8	5.4	6.4	9.0	10.6	9.5
Used in Past Month	2.5	2.0	3.5	3.3	6.0	6.5	6.2

Source: National Household Survey on Drug Abuse, 1972-1985.

Trends in Lifetime, Past Year, Past Month and Daily Use[1]/
of Marijuana by High School Seniors
1980-1987

	Class of							
	1980	1981	1982	1983	1984	1985	1986	1987
Ever Used	60.3	59.5	58.7	57.0	54.9	54.2	50.9	50.2
Used in Past Year	48.8	46.1	44.3	42.3	40.0	40.6	38.8	36.3
Used in Past Month	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0
Used Daily/Past Month	9.1	7.0	6.3	5.5	5.0	4.9	4.0	3.3

1/Daily use is defined as use 20 or more times in the past month.

Source: Monitoring the Future Study, 1980-1987.

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

Total DAWN System and Metropolitan Areas	July 1983 thru June 1984	July 1984 thru June 1985	July 1985 thru June 1986	July 1986 thru June 1987	July 1987 thru June 1988
Total ER Mentions*	3,490	3,508	4,250	5,564	7,934
of which:					
Washington, D.C.	237	207	424	903	1,378
Chicago	180	267	438	541	757
New York	688	517	538	531	734
Detroit	461	226	493	591	731
New Orleans	97	141	180	415	556
Dallas	29	117	216	401	547
Philadelphia	214	210	269	289	404
Los Angeles	567	636	497	264	315
Phoenix	60	47	56	114	287
Total ME Mentions (less Newark and New York City)	107	109	125	107	147**
of which:					
Washington, D.C.	43	43	52	34	36
St. Louis	0	1	9	2	29
Detroit	11	5	19	31	23
Philadelphia	22	23	17	13	13
San Francisco	0	1	1	7	11
New York City	--	--	--	--	6
Newark	8	12	18	11	19

*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 at least 76 percent of the mentions in the 12-month period ending June 1988.

**Provisional data due to lag in reporting.

--Data not available

Source: NIDA, Drug Abuse Warning Network (DAWN) September 1988 data file.

PCP Trends

Data from the 1985 National Household Survey on Drug Abuse indicate that among youth and young adults the percentage that have ever tried PCP is decreasing. A decreasing trend in lifetime prevalence is also seen among high school seniors since 1980. Current or past month use by high school seniors decreased between 1986 and 1987.

The number of PCP related emergencies reported in all metropolitan areas increased somewhat over five 12-month periods from 5,991 mentions in the 12-month period ending June 1984 to 7,730 mentions in the 12-month period ending June 1988. Of the seven metropolitan areas examined, which represent 93% of all PCP mentions, all showed increases in PCP mentions except in New York where a steady decline was reported with 983 mentions in the 12-month period ending June 1984 to 199 mentions in the 12-month period ending June 1988. The St. Louis area showed a substantial increase in PCP cases over the past three 12-month periods from 55 mentions in the 12-month period ending June 1986, 357 mentions in the 12-month period ending June 1987, then increasing to 549 mentions in the 12-month period ending June 1988. Two other metropolitan areas that showed nearly a doubling of PCP mentions were Baltimore and San Francisco. The Los Angeles area has shown steadily decreasing PCP mentions over the first four 12-month periods, then showing a slight increase in mentions in the 12-month period ending June 1988. The PCP mentions reported by the Washington, D.C. area in the 12-month period ending June 1988 are more than triple the PCP mentions reported by Los Angeles, which ranks second in PCP mentions.

The number of PCP related deaths reportd in all metropolitan areas fluctuated over the five 12-month periods with provisional data for the 12-month period ending June 1988 showing 211 PCP-related deaths. The majority of PCP deaths (78%) were reported from the Washington, D.C. and Los Angeles areas. The Los Angeles area showed steady decreases across the entire five 12-month periods dropping from 165 deaths in the 12-month period ending June 1984 to 71 deaths in the 12-month period ending June 1988.

Demographics

Recent demographic data for PCP emergency room patients in 1987 show that the majority are black (60%), male (74%), and 20-29 years of age (58%). Data on PCP related deaths show similar distributions for sex (86% male) and age (44% 20-29 years of age) distributions. Sixty-one percent of the decedents were black, 18 percent white, and 18 percent Hispanic.

Data on treatment admissions from 15 States show that in 1985 twenty-eight percent of the primary PCP clients were black, 44 percent were Hispanic, and 27 percent were white. The majority of PCP clients were males (64%) and between the ages of 20-29 (64%).

Trends in Lifetime Use of PCP by Age Category
1976-1985

	Estimated Percent of the Population				
	1976	1977	1979	1982	1985
Age 12-17	3.0	5.8	3.9	2.2	1.2
Age 18-25	9.5	13.9	14.5	10.5	6.1
Age 26+	0.7	1.1	2.2	2.4	5.0

Source: National Household Survey on Drug Abuse, 1976-1985.

Trends in Lifetime, Past Year and Past Month Use of
PCP by High School Seniors
1980-1987

	Class of							
	1980	1981	1982	1983	1984	1985	1986	1987
Ever Used	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0
Used in Past Year	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3
Used in Past Month	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6
Used Daily Past Month	.1	.1	.1	.1	.1	.3	.2	0.3

Daily Use is defined as use 20 or more times in the past month.

Source: Monitoring the Future Study, 1980-1987.

Trends in Hospital Emergency Room (ER) and Medical Examiner (ME) Mentions of PCP

Total DAWN System and Metropolitan Areas	July 1983 thru June 1984	July 1984 thru June 1985	July 1985 thru June 1986	July 1986 thru June 1987	July 1987 thru June 1988
Total ER Mentions*	5,991	5,110	5,186	6,036	7,730
of which:					
Washington, D.C.	858	1,252	1,639	2,737	3,816
Los Angeles	2,939	2,039	1,928	1,065	1,134
Chicago	329	307	362	601	694
San Francisco	122	139	190	329	615
St. Louis	18	15	55	357	549
New York	983	775	381	251	199
Baltimore	39	39	51	85	156
Total ME Mentions (less Newark and New York City)	239	225	247	223	211**
of which:					
Washington, D.C.	34	61	61	76	93
Los Angeles	165	114	127	94	71
New York City	--	--	--	--	6
Newark	1	8	1	1	3

*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 at least 78 percent of the mentions in the 12-month period ending June 1988.

**Provisional data due to lag in reporting.

--Data not available

Source: NIDA, Drug Abuse Warning Network (DAWN) September 1988 data file.

1) loss of hope

2) four-pronged law enforcement interdiction + sequence

3) Encouraged, but must see even more states join together on their efforts.

4) "Matched" out - like you, we're ...

5) Seizure and forfeiture sharing new? Check (NEW?) — (HOW MUCH NEW?)

6) WSC - Churchill

We shall never surrender - we shall never give up until the last pusher... is behind

last abuser gets help. (?)

[COME BACK TO AT VERY END.]

(as I said before...

- ACK: BUDGET is finite -

NEWSVALUE!

3/2/89

[redacted] DEB LOUSIN : More surplus than not?
[redacted] Most re-elected?

$ - BOTTOM 2 "frugal ag"

* { STATES - SURPLUS DO MENTION SURPLUS -
HOW
SOME DO - TURN BACKS - DEFICITS GROWING -

INDIANAPOLIS 25 to 30%
1/3 ARE NEW

TURN

[redacted] STATE LEGIS.

300 + SOME STATE LEGIS ARE "LEADERS"
(Whips, Maj. Ldrs,

MARGY

10-15 / TO KEEP OUT OF Q+A.

{ NO LINE-ITEM VETO/
NO BALANCED BUDGET / DUKAKIS }

DAVE RUNKLE

633-2107

PUBLIC AFFAIRS

Janet Hale

A-OK

READ middle SECTION TO HIM - HE OKED — 3/6/89

(f) Executive Order No. 12435, establishing the President's Commission on Organized Crime.

(g) Executive Order No. 12575, establishing the President's Special Review Board.

(h) Executive Order No. 12546, establishing the Presidential Commission on the Space Shuttle Challenger Accident.

Sec. 4. Executive Order No. 12534 is superseded.

Sec. 5. This Order shall be effective September 30, 1987.

THE WHITE HOUSE,
September 30, 1987.

RONALD REAGAN

Executive Order 12611 of October 15, 1987

Delegating Authority To Implement Assistance for Central American Democracies and the Nicaraguan Democratic Resistance

By the authority vested in me as President by the Constitution and laws of the United States of America, including the Military Construction Appropriations Act, 1987, enacted by section 101(k) of the Joint Resolution Making Continuing Appropriations for the Fiscal Year 1987 (Public Laws 99–500 and 99–591), the Foreign Assistance Act of 1961, as amended (22 U.S.C. 2151 *et seq.*), the Joint Resolution Making Continuing Appropriations for the Fiscal Year 1988 (Public Law 100–120), and section 301 of title 3 of the United States Code, and in order to delegate certain functions concerning the use of funds, it is hereby ordered as follows:

Section 1. Executive Order No. 12570 of October 24, 1986, is amended by adding the following to the end of Section 2(b):

"and funds provided in the Joint Resolution Making Continuing Appropriations for the Fiscal Year 1988 (Public Law 100–120).".

Sec. 2. This Order shall be effective immediately.

THE WHITE HOUSE,
October 15, 1987.

RONALD REAGAN

Executive Order 12612 of October 26, 1987

Federalism

By the authority vested in me as President by the Constitution and laws of the United States of America, and in order to restore the division of governmental responsibilities between the national government and the States

blishing the President's Commission on

blishing the President's Special Review

blishing the Presidential Commission on
nt.

superseded.

September 30, 1987.

RONALD REAGAN

, 1987

ement Assistance for Central
e Nicaraguan Democratic

esident by the Constitution and laws of
ding the Military Construction Appro-
ection 101(k) of the Joint Resolution
for the Fiscal Year 1987 (Public Laws
ssistance Act of 1961, as amended (22
tion Making Continuing Appropriations
v 100–120), and section 301 of title 3 of
r to delegate certain functions concern-
ered as follows:

70 of October 24, 1986, is amended by
ection 2(b):

solution Making Continuing Appropria-
Law 100–120).".

immediately.

RONALD REAGAN

, 1987

esident by the Constitution and laws of
order to restore the division of govern-
national government and the States

252

that was intended by the Framers of the Constitution and to ensure that the principles of federalism established by the Framers guide the Executive departments and agencies in the formulation and implementation of policies, it is hereby ordered as follows:

Section 1. *Definitions.* For purposes of this Order:

(a) "Policies that have federalism implications" refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

(b) "State" or "States" refer to the States of the United States of America, individually or collectively, and, where relevant, to State governments, including units of local government and other political subdivisions established by the States.

Sec. 2. *Fundamental Federalism Principles.* In formulating and implementing policies that have federalism implications, Executive departments and agencies shall be guided by the following fundamental federalism principles:

(a) Federalism is rooted in the knowledge that our political liberties are best assured by limiting the size and scope of the national government.

(b) The people of the States created the national government when they delegated to it those enumerated governmental powers relating to matters beyond the competence of the individual States. All other sovereign powers, save those expressly prohibited the States by the Constitution, are reserved to the States or to the people.

(c) The constitutional relationship among sovereign governments, State and national, is formalized in and protected by the Tenth Amendment to the Constitution.

(d) The people of the States are free, subject only to restrictions in the Constitution itself or in constitutionally authorized Acts of Congress, to define the moral, political, and legal character of their lives.

(e) In most areas of governmental concern, the States uniquely possess the constitutional authority, the resources, and the competence to discern the sentiments of the people and to govern accordingly. In Thomas Jefferson's words, the States are "the most competent administrations for our domestic concerns and the surest bulwarks against antirepublican tendencies."

(f) The nature of our constitutional system encourages a healthy diversity in the public policies adopted by the people of the several States according to their own conditions, needs, and desires. In the search for enlightened public policy, individual States and communities are free to experiment with a variety of approaches to public issues.

(g) Acts of the national government—whether legislative, executive, or judicial in nature—that exceed the enumerated powers of that government under the Constitution violate the principle of federalism established by the Framers.

(h) Policies of the national government should recognize the responsibility of—and should encourage opportunities for—individuals, families, neighbor-

hoods, local governments, and private associations to achieve their personal, social, and economic objectives through cooperative effort.

(i) In the absence of clear constitutional or statutory authority, the presumption of sovereignty should rest with the individual States. Uncertainties regarding the legitimate authority of the national government should be resolved against regulation at the national level.

Sec. 3. *Federalism Policymaking Criteria.* In addition to the fundamental federalism principles set forth in section 2, Executive departments and agencies shall adhere, to the extent permitted by law, to the following criteria when formulating and implementing policies that have federalism implications:

(a) There should be strict adherence to constitutional principles. Executive departments and agencies should closely examine the constitutional and statutory authority supporting any Federal action that would limit the policymaking discretion of the States, and should carefully assess the necessity for such action. To the extent practicable, the States should be consulted before any such action is implemented. Executive Order No. 12372 ("Intergovernmental Review of Federal Programs") remains in effect for the programs and activities to which it is applicable.

(b) Federal action limiting the policymaking discretion of the States should be taken only where constitutional authority for the action is clear and certain and the national activity is necessitated by the presence of a problem of national scope. For the purposes of this Order:

(1) It is important to recognize the distinction between problems of national scope (which may justify Federal action) and problems that are merely common to the States (which will not justify Federal action because individual States, acting individually or together, can effectively deal with them).

(2) Constitutional authority for Federal action is clear and certain only when authority for the action may be found in a specific provision of the Constitution, there is no provision in the Constitution prohibiting Federal action, and the action does not encroach upon authority reserved to the States.

(c) With respect to national policies administered by the States, the national government should grant the States the maximum administrative discretion possible. Intrusive, Federal oversight of State administration is neither necessary nor desirable.

(d) When undertaking to formulate and implement policies that have federalism implications, Executive departments and agencies shall:

(1) Encourage States to develop their own policies to achieve program objectives and to work with appropriate officials in other States.

(2) Refrain, to the maximum extent possible, from establishing uniform, national standards for programs and, when possible, defer to the States to establish standards.

(3) When national standards are required, consult with appropriate officials and organizations representing the States in developing those standards.

private associations to achieve their person-
ves through cooperative effort.

itutional or statutory authority, the presump-
with the individual States. Uncertainties re-
of the national government should be re-
national level.

g Criteria. In addition to the fundamental
in section 2, Executive departments and
ent permitted by law, to the following crite-
menting policies that have federalism impli-

ence to constitutional principles. Executive
ld closely examine the constitutional and
ny Federal action that would limit the pol-
es, and should carefully assess the necessi-
practicable, the States should be consulted
nented. Executive Order No. 12372 ("Inter-
Programs") remains in effect for the pro-
s applicable.

licymaking discretion of the States should
al authority for the action is clear and cer-
necessitated by the presence of a problem
es of this Order:

e distinction between problems of national
al action) and problems that are merely
ll not justify Federal action because indi-
y or together, can effectively deal with

Federal action is clear and certain only
y be found in a specific provision of the
n in the Constitution prohibiting Federal
encroach upon authority reserved to the

es administered by the States, the nation-
ates the maximum administrative discre-
ersight of State administration is neither

and implement policies that have feder-
rtments and agencies shall:

eir own policies to achieve program ob-
ate officials in other States.

possible, from establishing uniform, na-
when possible, defer to the States to es-

quired, consult with appropriate officials
States in developing those standards.

Sec. 4. *Special Requirements for Preemption.* (a) To the extent permitted by law, Executive departments and agencies shall construe, in regulations and otherwise, a Federal statute to preempt State law only when the statute contains an express preemption provision or there is some other firm and palpable evidence compelling the conclusion that the Congress intended preemption of State law, or when the exercise of State authority directly conflicts with the exercise of Federal authority under the Federal statute.

(b) Where a Federal statute does not preempt State law (as addressed in subsection (a) of this section), Executive departments and agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rule-making only when the statute expressly authorizes issuance of preemptive regulations or there is some other firm and palpable evidence compelling the conclusion that the Congress intended to delegate to the department or agency the authority to issue regulations preempting State law.

(c) Any regulatory preemption of State law shall be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations are promulgated.

(d) As soon as an Executive department or agency foresees the possibility of a conflict between State law and Federally protected interests within its area of regulatory responsibility, the department or agency shall consult, to the extent practicable, with appropriate officials and organizations representing the States in an effort to avoid such a conflict.

(e) When an Executive department or agency proposes to act through adjudication or rule-making to preempt State law, the department or agency shall provide all affected States notice and an opportunity for appropriate participation in the proceedings.

Sec. 5. *Special Requirements for Legislative Proposals.* Executive departments and agencies shall not submit to the Congress legislation that would:

(a) Directly regulate the States in ways that would interfere with functions essential to the States' separate and independent existence or operate to directly displace the States' freedom to structure integral operations in areas of traditional governmental functions;

(b) Attach to Federal grants conditions that are not directly related to the purpose of the grant; or

(c) Preempt State law, unless preemption is consistent with the fundamental federalism principles set forth in section 2, and unless a clearly legitimate national purpose, consistent with the federalism policymaking criteria set forth in section 3, cannot otherwise be met.

Sec. 6. *Agency Implementation.* (a) The head of each Executive department and agency shall designate an official to be responsible for ensuring the implementation of this Order.

(b) In addition to whatever other actions the designated official may take to ensure implementation of this Order, the designated official shall determine which proposed policies have sufficient federalism implications to warrant the preparation of a Federalism Assessment. With respect to each such policy for which an affirmative determination is made, a Federalism Assessment, as described in subsection (c) of this section, shall be prepared.

The department or agency head shall consider any such Assessment in all decisions involved in promulgating and implementing the policy.

(c) Each Federalism Assessment shall accompany any submission concerning the policy that is made to the Office of Management and Budget pursuant to Executive Order No. 12291 or OMB Circular No. A–19, and shall:

(1) Contain the designated official's certification that the policy has been assessed in light of the principles, criteria, and requirements stated in sections 2 through 5 of this Order;

(2) Identify any provision or element of the policy that is inconsistent with the principles, criteria, and requirements stated in sections 2 through 5 of this Order;

(3) Identify the extent to which the policy imposes additional costs or burdens on the States, including the likely source of funding for the States and the ability of the States to fulfill the purposes of the policy; and

(4) Identify the extent to which the policy would affect the States' ability to discharge traditional State governmental functions, or other aspects of State sovereignty.

Sec. 7. *Government-wide Federalism Coordination and Review.* (a) In implementing Executive Order Nos. 12291 and 12498 and OMB Circular No. A–19, the Office of Management and Budget, to the extent permitted by law and consistent with the provisions of those authorities, shall take action to ensure that the policies of the Executive departments and agencies are consistent with the principles, criteria, and requirements stated in sections 2 through 5 of this Order.

(b) In submissions to the Office of Management and Budget pursuant to Executive Order No. 12291 and OMB Circular No. A–19, Executive departments and agencies shall identify proposed regulatory and statutory provisions that have significant federalism implications and shall address any substantial federalism concerns. Where the departments or agencies deem it appropriate, substantial federalism concerns should also be addressed in notices of proposed rule-making and messages transmitting legislative proposals to the Congress.

Sec. 8. *Judicial Review.* This Order is intended only to improve the internal management of the Executive branch, and is not intended to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, its officers, or any person.

RONALD REAGAN

THE WHITE HOUSE,
October 26, 1987.

Executive Order 12613 of October 29, 1987

Prohibiting Imports From Iran

By the authority vested in me as President by the Constitution and laws of the United States of America, including section 505 of the International Se-

Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
01. Notes	Handwritten notes, Re: National Conference of State Legislators [double-sided]. (2 pp.)	01/01/89	~~P-5~~	

Collection:

Record Group: Bush Presidential Records
Office: Speechwriting, White House Office of
Series: Davis, Mark William
Subseries: Subject File
WHORM Cat.:
File Location: National Conference of State Legislators 3/10/89 [1]

Open on Expiration of PRA
(Document Follows)
By CAP (NLGB) on 4/5/05

Date Closed:	12/14/2004	**OA/ID Number:**	13873-007
FOIA/SYS Case #:	S	**Appeal Case #:**	
Re-review Case #:	2005-0481-S	**Appeal Disposition:**	
P-2/P-5 Review Case #:		**Disposition Date:**	
AR Case #:		**MR Case #:**	
AR Disposition:		**MR Disposition:**	
AR Disposition Date:		**MR Disposition Date:**	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P-3 Release would violate a Federal statute [(a)(3) of the PRA]
P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
(b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
(b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
(b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
(b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
(b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
(b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
(b)(9) Release would disclose geological or geophysical information

1/1/89

Kate Moore - O.M.B. - ED DALE [5883]
→ Barbara Clay O.M.B.
[redacted] LAST YR WE WANTED TO ZERO OUT STATE + LOCAL. WANTED FOR DEA.
[redacted] REPROPOSING TO ZERO OUT in JAN. CURRENT POLICY UNKNOWN

HOWEVER, note page - #74

7170 INTERGOVERMENTAL AFFAIRS
[redacted] MARGY CACCIA

/ Ohio - Shine

Father Shay ->

Belvjew, Ohio
Kathleen in political

DON'T TALK ABOUT ED
I'm committed to same principles Balance Deregulation

JAYNE VICTOR [ ]

Denby G.
SURVEY → (Think of more local - mayors + other.
FISCAL, CHILD CARE top priorities.
NOT TERRIBLY CONCERNED of funding - N.C.S.L.

105% JOKE

NOT DEFIATIVE

~~I'm committed to continuing~~
~~Michael Wms - A.G. special assist.~~

mention Bennett

drug education -

	DOD 1988	1989	1990
REAGAN EDUCATION —	$ 191.5	$ 287.7	297.5

Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
02. Notes	Handwritten notes, Re: National Conference of State Legislators. (1 pp.)	n.d.	~~P-5~~	

Collection:

Record Group: Bush Presidential Records
Office: Speechwriting, White House Office of
Series: Davis, Mark William
Subseries: Subject File
WHORM Cat.:
File Location: National Conference of State Legislators 3/10/89 [1]

Open on Expiration of PRA
(Document Follows)
By CAP (NLGB) on 4/5/05

Date Closed:	12/14/2004	**OA/ID Number:**	13873-007
FOIA/SYS Case #:	S	**Appeal Case #:**	
Re-review Case #:	2005-0481-S	**Appeal Disposition:**	
P-2/P-5 Review Case #:		**Disposition Date:**	
AR Case #:		**MR Case #:**	
AR Disposition:		**MR Disposition:**	
AR Disposition Date:		**MR Disposition Date:**	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P-3 Release would violate a Federal statute [(a)(3) of the PRA]
P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
(b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
(b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
(b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
(b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
(b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
(b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
(b)(9) Release would disclose geological or geophysical information

JAYME VICTOR

(305) 441-1234 / Call Daily tom. HYATT Reg. C.G.F.

Pres. Group. La. Sammy Nũnez (NOO-NĒZ)
Conservative Demo.
Mention "Duke?"
Lee Daniels (former Dole) - Ill.

ALL LEGIS. LEADERS -
DRUGS ✓ GOOD ISSUE -
PROB. ~~100~~ PEOPLE

ANNUAL LEADER-to-LEADER meeting

NCSL - DEB LOUISIN [202] 624-5400

REPUBLICAN / BUSH CAMPAIGN

160 PEOPLE
Sen. SAMMY NŨNEZ - PROS. PRO-TEM La. Sen.
Rep. LEE DANIELS - PRES.-ELECT Ill ~~Ill~~ Assemb. in Dec.

(REAFFIRM FEDERALISM EXEC. ORDER ('87?) 12612
FITS in w/ V.P. REG. COMMISSION ON FEDERALISM)

WORK w/ all elected officials
~~Gov.~~ ~~Pres.~~ Pres. will work w/ legis. as well as govs.

Marge

DRUG Bill LAST YR

FED. MANDATES - States haven't seen $ yet -, States are angry that they haven't seen any thing

- Reaffirmation of fed. role -

/

SEE JANET HALE REMARKS

Davis/Dooley

March 2, 1989

3 p.m.

REMARKS: NATIONAL CONFERENCE OF STATE LEGISLATORS
OLD EXECUTIVE OFFICE BUILDING/RM 450
MARCH 10, 1989

Thank you Sammy Nunez (Noo-nez). Thank you Lee Daniels. Thank you all.

The last time I spoke to you, we were in the middle of America, in the middle of summer, and in the midst of a tough campaign year.

Fate has smiled on us since that July day in Indianapolis. Then, we were all candidates. Today, everyone in this room is a winner. For those of you who are Republicans, I hope my coattails were of use. For those of you who are Democrats, I claim absolutely no credit whatsoever . . .

In all sincerity, I want to congratulate every legislative leader in this room, Democratic as well as Republican. You won more than a political victory. You won the highest honor of all -- the chance to serve your state and your country.

The problems that confront our country as we near the end of this century often seem bigger than our ability to solve them. And they are -- if we face these problems as only Democrats or Republicans, as members of a region, or a faction, or an interest.

But by working together, as Americans, we can lick any problem -- no matter how big, how complex or how deeply rooted it may be.

True, there are always some who say that we will never cleanse the environment; that we will never shelter the homeless; never solve the age-old afflictions of mankind -- the poverty of opportunity called despair, the poverty of the soul called crime.

But the cynics never take into account one of the great success stories of our times -- state government. In this decade, power flowed from Washington to Austin, to Springfield, to Sacramento and to every other state capital. With this power came new responsibilities. And history will show that you met your broadened responsibilities with distinction.

I know funds at all levels of government are tight. I know you are called upon to make hard choices, as I am. But, by and large, you are meeting the challenge of a frugal age by devising creative new solutions to the age-old problems of care and concern for the very young and the very elderly.

So whenever I see a problem that some say is insurmountable, I draw inspiration from what you are already doing in the states.

The resilience of state government in the 1980s vindicates the wisdom of the Founding Fathers, and forever discredits those who would have Washington do it all. Let me assure you: I will preserve and protect a healthy balance, a sharing of power between the states and the federal government.

As you know, one policy area clearly designated as a prime responsibility of the federal government is our national defense. So perhaps the appeal I am going to make to you today will be all the more unprecedented. The time has come for me to enlist your expertise in what I consider a national security crisis -- the threat of drug abuse to the health, the very future, of our nation.

Crack. Heroin. P.C.P. These drugs are a plague that leave shattered minds, ruined bodies and wasted potential. No state in the union is immune to this plague. Drug crimes have claimed thousands of lives, and turned whole communities upside down from the Eastern Seaboard to the Pacific Coast. It is becoming apparent that our struggle against the drug trade is not merely the moral equivalent of war.

It is war.

As with any war, we are all in this together -- as Americans. And as with any war, we must have a strategy. Our strategy is three-pronged: law enforcement and interdiction -- rehabilitation -- and prevention through education.

I am pleased to note how many state governments have formed intrastate drug task forces, and interstate panels to share resources and intelligence.

We have matched your efforts in Washington. Since 1981, the federal anti-drug budget has grown by nearly 370 percent. But more was needed, so I am asking the Congress for $6 billion for our anti-drug program in 1990 -- a 21 percent increase over 1989, and a 47 percent increase over 1988. More than $4 billion will be spent to provide grants to state and local law enforcement agencies, to beef up federal enforcement, and to enhance our prosecution, detention and intelligence capabilities . . .

— Same as '89 / BUT $150 more Reagan

IS THIS AN INCREASE OVER '89 JANET HALE 3/20

This includes an allocation of $150 million for the Department of Justice drug grant program, $105 million of which will be devoted to assisting state and local law enforcement agencies. The remaining $45 million will fund state and local drug prevention programs. JANET HALE

Another shining example of federal and state cooperation is the seizure and forfeiture of assets from drug dealers. State agencies that cooperate in drug cases will share the benefits from the sale of yachts, planes and autos used in drug deals. To convert the profits of vice to finance our war against the multi-billion dollar drug empire is more than good financial sense. It is sweet irony and swift justice . . .

JANET confirms

#1.1

To paraphrase Winston Churchill, we must fight the drug lords on the streets, interdict them in the skies and on the high seas. And we must also fight them in the classroom. Toward this end, some $367 million of the Department of Education budget has been targeted to our drug-free schools and communities program, to ~~expel~~ KEEP (OUT OF) drugs ~~from~~ schoolyards, campuses and neighborhoods. You will be able to take the lead in this effort, since more than 80 percent of these funds will be allocated to the states and territories.

I'm ~~[illegible]~~ FOR DRUGS, (of which will GO TO)

JANET — EDUCATION: $1 BILLION ON EDUCATION, ~~REDUCTION~~

As you may have heard, we can already take heart from some good news from the classrooms of America. According to the 1988 National High School Senior Survey, the proportion of seniors using illicit drugs during the prior year fell from 42 percent in 1987 to 39 percent in 1988. This compares with the peak year of 1979, when an astounding 54 percent of all American high school seniors abused drugs.

Still, 39 percent is 39 percent more than I will accept. How can we convince these teen-agers to leave drugs alone?

Presidents usually do not speak in favor of intolerance. But the day must come when this nation is utterly intolerant of so-called casual drug abuse. Then, and only then, will we be able to declare victory.

It is with this in mind that I hope the Senate soon confirms Bill Bennett as the nation's drug czar. Bill's talent as an educator, and his rapport with young people, will be of particular help in communicating our attitude of zero tolerance to the next generation.

Over the next four years, we will face many common challenges -- to our environment, to our prosperity, to our compassion for those who have yet to fully participate in the American Dream. But we face no common domestic challenge greater than that of drug abuse.

I pledge to work with you and your state governments in this struggle. With your help, and your leadership at the state level, I know that we will prevail.

Thank you.

# # #

(Kemp, Skinner, Dole)

LAST TIME WE GOT TOGETHER, IN INDIANAPOLIS, it WAS July "hot" Summer.

TIME TO PUT DIVISENESS behind us. Join together, AS YOU HAVE DONE.

YOU ARE DOING MORE BECAUSE you HAVE MORE power - but power balanced by Responsibility.

MOST STATES BALANCE THEIR BUDGETS.

MOST STATES line-ITEM VETO

STATE SURPLUSES in U.S. TREASURY.

You're showing Wash. how to do it!

Health, ed., welfare + environment.

One area delegated only to fed. gov. is our national defense. Until now. I want to enlist you in a nat. security effort - scourge of drugs.

We think of the West Bank as a hot spot - more murders are occuring right here in DC -

Thousands are losing their lives.

- What you have done - But you must do more.

- What I have done - BUT I DON'T INTEND TO STOP here.

- Education the answer. The day must come when America is utterly intolerant of so-called casual drug abuse.

Challenge

Puerto Rico

BENNETT → continued

BEAFFIEM 12612 AD

DICK WEATHERLY