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THE WHITE HOUSE
WASHINGTON

December 18, 1981

Dear Dr. Munnik:


Please excuse the delay in writing to you. Since you departed our office has been extremely busy getting our drug policy formulated.

Enclosed you will find a copy of my testimony before the Senate this is the President's broad policy. We will now integrate strategy details and publish the federal strategy in June of 1982.

The testimony was presented to the President on November 17th.

Mary Ann and I enjoyed meeting and visiting with you and your gracious wife. We hope it will be possible for us to get together in the future to discuss broad health issues and renew friendships.

Sincerely,



Carlton E. Turner, Ph.D.
Senior Policy Adviser
for Drug Policy

The Honorable Dr. L.A.P.A. Munnik
Ministry of Health
Civitas
Pretoria 0002
Republic of South Africa

P.S. Mary Ann has enjoyed using the apron. She was delighted with the thoughtfulness!

THE WHITE HOUSE

WASHINGTON

November 30, 1981

Dear Mrs. Dvorsky:

Thank you for your letter of support for the President's drug initiatives. We are delighted that groups such as the American Medical Association Auxiliary, Inc. is involved in drug education and prevention.

We are enclosing a copy of the testimony I delivered before the Congress outlining the President's initiatives.

As the President's drug policy adviser, I will be developing a comprehensive strategy that will involve many sectors of society. The private sector and voluntary citizen efforts will be critical to the successful implementation of a national prevention and education campaign.

May we call upon your organization in the near future to work with us in the design and implementation of that effort?

Sincerely,



Carlton E. Turner, Ph.D.
Senior Policy Adviser
for Drug Policy

Mrs. Harry S. Dvorsky
President
American Medical Association Auxiliary, Inc.
535 North Dearborn Street
Chicago, Illinois 60610

THE
AMA



AUXILIARY:

A
FEDERATION
FOR
GOOD
HEALTH

The American Medical Association Auxiliary is a nationwide, volunteer organization of 81,000 physicians' spouses who use their talents and abilities to help people achieve and maintain optimum healthy living.

Through a federated structure of county, state, and national organizations, the AMA Auxiliary pursues its goals of protecting and improving public health and assisting physicians in providing quality medical care.

Primary focuses are

- community health projects such as the national Shape Up for Life campaign to encourage good nutrition, regular exercise, and stress control; immunization awareness to see that every child is protected; health education in the schools, through legislation, public awareness, curriculum planning
- legislative activities to assist the AMA and state and county medical associations in their work to see that sound health legislation is initiated and made into law
- fund raising for AMA-ERF to ensure quality education and equipment for medical students and schools
- public relations and support for the medical profession.

Successful implementation of these programs is possible only through the cooperative endeavors of county, state, and national organizations, each with its own range of activities which help all reach their goals.

THE NATIONAL

The national organization serves as an umbrella for activities, providing

- coordination of programs to serve the medical profession
- assistance to the AMA in programs to improve health and quality of life
- liaison to national health and health-related organizations to communicate programs and plans
- information on fund raising, health projects, legislation, membership, bylaws, parliamentary procedure
- program materials, including pamphlets; Package Programs on 10 health topics; materials from the Project Bank, a national clearinghouse holding 850 local auxiliary projects
- administration, programs, and materials for AMA-ERF fund-raising activities
- field service from national officers and chairmen to provide information and expertise in all areas of auxiliary concern
- leadership training and information through an annual Confluence for state and county leaders; Regional Cluster Meeting for state leaders; Workshops for all officers and chairmen; a 100-page guide to the organization and its work
- educational seminars at AMA and AMA Auxiliary meetings to update both the volunteer and health professional on current issues
- legislative information through alerts, quarterly mailings, program packet
- national program direction through campaigns and materials such as Shape Up for Life, Immunization Awareness, High Blood Pressure Control
- membership recruitment tools through a Marketing Membership manual, membership pamphlets, brochures for present and potential members.
- publications for every member: FACETS, sent to all 81,000 members; DIRECT LINE, sent to 8,000 state and county leaders; NATIONAL NEWS, sent to 250 national and state leaders; NATIONALINE, sent to 1,200 county presidents and presidents-elect; HORIZONS, sent to 3,500 resident physicians' and medical students' spouses.

THE STATE

The state auxiliaries serve as coordinating bodies, providing

- service to the medical profession by promoting its programs, priorities, and goals
- programs to support physicians and families, such as those to aid impaired physicians and families, medical marriage seminars, fellowship and hospitality
- statewide programs which bring health care to every community through school health education legislation, immunization programs, dissemination of health information
- contact with all members within the state through newsletters, meetings, seminars
- forums for idea exchange among leaders and members
- leadership development through training and experience
- opportunities for participation at all organizational levels
- assistance and direction for county programs
- legislative alert systems to pass information to a network of volunteers
- coordination of AMA-ERF fund-raising activities
- communication of national program information to county leaders and members

THE COUNTY

The county auxiliary is where all programs are implemented. County organizations serve as catalysts for community health activities, as well as providing

- public relations for the medical profession through activities
- direct service to the people in the community
- research to find community needs and gaps in existing services
- programs to fill health needs
- volunteers for the medical society
- grassroots support and promotion for the Voluntary Effort
- manpower to respond to legislative issues when needed
- liaison to community organizations such as hospital auxiliaries, cancer societies, and other volunteer health organizations to increase cooperative efforts and decrease duplication of services
- membership recruitment for all levels of the organization
- support systems for physicians and their families through service and fellowship

THE FEDERATION

Through the federation, the AMA Auxiliary has been a driving force behind homemaker services, a major influence in programs for the aging, a leader in children's safety and immunization programs, and now, a measurable influence in the movement to help people achieve and maintain good health by modifying behavior.

These programs have been provided by the national organization, coordinated by the state organizations, and implemented by the county organizations. Since its founding in 1922, the AMA Auxiliary has had one basic purpose—to serve the people of the nation by ensuring quality health and health care for all through a federation of concerned, active physicians' spouses.



AMERICAN MEDICAL
ASSOCIATION AUXILIARY

535 North Dearborn Street
Chicago Illinois, 60610

AMERICAN MEDICAL ASSOCIATION AUXILIARY, INC.

NOV 30 1981

535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610
(312) 751-6166

NOV 9 1981

HAZEL J. LEWIS
EXECUTIVE DIRECTOR

November 5, 1981

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

Because of your mandate to the private sector to become involved in voluntary action to solve the social problems of this nation, I would like to bring to your attention the work of the American Medical Association Auxiliary.

The volunteer arm of the AMA, the auxiliary is an organization of 80,000 physicians' spouses whose long involvement in voluntary action to improve the health and welfare of people has brought about positive change in communities across the nation.

All community health needs are targeted for action by our local organizations. As an example, I enclose materials which outline projects to prevent drug abuse implemented in communities nationwide, as well as our national plan for action.

As an organization, our primary goal is voluntary action to improve the lives of the people we serve. As such, we offer you our expertise for national planning committees, our community manpower for positive action, and our commitment to your goal for the return of private sector involvement in the welfare of the nation.

Please let us know how we can be of service.

Sincerely,



ISOBEL DVORSKY
(Mrs. Harry S.)
President

✓ cc: Carlton E. Turner
Senior Policy Advisor, Drug Policy
Thomas Lias
Deputy Director, ACTION

Drug Abuse (inc. Smoking and Alcohol)

Description: Through panels, lectures, discussions, films, and literature distribution, auxiliaries inform the public of the hazards of smoking, alcohol, and drugs. Includes rehabilitation of addicts.

<u>Project</u>	<u>Auxiliary/Location</u>	<u>Population/#Volunteers</u>	<u>Format Differences</u>
8-HE-1-1	Queens County New York, N.Y.	1,986,473 10 volunteers	Auxiliary sponsored high school essay contest on hazards of drug abuse and smoking; provided students with resource materials.
8-HE-1-2	Cape Girardeau County Cape Girardeau, Mo.	50,000 58 volunteers	Religiously oriented rehabilitation for disturbed young men. Called "Mid-America Teen Challenge."
8-HE-1-3	Hennepin County Minneapolis, Minn.	500,000 16-20 volunteers	Volunteers present program on dangers of smoking to schoolchildren. Undergo extensive training by the American Lung Association. Presentations include puppets, glass-bottle lungs, and slides.
8-HE-1-4	St. Louis County Duluth, Minn.	100,000 6 volunteers	Auxiliaries provide elementary school teachers with materials to be used in programs on drug abuse. City-wide seminar on drug abuse also held.
8-HE-1-5	Hennepin County Bloomington, Minn.	500,000 3 volunteers	Panel of physician, physician's spouse, and three former drug abusers informed auxiliary of problems of chemical dependency, treatment, and recovery. Follow-up program, question-and-answer period.
8-HE-1-6	Wisconsin State Auxiliary	not stated 30 volunteers	Forum on alcohol use by adolescents and adults.
8-HE-1-7	Arlington/Alexandria/ Fairfax Counties Virginia	500,000 40 volunteers	Program on lung diseases addressed health effects of smoking, air pollution, and respiratory infections. Slides, films, and panel discussion geared toward layman.

HEALTH EDUCATION - cont.

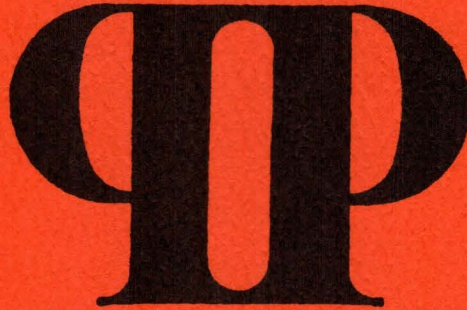
<u>Project</u>	<u>Auxiliary/Location</u>	<u>Population/#Volunteers</u>	<u>Format Differences</u>
8-HE-1-8	Spartanburg County Spartanburg, S.C.	150,000 21 volunteers	Auxiliary members visited schools with film "Drugs Are Like That." Directed at third-grade students in 13 schools, 45 classes.
8-HE-1-9	Dallas County Dallas, Tex.	1 million 2 volunteers	Physicians meet with first-time drug offenders to answer their questions, the hope being that this will deter the youths from a second offense. Program organized in conjunction with Dallas Police Department, and is offered once a week.
8-HE-1-10	Luzerne County Wilkes-Barre, Pa.	342,301 6 volunteers	Helped establish school policy and procedures for counseling, education, disciplinary action for alcohol use and drug abuse. Ongoing program.
8-HE-1-11	Orange County Orlando, Fla.	350,000 12 volunteers	No-smoking program written and presented by auxiliaries to sixth grade students. Students write about program as a follow-up.
8-HE-1-12	Wyandotte County Kansas City, Kan.	not stated 27 volunteers	Learning Center on Body Pollution. Auxiliaries developed this portable learning center to teach fourth, fifth, and sixth graders about the dangers of alcohol, drugs, tobacco, and poor nutrition. Much of the material is presented in the form of games. Center is transported to various schools.
8-HE-1-13	Jasper County Joplin, Mo.	119,000 12 volunteers	Public forum on causes and cures of alcoholism.
9-HE-1-14	Wisconsin State Auxiliary	over 50,000 40-50 volunteers	"Before You Solo, Pack Your Parachute." 3rd annual Wis. Work Week of Health. Two institutes to help teens prepare for life after school. Speakers discuss drugs, alcoholism, smoking, love, and decision-making.

HEALTH EDUCATION - cont.

<u>Project</u>	<u>Auxiliary/Location</u>	<u>Population/#Volunteers</u>	<u>Format Differences</u>
9-HE-1-15	Greenville County Greenville, S.C.	over 500 45-50 volunteers	"Smoking Sam" mannequin borrowed from Am. Cancer Society to demonstrate harm of smoking to grade schoolers.
9-HE-1-16	McCracken County Paducah, Ky.	10,000 to 50,000 3 volunteers	Presentation to parents, PTO's, etc., on common patterns of drug use in area; display of actual drugs and related paraphernalia.
0-HE-1-17	Fulton County Atlanta, Ga.	over 50,000 5 volunteers	"Drugs are a Drag" puppet show. Professionally developed and copyrighted for 3rd and 4th grades. Kit available for purchase.
0-HE-1-18	Montgomery County Montgomery, Md.	over 50,000 12 volunteers	Alcoholic Adolescent. Auxiliary sits on interorganizational board working to address needs and causes of alcoholic adolescents. Involves lobbying, surveys, forums, etc.
1-HE-1-19	Windham County Willimantic, Conn.	over 50,000 4 volunteers	Auxiliary informed local schools of free American Cancer Society materials available, via phone calls and informative meeting.
1-HE-1-20	Polk County Winter Haven, Fla.	over 50,000 6 volunteers	Substance Abuse. Auxiliary and school health education dept. sponsored all-day workshop.
1-HE-1-21	Waukesha County Menomonee Falls, Wis.	not stated 7 volunteers	Wellness Program. Auxiliary presentation included film and discussion, emphasizing the impact of lifestyle (alcohol use, smoking, drug abuse, and VD) on one's health.

DRUGS OF ABUSE

PACKAGE PROGRAM



American Medical Association Auxillary, Inc.

This Drugs of Abuse Package Program outlines the scope of drug use in the US, discusses each of the commonly abused drugs in detail, offers program ideas, lists program aids, identifies especially helpful films and publications, and names resource organizations.

We hope you will find this Package Program useful as you address the drug problems in your community.

American Medical Association Auxiliary, Inc.
535 N. Dearborn Street
Chicago, IL 60610
(312) 751-6166

Single copies free on request. Quantities available at \$1 per copy.

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DRUG USE AND ABUSE IN THE US

The fanfare, shock, and novelty surrounding the recreational drug use of the 1960s has long vanished, but recreational and nonmedical drug use is as prevalent today, if not more so. More people are taking prescription drugs for medical and nonmedical reasons--11 of the 15 most abused controlled substances involved in emergency room visits from July 1978 to August 1979 were prescription drugs. More people are selecting from the wide variety of drugs available, are using drugs more frequently, and are starting use at younger ages.

Experts see this as a consequence of the absence of uniformly accepted societal attitudes and standards of behavior concerning drug use. They also see it as a natural outcome of the belief that drugs are an acceptable way to modify any undesired physical or mental state. People learn from friends and advertisements that one can take pain killers for pain, sleeping pills for insomnia, tranquilizers for anxiety, marijuana or alcohol to socialize, stimulants for lack of energy, diet pills for overweight, antacids for indigestion--the list is endless.

Experts feel the wide choice of psychoactive drugs available in the US is also partially responsible for this increase. Most cultures in the past had only a few drugs at their disposal and their patterns of use were closely governed by established social customs.

Marijuana is the most widely used illicit drug--so widely used in fact that a substantial portion of the population has had some experience with marijuana. In the 22 to 25-year-old group a majority (62%) report having used marijuana. William Pollin, MD, director of the National Institute on Drug Abuse has declared marijuana "a major and serious public health hazard," especially among teenagers.

The AMA Council on Scientific Activities Reports on Marijuana (1977, 1979) reveal that the number of 12 to 17-year-olds who had ever used marijuana grew by 25% between 1976 and 1977, and a nearly 30% rise in the number of current users in that age group.

Alcohol, the most widely used and abused drug, licit or illicit, is often not even recognized as a drug. This is despite the facts that there are an estimated 10 million alcoholics in the US and alcohol in combination with other drugs was cited most frequently in drug related deaths and emergency room visits in 1978. (For more information on alcohol, refer to the Alcoholism Package Program.)

An estimated one to two million women have problems because of prescription drugs; thirty-two million (42%) women have used tranquilizers prescribed for them by physicians. The Drug Enforcement Administration (DEA) estimates that 10% of the dosage units of controlled substances manufactured in the US each year are diverted into illicit trade.

In a survey of high school seniors conducted by the University of Michigan Institute for Social Research, 60% of the Class of '79 reported using marijuana at sometime; 93% reported using alcohol, 74% cited cigarettes, 24% had used stimulants, and approximately 15% reported having used cocaine.

Although use of heroin had been declining in recent years, drug experts are virtually terrified of a "tidal wave" of heroin beginning to hit the US this year (1980). The supply from Mexico is dwindling but supplies from Iran, Afghanistan, and Pakistan are expected to flood the US as political instability turns governments' attention away from drug enforcement. Ten years ago when Turkey was producing about 80 metric tons of opium for heroin annually there were about 700,000 American heroin addicts. The DEA estimates the combined production of Iran, Afghanistan, and Pakistan will reach 1,500 metric tons. Beyond that, Mideast heroin is 34% to 44% pure while Mexican heroin is 3.5% pure. Marijuana smokers will be the prime target, predict the experts. The purer heroin can be smoked, so many people who would never dream of using heroin because of the stigma of using a needle may be tempted to smoke heroin for a far more powerful high than that produced by marijuana.

Estimates are hard to come by; actual figures elusive. But it appears that cocaine, the status recreational drug, is increasing in popularity despite its high price.

In short, there has been a "tremendous increase in the past 20 to 25 years" in the use of marijuana, hallucinogens, and other drugs, says Dr. Pollin.

HISTORY OF DRUG USE

Drug use is nothing new to the human race, despite any impressions the recent furor over increased drug use may have created. Mankind has been using drugs since before recorded history. Historians believe the ancient Sumerians used opium as early as 5000 BC. Alcohol can be traced to Egypt, when a beer brewery was mentioned in a tax record from 3700 BC. Marijuana was cited in a Chinese pharmacopoeia from 2500 BC, poppy juice was mentioned by the Greek naturalist Theophrastus, and American Indians have used peyote in religious rites for centuries.

Known as "Heavenly Guide" by Hindus, marijuana (cannabis) was introduced to India between 1500-800 BC. After Marco Polo introduced marijuana to Western Europe little is heard of it until the mid-19th century when some French and English writers revealed their use of it. Introduced to the United States by Mexican laborers, marijuana's popularity grew during the 1960s and 1970s to the point where it is estimated that 15 million Americans smoke one joint a day. Cannabis, in the form of hashish, continues to be a predominant drug of choice in the Middle East.

Opium use spread from Egypt in 1600 BC to the Greeks and Romans, reached Persia (Iran) and China by 800 AD, and became established in India by 1500. Opium trade into China by the British East India Co. reached such proportions that two wars were waged during the 1800s over China's attempt to block British imports. Throughout the 1800s English scientific opinion viewed opium as a good painkiller much less socially harmful than alcohol, even when misused. No laws regulating any type of drug existed during the 1700s and 1800s, giving entrepreneurs free rein in selling tonics and home remedies heavily laced with laudanum and opium. Some of the heaviest users during these years were middle and upper class women. During the late 1800s when the negative consequences of opium habituation were recognized, morphine, a more potent and addicting version of opium, was introduced and hailed as a "cure" for an opium habit. During these years alcohol, tobacco, and opium dependent people were increasingly being viewed as addicts suffering from a compulsion to indulge rather than morally weak people. This clinical perspective was largely advanced by the writing of Dr. Benjamin Rush. When morphine was recognized as more addicting than opium, heroin was introduced in 1898 as a cure for morphine. By 1914 it became clear that all three were addicting and the Harrison Narcotics Act made narcotics illegal except as prescribed by physicians. Two major results of this act were the creation of a black market and the introduction of the drug abuser into the world of crime. Since then the number of heroin addicts in the US has fluctuated, with the most recent increase occurring after the return of Viet Nam veterans who acquired the habit overseas.

Not only is alcohol the most widely used and abused drug worldwide, it is the most destructive. There are over 25 million alcoholics worldwide, and in France one-tenth of the entire population is alcoholic. But it was not until Dr. Rush viewed alcohol dependence from a clinical perspective that alcoholism was considered to be a medical rather than a moral problem.

Christopher Columbus learned from natives of the New World that inhaling the smoke of burning tobacco leaves relieved tiredness and monotony, and within 100 years the Spaniards were almost totally converted to tobacco. As production techniques improved and women gained independence, cigarette consumption grew and spread throughout the world. Publicity of smoking's harmful effects on health during the 1960s and 70s reversed the increase in cigarette smoking in America, but in many third world countries cigarette consumption is rising quickly as the standard of living rises. Nicotine, a stimulant, is also a potent poison. (For more information on smoking, refer to the AMA Auxiliary's Smoking Package Program.)

Since its origin in ancient Ethiopia, the coffee plant has become the world's most widely cultivated drug or beverage plant. A widely available, relatively mild, inexpensive drug, caffeine has been used for centuries as a mild stimulant.

Scientific breakthroughs during the early 1900s introduced two new types of chemicals hailed as effective therapeutic drugs: amphetamines (stimulants) and barbiturates (sedative/tranquilizers.) Physicians realized the habituation potential of these drugs within 10 to 20 years of their introduction, but formal federal efforts at regulation were not begun until the 1960s.

Experimentation with all types of drugs reached epidemic proportions, during that decade as young people turned on with marijuana, heroin, hashish, LSD, and a variety of other drugs, both legal and illegal. To curb the abuse of drugs, Congress passed the 1970 Controlled Substances Act which classified drugs and specified restrictions on use and penalties for misuse.

Drug use is nothing new. But there have never been so many drugs available for misuse, so many different economic and social groups using drugs, such a variety of use patterns, and so many different combinations of cross-addictions.

Sources:

A Family Response to the Drug Problem, National Institute on Mental Health
Drug Abuse: Drugs in a Chemically Dependent Society, Blue Shield

WHY PEOPLE TAKE DRUGS

Abstinence vs. Use vs. Abuse

Since the beginning of time people have used psychoactive drugs for various reasons: to alter consciousness, to promote socialization, and to heal. But why do people now use drugs for other than medical reasons?

Drugs make people "feel good." People enjoy the "high," the pleasurable experience of mind altering drugs. For some people, drugs are part of mystical or religious experiences.

Drugs provide a relief from tensions and stress.

Peer pressure, especially among young people, is often very strong to experiment with, and continue to use, a variety of drugs. Use of drugs such as tobacco, alcohol, and cannabis has become part of the "rite of passage" into adulthood along with learning to drive and sexual experimentation.

Drugs are part of the American way of life. It's not uncommon for a person to legally consume four drugs a day: nicotine, caffeine, alcohol, and amphetamines (diet pills) or tranquilizers. These drugs and a host of others are part of the vast array of technical wonders that can make "life a little easier." Powerful messages and forces in society, including advertising, teach people to turn to drugs as a way of solving problems and relieving pressure. One national commission studying the drug abuse problem in the 1960s estimated that by the age of 18 the average American has seen 180,000 television commercials that deliver this message.

Just as there are different reasons for using drugs, there are different patterns of drug use.

Some people are recreational users; they use drugs in social settings among friends. Although their drug taking is patterned, it will not necessarily escalate or lead to use of other drugs. Social drinkers fall in this category.

Circumstantial drug users take drugs because of a desire to achieve an anticipated effect in order to cope with a specific problem or situation of a personal or vocational nature.

Intense drug users administer the drug daily, motivated by a perceived need to achieve relief from a persistent problem or stressful situation or by the desire to maintain a certain self-prescribed level of performance. The intense drug users may still remain integrated within the larger social and economic structure.

However, the life of a compulsive drug user is dominated by drug use, at the expense of other social functioning. Compulsive use consists of patterned behavior at a high frequency and high level of intensity. It is

characterized by a high degree of psychological dependence and perhaps by physical dependence as well. Alcoholics, and barbiturate- and narcotic-dependent people are the most easily recognized compulsive drug users. These people would be classified as being "drug-dependent," "addicts," or "habituated." (See definitions in next section.)

What accounts for the difference in patterns of drug use? Many Americans drink alcohol, or smoke pot, or snort cocaine, and a few even inject heroin without becoming physically or psychologically dependent on the drug. What then distinguishes between users and abusers? Their motive for drug use? Personality characteristics? Genetic traits?

There is no definite answer, but using the National Institute of Drug Abuse data, experts have decided that there is one primary underlying reason for abusing drugs: they act as a substitute for something that is missing in the abuser's life, whether it is good feelings, competency, peace of mind or the feeling of being liked just for themselves.

It is important to state here that virtually all of the psychosocial data surrounding the reasons for drug use and abuse deals with correlates, not causes. Social scientists can fairly accurately determine what characteristics people with similar patterns of drug use share, but it is beyond their current ability to declare any firm "cause and effect" relationship involving personality traits and drug use.

The following statements describing drug use and drug users were compiled by Kandel (1979) from a selected group of longitudinal studies. These are probability statements which generalize about the majority of drug users. There are exceptions to each statement. These statements are valuable because they give drug abuse prevention educators a better understanding of a majority of their target audience. Hopefully, a better understanding of drug users, their characteristics and attitudes, will result in more effective prevention programs.

- 1) The period for risk of initiation into illicit drug use is usually over by the mid-twenties.
- 2) A high proportion of youths who have tried marijuana will usually go on to experiment with other illicit drugs.
- 3) Later age of onset is usually associated with lesser involvement and greater probability of stopping.
- 4) There are usually clear-cut developmental steps and sequences in drug behavior; use of one of the legal drugs almost always precedes use of the illegal drugs.
- 5) Addiction to heroin is not usually a permanent state.
- 6) Occasional use of heroin does not necessarily lead to addiction.
- 7) The dysfunctional attributes of drug users usually appear to precede rather than to derive from drug use.
- 8) Different factors are usually involved in the transitions into different stages of drug use.
- 9) Personality factors indicative of maladjustment usually precede the use of marijuana and of other illicit drugs.
- 10) Poor school performance is usually a common antecedent of initiation into illicit drugs.

- 11) Delinquent and deviant activities usually precede involvement in illicit drugs.
- 12) A constellation of attitudes and values favorable to deviance usually precedes involvement in illicit drugs.
- 13) There is a process of anticipatory socialization wherein youths who will initiate the use of drugs usually develop attitudes favorable to the use of legal and illegal drugs prior to initiation.
- 14) Drug behavior and drug-related attitudes of peers are usually among the most potent predictors of drug involvement.
- 15) Parental behaviors, parental attitudes, and parental closeness to their children usually have differential importance at different stages of involvement in drugs.
- 16) Sociodemographic variables usually hold little predictive power for initiation into marijuana.
- 17) Time of onset of drug use usually declines as degree of deviance proneness increases.
- 18) A social setting favorable to drug use usually reinforces and increases individual predisposition to use.
- 19) Nonaddictive illicit drug use usually does not by itself lead to increased criminality.
- 20) Cannabis use usually does not appear to lead to the "amotivational" syndrome.

By definition, principles are probability statements that ignore small deviations. To assure that the exceptions are recognized, we add qualifying comments to the above:

- Some parents are initiated into illicit drug use by their youngsters.
- Amphetamines may sometimes be the initial illicit drug rather than marijuana. (In fact, underage smoking and drinking are the usual illicit antecedents to use of the unlawful compounds.)
- Later age of onset also is associated with better treatment outcomes.
- In hippie families, young children may not start with legal drugs but be administered hallucinogens or cannabis before they can initiate their own use.
- Addiction is as much a role as a state. Physical dependence, the pharmacological condition, is intermittent and often terminated. The addict role requires intention, effort, and learning, whereas physical dependency, to be produced, requires repeated doses.
- Drug use can lead to bad outcomes, either acute or chronic, and repetitive use may further limit coping, judgment, and maturation.
- Maladjustment and pathological traits will not discriminate between users and nonusers when use is or becomes conventional in a population. Even then, though, some initial use will be triggered by individual psychodynamics as will be varieties of response.
- Peer influence dominates especially when families suffer or create conditions for it or reduce control. Although parental influence has different impact at different stages of drug involvement, there is some impact at any age.
- Age is a powerful predictor of marijuana (and most other drug) use. At the present time other sociodemographic characteristics do not distinguish strongly.
- Drug use may not inevitably create the amotivational syndrome, but acute effects of drugs easily impair judgment and motor coordination, and intensive use of some substances is incompatible with adequate social performance.

Sources:

Psychoactive Drugs, American Medical Association, 1979

Handbook on Drugs, National Institute on Drug Abuse, 1979

It Starts With People, National Institute on Drug Abuse, 1978

DEFINITIONS

Addiction--An ambiguous term with various meanings in different situations.

The concept usually implies a strong psychological dependence (or compulsion to use) and/or physical dependence (withdrawal symptoms in abstinence) and, often, a tendency to increase dose (tolerance).

Antagonist--A drug which blocks or counteracts certain effects of another drug.

Aphrodisiac--Sex-drive stimulating.

Cross dependence--A condition in which one drug can prevent the withdrawal symptoms associated with physical dependence on a different drug.

Drug--Any substance that, when taken into the living organism, may modify one or more of its functions.

Drug dependence--A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

Habituation--An ambiguous term which usually implies (1) a desire (but not a compulsion) to continue drug use, (2) little or no tolerance, (3) no physical dependence.

Physical dependence--An adaptive state that manifests itself by intense physical disturbances when the administration of the drug is suspended or when its action is affected by the administration of a specific antagonist. These disturbances, i.e., the withdrawal or abstinence syndromes, are made up of specific arrays of symptoms and signs of psychic and physical nature that are characteristic for each drug type. These conditions are relieved by readministration of the same drug or of another drug of similar pharmacological action...No overt manifestation of physical dependence is evident if an adequate dosage is maintained. Physical dependence is a powerful factor in reinforcing the influence of psychic dependence upon continuing drug use or relapse to drug use after attempted withdrawal.

Potentiation--An overall effect of two drugs taken together which is greater than the sum of the effects of each drug taken alone.

Psychic dependence--A condition in which a drug produces a feeling of satisfaction and a psychic drive that requires periodic or continuous administration of the drug to produce pleasure or to avoid discomfort. Indeed, this mental state is the most powerful of all the factors involved in chronic intoxication with psychotropic drugs, and with certain types of drugs it may be the only factor.

Psychoactive--Those drugs which alter sensation, mood, consciousness, or other psychological or behavioral functions.

Reverse tolerance--A condition in which the response to a certain dose of a drug increases with repeated use.

Tolerance--An adaptive state characterized by diminished responses to the same quantity of a drug or by the fact that a larger dose is required to produce the same degree of pharmacodynamic effect.

Withdrawal Syndrome (or Symptoms)--A characteristic set of adverse physiological (and psychological) symptoms which occur, after the development of physical dependence, when the regular administration of the drug is stopped (or its effect inhibited by an antagonist). Also called the abstinence syndrome. The characteristics of withdrawal vary with different drugs and with the individual patterns of use associated with the dependent. Severe instances of withdrawal symptoms may be fatal, especially with alcohol and barbiturates.

Sources:

A Manual on Drug Dependence, World Health Organization

A Family Response to the Drug Problem, National Institute of Mental Health

SLANG TERMS

Drug abusers develop a language all of their own. Since most of their definitions to the words below won't be found in Webster's or Funk and Wagnalls, their language is more flexible and changing than regular American slang. Words are quickly added, dropped, or given new meanings. Note that the terms given below are those believed to be the most commonly used; people in different states and cities, even people in different social circles within a city, may have their own unique terms.

Slang terms for specific drugs can be found in the drugs of abuse chart, pages 14-17.

bad trip--a bad drug experience, especially from LSD

bag--taken from the fact that many drugs are purchased in "Baggies," it refers to a quantity of drug, most commonly marijuana

blast, blasted--a sudden strong reaction to a drug; to be drugged

bong--a device used in smoking marijuana, designed to retain all the smoke and so produce a more intense high. Available in head shops and record stores in all shapes, sizes, and materials (i.e., metal, wood, ceramic, plastic, bamboo)

bowl, "do a bowl"--to smoke the marijuana or hashish in a pipe or bong

busted--arrested

coke spoon--a tiny spoon with long handle and tiny bowl used in snorting cocaine

catch a buzz--to reach a high

clean--not carrying or using drugs; also, to remove stems and seeds from marijuana

come down--to lose drug-induced euphoria (cf. bring down)

cop--to buy drugs

crash--to come down hard from a drug experience; to sleep after a drug experience

cut--to adulterate drugs

deal, dealer--to sell drugs; a drug peddler

dime--a \$10 bag of marijuana

do a line--to inhale a prepared amount of cocaine. Cocaine is spread on a small hand mirror, chopped fine with a single-edged razor, separated into two thin one inch long lines one for each nostril, and inhaled through a rolled dollar bill or straw

down, downer--depression; a barbiturate or other sedative

drop--to swallow, as, drop acid

fix--to inject narcotics; also, a single injection of heroin

flashback--a recurrence of a drug reaction without using the drug again

freak--a drug user obsessed with his drug, as, a speed freak (a heavy user of methamphetamine)

freak out--to lose contact with reality

grams--a measurement of MDA, cocaine, or similar drug in powder form

head--a steady user of drugs; also, used to describe anything that is drug-oriented, as head shop, head music

head shop--stores that sell drug paraphernalia (head supplies) such as bongs, rolling papers, roach clips, stash cans, drug literature, coke spoons, etc.

hit--to take drugs, a full dose or a "taste"; "Give me a hit off that joint"

into--using, as to be into pot

j--a marijuana cigarette

joint--a marijuana cigarette

junky--a heroin addict
kilo--a kilogram (2.2 pounds) of a drug sold in bulk lots
lid--one ounce (32 grams) of marijuana
LB--one pound, as in a pound of marijuana
narc--a narcotics law enforcement agent
nickel--a \$5 bag of marijuana
OD--overdose
papers--papers used for rolling marijuana cigarettes
pusher--a drug peddler
roach--the butt of a marijuana cigarette, said to contain a high concentration of the drug
roach clip--a small tweezer-like clip for holding the burning roach when it becomes too small to be held by the fingers
rush--a quick, short, high sensation
score--to buy drugs
shoot-up--to inject drugs
sniff--to inhale drugs through the nose
snort--to inhale drugs through the nose
spaced (out)--in a mind-altered state; high, also, extended to mean dazed, sick from excessive drug use
stash--a hidden supply of drugs
stoned--intoxicated by drugs
straight--a nonuser of drugs; also, a dealer who sells good stuff; also a drug user when he's not high
stuff--drugs
toke (up)--to smoke marijuana; to light up a marijuana cigarette
toot--one inhalation of cocaine
trip--hallucinations and other experiences after taking drugs; especially LSD
wasted--intoxicated by drugs
wired--high, usually on amphetamines

DRUGS OF ABUSE CHART

Chemical and Trade Names	Slang Terms	Appearance	Tolerance
<u>STIMULANTS</u>			
Amphetamines Dextroamphetamine Methamphetamine Benzidrene Dexedrine Cocaine caffiene, nicotine	speed, uppers, pep pills, dexies, hearts meth, crystal bennies, cartwheels coke, snow, happy dust, flake, Bernice	tablets, capsules odorless white granular or fluffy powder	yes high
<u>DEPRESSANTS</u>			
Barbiturates Phenobarbital Pentaobarbital Secobarbital Amobarbital Chloral hydrate Methaqualone Tranquilizers (Anti-anxiety drugs) Trade Names: Librium, Tranxene Valium, Ativan, Serax, and others Alcohol	barbs, downers, goofballs phennies yellow jacket, nimbies red devils, pinks blue devils, blues mickey finn, mickey, peter, knockout drops quads, blues, Quaaludes booze, juice, hard stuff	tablets or capsules soft gelatin capsules tablets or capsules yes yes	high possible yes yes yes
<u>NARCOTICS</u>			
Opium Morphine Codeine Heroin	opium, OP, pen yan, hop, tar, black stuff white stuff, hard stuff, M, Miss Emma, unkie school boy H, junk, smack, horse, harry, joy powder, snow, sugar, scag	dark brown, coagulated, plastic-like odorless, light brown or white crystalline powder often tablets or capsules white crystalline powder or tablet added to various liquids (cough syrup) odorless, white, off-white, or light brown powder	yes yes yes yes

Drug's Effects/ Signs of Use	How Ingested	Duration of Effects	Potential for:		organic damage
			physical need	mental dependency	

STIMULANTS

dilated pupils, decreased appetite, increased perspiration, restlessness, nervousness, talkative, compulsive but purposeless activity	oral, injected	2-4 hours	doubted	yes	suspected
short, intense euphoria followed by feelings of anxiety and depression; fixed, dilated pupils	sniffed, injected	1-2 hours	no	yes	suspected

DEPRESSANTS

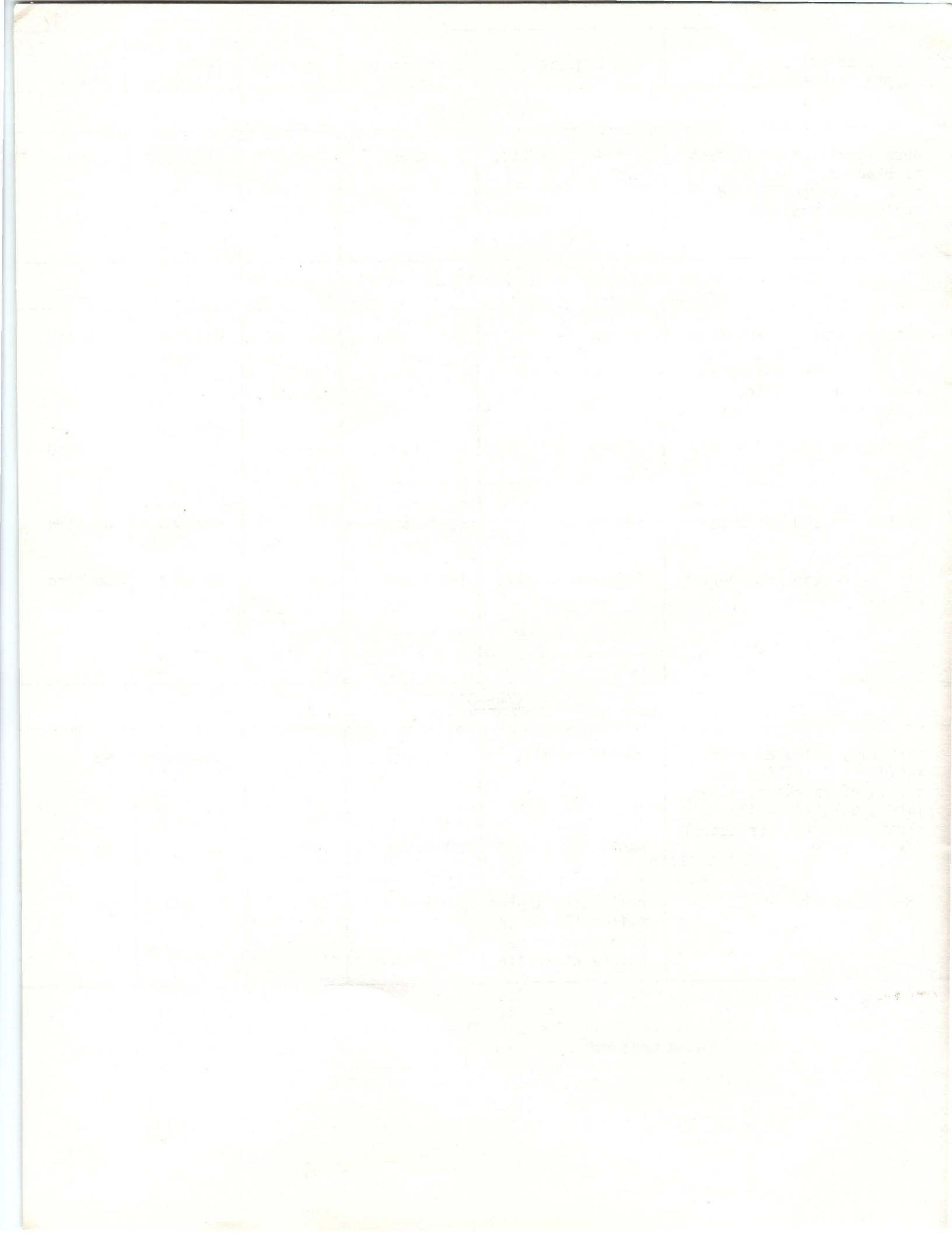
drunken behavior with no odor of alcohol, drowsiness, slowed reflexes, dilated pupils	oral, injected, rectally	1-16 hours	yes	yes	yes
same as barbiturates	oral	5-8 hours	yes	yes	yes
same as barbiturates	oral, injected	4-8 hours	yes	yes	yes
same as barbiturates	oral, injected	4-8 hours	yes	yes	?
slowed reflexes, drowsiness	oral		yes	yes	yes

NARCOTICS

euphoria, drowsiness, constricted pupils, respiratory depression, loss of appetite; same as opium but scars, "tracks" on arms or hands	oral, smoked	3-6 hours	yes	yes	yes
	oral, injected, smoked	3-6 hours	yes	yes	yes
little evidence	oral, injected	3-6 hours	yes	yes	yes
same as morphine	injected, sniffed, smoked	3-6 hours	yes	yes	yes

Chemical and Trade Names	Slang Terms	Appearance	Tolerance
<u>PHENCYCLIDINE</u>			
Phencyclidine	PCP, angel dust, hog, tic, elephant or horse tranquilizer, killer weed, rocket fuel, TLC, toc	odorless, many colors tablet or powder form	yes
<u>HALLUCINOGENS</u>			
LSD (lysergic acid diethylamide)	acid, microdots, cubes, big D, blotter, window-pane	white powder or tablet; clear colorless, odorless liquid; clear gelatin squares or dots on paper (like candy)	yes
Mescaline	peyote, plants, buttons, cactus	actual dried "button" from peyote cactus; gelatin capsule	yes
Psilocybin	mushrooms, magic mushrooms	actual dried mushroom; capsule	yes
DMT(Dimethyl-tryptamine)	DMT	orange liquid or orange crystals; color ranges from bright to dirty orange depending on purity	not established
<u>CANNABIS</u>			
Marijuana	pot, grass, tea, weed, reefer, mary jane, hemp, Panama Red, Acapulco gold	usually looks like green tobacco and often contains seeds and stems	yes
Hashish	hash	brown balls, cakes, bricks, or other forms	yes
Hashish Oil		dark viscuous liquid	yes

Drug's Effects/ Signs of Use	How Ingested	Duration of Effects	Potential for: physical need	mental dependency	organic damage
<u>PHENCYCLIDINE</u>					
depersonalization, speech is blocked, touch and pain sensations dulled, co-ordination impaired	sniffed, smoked, orally	4-6 hours	unknown	unknown	unknown
<u>HALLUCINOGENS</u>					
dilated pupils, rambling speech; behavior and mood vary from trance-like to fearful or terrified states; hallucinations	orally	8-12 hours	no	doubted	doubted
similar to LSD but milder	orally	5-12 hours	no	doubted	doubted
similar to LSD but milder	orally	up to 6 hours	no	doubted	doubted
similar to LSD but shorter shorter duration	injected, smoked	1-3 hours	no	doubted	doubted
<u>CANNABIS</u>					
initially animated with rapid, loud talking and bursts of laughter, sleepy later, dilated pupils, bloodshot eyes, perceptual distortion	smoked, orally	2-5 hours	no	suspected	no
same as marijuana	smoked in a pipe	2-5 hours	no	suspected	no
	orally, or smoked (after spread on a tobacco or marijuana cigarette)	2-5 hours	no	suspected	no



CANNABIS

Marijuana

Cannabis sativa, the hemp plant referred to as marijuana by Americans, grows wild and under cultivation in many parts of the world. Used as a drug for centuries, marijuana was used in treating a wide range of physical and mental illnesses during the 19th century. It was gradually replaced by synthetic drugs and by 1941 it was considered to have no legitimate medical use.

Scientists believe that the psychoactive ingredient delta-9-tetrahydrocannabinol (THC), one of the 419 chemicals in marijuana, causes intoxication of users. THC concentration, which determined the potency of the marijuana, is found in different concentrations in different parts of the same plant and also varies with plant strain, climate, soil conditions, and harvesting.

Marijuana used in America is made of dried particles of the whole plant, except the main stem and roots. The potency of commonly available marijuana has sharply increased as the primary sources shifted from Mexico to Colombia. Several years ago most pot had a THC concentration of .5% to 1% or 2%. Now most pot is about 4% THC or greater. Sinsemilla, a cultivated form of marijuana which is becoming more frequently available in the US, may contain as much as 7% THC.

While marijuana is usually rolled into "joints" resembling cigarettes and smoked, it is also often eaten after being cooked into brownies or chocolate chip cookies. Effects are felt within minutes, reach their peak 10 to 30 minutes later, and may linger for 2 to 3 hours.

Reactions to pot vary considerably since they are influenced by a user's experience with the drug, his expectations, the surroundings, potency of dose, and interaction with other drugs present in the body. Most commonly, users report feelings of euphoria and relaxation after smoking moderate amounts. Higher doses can result in image distortion and hallucinations.

Physically, users experience an increase in heart and pulse rate, a reddening of the eyes, a dryness in the mouth and throat, a mild decrease in body temperature, and, on occasion, a sudden appetite.

Studies show that even moderate amounts of marijuana produce mental effects including temporary impairment of short term memory, alteration of sense of time, and reduced ability to perform tasks requiring concentration, swift reactions, and coordination. This state of intoxication is frequently not noticeable to an observer.

Some people react badly to marijuana. The most common adverse reaction is a state of anxiety, sometimes accompanied by paranoid thoughts which can range from general suspicion to a fear of losing control and going crazy. Acute anxiety reactions are usually experienced by novice users and the symptoms generally disappear in a few hours as the drug's effects wear off. While anxiety reactions can usually be quieted by simple reassurance, some users may need professional help.

Marijuana does not directly cause mental problems, but like many other drugs, it appears to bring to the surface emotional problems and can even trigger more severe disorders, particularly schizophrenia. People suffering from depression or other emotional disturbances who use marijuana to treat their symptoms often cause a worsening of the problem. Because more people are using marijuana and many are reporting it is causing disruption to their lives, self-help groups are now forming to help these people beat their marijuana habit. An estimated 5,000 people seek professional treatment every month for problems related to marijuana.

In addition to the physical effects of marijuana, a very real danger of use among adolescents and children is its possible interference with the maturation process. Research shows the effects of marijuana can interfere with learning by impairing thinking, reading comprehension, and verbal and arithmetic skills.

Scientists also believe that the drug may interfere with the development of adequate social skills and may encourage a kind of psychological escapism. Young people need to learn how to make decisions, to handle success, to cope with failure, and to form their own beliefs and values. By providing an escape from "growing pains," drugs can prevent young people from learning to become mature, independent, and responsible.

"Burn out" is a term first used by marijuana users to describe the effects of prolonged use on each other. Young people who smoke marijuana heavily (anywhere from one to three or four joints a day) over long periods of time can become dull, slowing moving, and inattentive. These burned out users, also referred to as being "vegged out" or "space cadets," are sometimes so unaware of their surroundings that they do not respond when friends speak to them. Such youngsters however, do not consider themselves to be burned out. Scientists believe that burn out may be a sign of drug-related mental impairment that may not be completely reversible, or is reversible only after months of abstinence.

While marijuana is not physically addicting, users develop a tolerance and many are reporting difficulty in stopping after heavy or long term use.

Marijuana is often accused of automatically leading to harder drugs. It is true that the vast majority of drug users began their experimentation with alcohol, nicotine, and cannabis. As such, marijuana is rightfully considered a "gateway" drug. However, the overwhelming majority of marijuana users do not go on to use harder drugs. One determining factor is the age at which marijuana use begins; the younger the age at first use, the more likely that use will continue and become heavy and the greater the likelihood of subsequent experimentation with other drugs.

Results of marijuana research and studies make headlines each day, bombarding the public with simplified explanations of not-always-reliable scientific studies. Marijuana has been credited with causing sterility in men, easing the pain of glaucoma and terminal cancer patients, destroying motivation, or having absolutely no harmful side effects.

Advocates of marijuana use consistently point out that the studies are inconclusive and there isn't any definite proof. To a certain extent, they are right. Since 1967, the US federal government has spent \$35 million on marijuana research to support over 1,000 research projects. In fiscal year

1979 alone the National Institute spent \$3.8 million supporting approximately 100 research studies. All this has produced enough evidence to cause the NIDA to say that marijuana is not a "safe" substance, but not enough to list "proven" health hazards. This doesn't mean that direct links don't exist. After all, as Dr. Pollin, NIDA Director says, "It required 50 years of research for the truly serious implications of cigarette smoking to become apparent."

The following health hazards of marijuana smoking are summarized from testimony presented by Dr. Pollin before the Select Committee on Narcotics Abuse and Control, on July 19, 1979.

Mental Performance. Acute intoxication impairs learning, memory, and intellectual performance.

Driving. Marijuana intoxication impairs driving and other skilled performances. Evidence suggests that being "high" on social usage levels of marijuana interferes with driving, flying, and other complex psychomotor performance. A study conducted for the National Highway Traffic Safety Administration of drivers involved in fatal accidents indicated possible marijuana involvement.

Despite users' commonly expressed belief that their driving skills are impaired by cannabis intoxication, there is reason to believe that more pot users are driving while "high" than in the past. And, as use becomes increasingly common and socially acceptable, and as the risk of arrest for simple possession decreases, still more people are likely to risk driving while "high." The simultaneous use of marijuana and alcohol is quite common, and the risk of the two drugs used in combination may well be greater than that posed by either alone.

"At present, it is clearly desirable to discourage driving while marijuana-intoxicated," concludes Dr. Pollin.

While many marijuana users realize their driving ability is impaired while they are high, most don't realize that some of the performance or perceptual decrements resulting from marijuana use may persist for some time, possibly for several hours beyond the time during which they "feel" high.

Effects on the Heart. While marijuana use appears to pose no health hazard to healthy young males, those with heart conditions or at high risk should avoid marijuana use and the subsequent increased heart rate and poor circulation.

Lung Damage. From the total body of clinical and experimental evidence accumulated to date, it appears very likely that daily use of marijuana may lead to lung damage similar to that resulting from heavy cigarette smoking.

Immune System. Research results to date are far from clear-cut in establishing whether or not the human immune system is impaired by marijuana.

Brain Damage. Many clinicians feel that regular marijuana use may seriously interfere with psychological functioning and personality development, especially in childhood and adolescence. There is increasing clinical concern that at least some percentage of regular heavy daily users do develop a psychological dependence on marijuana to the extent that it interferes with functioning in a way analogous to heavy alcohol use. It has not yet been determined if enduring psychological effects occur in chronic users.

Endocrine System. There is evidence that marijuana can affect the network of glands and hormones which are involved in such functions as growth, energy levels, and reproduction but the long term significance of these results remains to be determined.

Reproductive Functions. While research directly concerning effects on human reproduction is very limited and the NIDA is aware of no clinical reports directly linking marijuana use and birth abnormality, numerous studies underscore the undesirability of using marijuana, especially during pregnancy.

Chromosome Abnormalities. Overall, there continues to be no convincing evidence that marijuana use causes clinically significant chromosome damage. However, it should be emphasized that the limitations of the research to date preclude definitive conclusions.

Use of marijuana vs. use of alcohol and nicotine. "Any comparison of alcohol and tobacco use and that of marijuana compares drugs with great differences in social acceptability, period of use, and degree of availability. The hazards of alcohol and tobacco are reasonably well known, and the social and public health costs quite high," says Dr. Pollin, NIDA Director.

"...By contrast, marijuana has only recently become a popular substance; it remains illegal and most use is not habitual at present...much less is known about the implications of marijuana use.

"Thus, any attempt to compare the health impact of marijuana with that of alcohol and tobacco at current levels of use is certain to minimize the hazards of marijuana. But any comparison at levels of anticipated use involves many assumptions that are at best dubious and at worst may be dangerously misleading. Such a comparison seems, therefore, useless and undesirable until such time as the parameters of risk are better specified than they can be at present.

"I believe we can state that there is no controversy with respect to the hazards of use by children and young people....As a psychiatrist, I would also like to stress that virtually all clinicians working with children and adolescents agree that regular use of marijuana by youngsters is highly undesirable. Although experimental evidence concerning the implications of use in this group is not easily obtained, there is little serious question that regular use of an intoxicant that blurs reality and encourages a kind of psychological escapism makes growing up more difficult. While there is controversy over the implications of present research concerning adult use, few would argue that every effort should be made to actively discourage use by children and adolescents."

Sources:

Statement on Health Consequences of Marijuana Use, Dr. William Pollin, National Institute on Drug Abuse Director, before the Select Committee on Narcotics Abuse and Control, House of Representatives, July 19, 1979

Statement on Marijuana, American Academy of Pediatrics Committee on Drugs, October 2, 1979

Drugs of Abuse, Drug Enforcement Administration, 1979

Marijuana: What It Is and What It Does, Drug Abuse Facts series, National Institute on Drug Abuse

Hashish

The Middle East is the main source of hashish. It consists of the drug-rich resinous secretions of the cannabis plant which are collected, dried, and then compressed into a variety of forms, such as balls, cakes, or cookie-like sheets. Hashish in the US varies in potency as in appearance, ranging in THC content from trace amounts to 10%. The average reported is 1.8%.

Hashish Oil

The name comes from the drug culture and is a misnomer in suggesting any resemblance to hashish other than its objective of further concentration. Hashish oil is produced by a process of repeated extraction of cannabis plant materials to yield a dark viscous liquid, current samples of which average about 20% THC. In terms of its psychoactive effect, a drop or two of this liquid on a tobacco cigarette is equal to a single "joint" of marijuana.

Source:

Drugs of Abuse, Drug Enforcement Administration, 1979

MARIJUANA USE

The increase in marijuana use and the concurrent changes in social acceptability over the past 15 years represent a major change in public attitudes falling just short of a cultural revolution. Just some 15 years ago pot belonged to the inner city ghetto, to blacks, or to jazz musicians. In 1977 the National Institute on Drug Abuse estimated that about 43 million people had tried marijuana and 16 million were current users. Not only is it widely accepted, particularly in certain social and age groups, but also acceptance in diverse age and social groups continues to increase. People are using marijuana at earlier ages, they are indulging more often, and more people are using it.

As early as 1977, data from nationwide surveys indicated that some experience with marijuana had become statistically normative among older adolescents and young adults, and that about a third of those in that age range had used marijuana in the past month.

By early 1978, marijuana was clearly the most widely used illicit drug. A substantial proportion of the population--within some age groups it is a sizable majority--has had some experience with marijuana. This data from the most recent national survey of the general population shows that lifetime use is substantial among older adolescents and young adults. It should be noted that most of those who have had experience with marijuana have had only limited experience, and for many of them use is not current.

<u>Age</u>	<u>% Ever Used</u>
12-13	8
14-15	29
16-17	47
18-21	59
22-25	62
26-34	44
35+	7

Two other indicators of the social climate surrounding marijuana use suggest that involvement with marijuana is likely to continue to increase in the future. First, many of the factors that are immediately relevant to the likelihood of marijuana use have increased. These factors include: knowing someone who has used marijuana; having the opportunity to use marijuana; beliefs about the harmfulness and risk associated with marijuana use; and attitudes whether marijuana use should be legalized or decriminalized. (The American Council on Education survey of 300,000 entering freshmen to colleges and universities in the US in fall of 1977 found, for the first time, that a majority, 53%, of freshmen supported legalization of marijuana.)

Secondly, the surveys quoted here tend to draw from households and students, therefore bypassing non-household members and school drop outs, two population groups that would tend to have higher rates of drug use.

While occasional, moderate marijuana use by healthy, nonpregnant adults is not hazardous, parents, pediatricians, and public servants are concerned by rising marijuana use among teens.

NIDA Director William Pollin, MD, stated in early 1980 that marijuana is "a serious public health hazard," particularly among teenagers. An estimated 15 million American teenagers now use pot daily, Dr. Pollin stated. Also, over the past five years alcohol use among high school seniors has remained constant (one in 20) while marijuana use has increased (from one in 20 to one in 10).

The American Academy of Pediatrics' Committee on Drugs agrees that "there is little evidence that an individual who only rarely smokes marijuana will be harmed by that exposure," but warns that since "school age children and adolescents experience and respond to overwhelming peer pressure, the risk is that occasional users will increase their frequency of marijuana use or develop a pattern of frequent use of other psychoactive drugs that will accompany them into adulthood."

DEPRESSANTS

Substances regulated under the CSA as depressants have a high potential for abuse associated with both physical and psychological dependence.

Taken as prescribed by a physician, depressants may be beneficial for the relief of anxiety, irritability, and tension, and for the symptomatic treatment of insomnia. In excessive amounts, however, they produce a state of intoxication that is remarkably similar to alcohol.

As in the case of alcohol, these effects may vary not only from person to person but from time to time in the same individual. Low doses produce mild sedation. Higher doses, insofar as they relieve anxiety or stress, may produce a temporary sense of well-being; they may also produce mood depression and apathy. In marked contrast to the effects of narcotics, however, intoxicating doses invariably result in impaired judgment, slurred speech, and loss of motor coordination. In addition to the dangers of disorientation, resulting in a high incidence of highway accidents, recurrent users incur risks of long-term involvement with depressants.

Tolerance to the intoxicating effects develops rapidly, leading to a progressive narrowing of the margin of safety between an intoxicating and lethal dose. The person who is unaware of the dangers of increasing dependence will often increase the daily dose up to 10 or 20 times the recommended therapeutic level. The source of supply may be no further than the family medicine cabinet. Depressants are also frequently obtained by theft, illegal prescription, or purchase on the illicit market.

Drug abusers often resort to the use of depressants as self-medication to soothe jangled nerves brought on by the use of stimulants, to quell the anxiety of "flashbacks" resulting from prior use of hallucinogens, or to ease their withdrawal from heroin. The dangers, it should be stressed, are compounded when depressants are used in combination with alcohol or other drugs. Chronic intoxication, though it affects every age group, is most common in middle age. The problem often remains unrecognized until the user exhibits recurrent confusion or an obvious inability to function. Depressants also serve as a means of suicide, a pattern particularly common among women.

The depressants vary with respect to their potential for overdose. Moderate depressant poisoning closely resembles alcoholic inebriation. The symptoms of severe depressant poisoning are coma, a cold clammy skin, a weak and rapid pulse, and a slow or rapid but shallow respiration. Death will follow if the reduced respiration and low blood pressure are not counteracted by proper medical treatment.

The abrupt cessation or reduction of high-dose depressant intake may result in a characteristic withdrawal syndrome, which should be recognized as a medical emergency more serious than that of any other drugs of abuse.

Detoxification and treatment must therefore be carried out under close medical supervision. While treatment techniques vary to some extent, they share common

objectives: stabilization of the drug-dependent state to allay withdrawal symptoms followed by gradual withdrawal to prevent their recurrence.

Among depressants that give rise to the general conditions described are chloral hydrate, a broad array of barbiturates, glutethimide, methaqualone, meprobamate, and the benzodiazepines.

Chloral Hydrate

The oldest of the hypnotic (sleep-inducing) drugs, chloral hydrate was first synthesized in 1862 and soon supplanted alcohol, opium, and cannabis preparations for inducing sedation and sleep. Its popularity declined after the introduction of the barbiturates, but chloral hydrate is still widely used. It has a penetrating, slightly acrid odor, and a bitter caustic taste. Its depressant effects, as well as resulting tolerance and dependence, are comparable to those of alcohol, and withdrawal symptoms resemble delirium tremens. Chloral hydrate is a liquid, marketed in the form of syrups and soft gelatin capsules. Cases of poisoning have occurred from mixing chloral hydrate with alcoholic drinks. Chloral hydrate is not a street drug of choice. Its main misuse is by older adults.

Barbiturates

Among the drugs most frequently prescribed to induce sedation and sleep by both physicians and veterinarians are the barbiturates. About 2,500 derivatives of barbituric acid have been synthesized, but of these only about 15 remain in medical use. Small therapeutic doses tend to calm nervous conditions, and larger doses cause sleep 20 to 60 minutes after oral administration. As in the case of alcohol, some individuals may experience a sense of excitement before sedation takes effect. If dosage is increased, however, the effects of the barbiturates may progress through successive stages of sedation, sleep, and coma to death from respiratory arrest and cardiovascular complications.

Barbiturates are classified as ultrashort, short, intermediate, and long-acting. The ultrashort-acting barbiturates produce anesthesia within one minute after intravenous administration. The rapid onset and brief duration of action make them undesirable for purposes of abuse.

Among the short-acting and intermediate-acting barbiturates are pentobarbital (Nembutal), secobarbital (Seconal), and amobarbital (Amytal)--three of the drugs in the depressant category most sought after by abusers. After oral administration the onset time of action is from 15 to 40 minutes and duration of action is up to 6 hours. Physicians prescribe short-acting barbiturates to induce sedation or sleep.

Long-acting barbiturates, have onset times of up to one hour and duration of action up to 16 hours. They are used medicinally as sedatives, hypnotics, and anticonvulsants. Their slow onset of action discourages their use for episodic intoxication, and they are not ordinarily distributed on the illicit market except when sold as something else. It should be emphasized, however, that all barbiturates result in a buildup of tolerance, and dependence on them is widespread.

Glutethimide

When glutethimide (Doriden) was introduced in 1954, it was said to be a safe barbiturate substitute without an addiction potential. But experience has shown glutethimide to be another CNS depressant, having no particular advantage over the barbiturates and several important disadvantages. Because the effects of this drug are of long duration, it is exceptionally difficult to reverse overdoses, which often result in death.

Methaqualone

Methaqualone is a synthetic sedative chemically unrelated to the barbiturates, glutethimide, or chloral hydrate. It has been widely abused because it was once mistakenly thought to be non-addictive and effective as an aphrodisiac. Actually, methaqualone has caused many cases of serious poisoning. It is administered orally. Large doses cause coma, which may be accompanied by thrashing movements or convulsions. Continued heavy use of large doses leads to tolerance and dependence.

Methaqualone has been marketed in the United States under various brand names such as Quaalude, Parest, Optimil, Somnafac, and Sopor. Counterfeit Quaalude tablets which do not necessarily contain methaqualone are prevalent on the US illicit market.

Tranquilizers

The group of drugs known as "minor tranquilizers" or anti-anxiety drugs contain either meprobamate or benzodiazepine. In the United States today more than 200 tons of meprobamate are distributed annually under the generic name as well as under brand names such as Miltown, Equanil, Kesso-Bamate, and SK-Bamate. Meprobamate is prescribed primarily for the relief of anxiety, tension, and associated muscle spasms. Its onset and duration of action are like those of the intermediate-acting barbiturates; it differs from them in that it is a muscle relaxant, does not produce sleep at therapeutic doses, and is relatively less toxic. Excessive use, however, can result in psychological and physical dependence. Mebutamate (Dormate), a drug similar to meprobamate in its chemical makeup and effects, is also regulated under the CSA.

The benzodiazepine family of depressants relieve anxiety, tension, and muscle spasms, produce sedation, and prevent convulsions. These substances are marketed as mild or minor tranquilizers, sedatives, hypnotics, or anticonvulsants. Their margin of safety is greater than that of other depressants. Eight members of the group are currently marketed in the United States. Librium and Valium are among the drugs most widely prescribed in this country. These drugs have a relatively slow onset but long duration of action. Prolonged use of excessive doses may result in physical and psychological dependence. Withdrawal symptoms develop approximately one week to 10 days after continual high doses are abruptly discontinued. The delay in the appearance of the abstinence syndrome is due to the slow elimination of the drug from the body. When these drugs are used to obtain a "high," they are usually taken in conjunction with another drug such as alcohol or marijuana.

Source:

Drugs of Abuse, Drug Enforcement Administration, 1979

HALLUCINOGENS

Hallucinogenic drugs, both natural and synthetic, distort the perception of reality. The central nervous system becomes excited, resulting in alterations of moods, usually euphoric but sometimes severely depressive. Pupils dilate, and body temperature and blood pressure rise. The senses of direction, distance, and time become disoriented. The user may "see" sounds and "hear" colors. In large doses, they produce delusions and hallucinations. Severe depression and depersonalization may result in suicide, but the usual danger is impaired judgment leading to rash decisions and accidents. Persons in hallucinogenic states should therefore be closely supervised and upset as little as possible to keep them from harming themselves or others. Acute anxiety, restlessness, and sleeplessness are common until the drug wears off.

Users may experience flashbacks, and while repeated uses do not produce a physical dependency, tolerance develops, and users may become psychologically dependent. Abuse of hallucinogens peaked in popularity during the late 1960s, subsided for a while, and became more popular again in the late 1970s.

Psilocybin and Psilocyn

Like the peyote cactus, Mexican psilocybin mushrooms have been used for centuries in Indian rites. When eaten, these "sacred" or "magic" mushrooms affect mood and perception in a manner similar to mescaline and LSD. Their active ingredients, psilocybin and psilocyn, are chemically related to LSD. They can now be made synthetically, but much of what is sold under these names on the illicit market consists of other chemical compounds.

The mushrooms are either ingested in their natural form or dried and ground up in capsule form.

DMT (Dimethyltryptamine) and DET (diethyltryptamine)

Synthetic compounds of tryptamine, DET and DMT produce effects similar to LSD but of shorter duration with highs lasting 1 to 3 hours. Time and visual distortion have been reported with DET. In solution they can be injected. Or, a joint soaked in a solution can be smoked.

LSD (lysergic acid diethylamide)

The most potent hallucinogen, LSD is a powerful man-made drug developed in 1938. Its only legal use in the US is for government-controlled research projects. The effects of LSD vary with the dose ingested. The average dose, a tiny speck of material smaller than a grain of salt, produces effects lasting from 8 to 12 hours. Since the amount of LSD ingested is so small, it is usually incorporated into and sold in other forms: tablets, thin squares of gelatin ("window panes"), impregnated paper ("blotter acid"), or in tiny particles ("microdots").

Psychological effects of LSD vary with the dose, personality of the user, and the environment, but a prominent characteristic of LSD is the unpredictability of its effects and possibility of a bad "trip" or "bummer." During a trip, the user may experience hallucinations, intensification and distortion of sensory perception, panic, violence, suicide, or a loss of sanity. It can

produce a feeling of complete detachment from reality and can cause actions that lead to serious injury, e.g., jumping out of windows or walking in front of cars due to feelings of invulnerability.

Flashbacks, hallucinations occasionally of the same intensity of the original trip, may occur at any time up to two years after the original trip. The occurrence is unpredictable and can lead to panic, depression, and even suicide.

Mescaline

Mescaline, the primary active ingredient in the peyote cactus, is derived from the fleshy parts of buttons of the cactus. Since earliest recorded time Indians in northern Mexico have used peyote as part of their traditional religious rites.

The button is usually dried and ground into a dark brown powder, often put into gelatin capsules, and taken orally. It produces effects similar to those of LSD but usually with a more intense stimulation of visual sensation.

DOM, DOB, MDA, and MDMA

Man-made chemical variations of mescaline and amphetamine, these drugs have won acceptance in the drug culture at various times. They differ from one another in their speed of onset, duration of action, potency, and capacity to modify mood with or without producing hallucinations. Usually taken orally, they are sometimes snorted and rarely injected. Because they are produced in "basement" laboratories, they are seldom pure, and the dose in a tablet, capsule, or on a square of impregnated paper may vary considerably. A wide variety of other chemicals are sold as DOM, DOB, MDA and MDMA.

Sources:

Drugs of Abuse, Drug Enforcement Administration, 1979

Drug Abuse and Misuse, Drug Enforcement Administration, 1979

INHALANTS

For over 200 years people have deliberately inhaled volatile substances to obtain an immediate, intense, but brief high. Volatile substances, chemicals which vaporize to a gaseous form at normal room temperature, include a wide variety of chemical compounds found in countless commercial preparations such as: gasoline, glue, paint, aerosols, paint thinner, turpentine, and even canned whipped cream. While most of these commercial preparations are generally safe when used as directed for their intended purpose, and often do not result in permanent injury even when abused, some of the substances, such as aerosols, have proven to be harmful or even fatal.

Abused volatile substances can be classified under three headings:

- 1) anesthetics: ether, chloroform, and nitrous oxide (laughing gas)
- 2) solvents: gasoline, paint and lacquer thinner, nail polish remover, shoe polish, lighter fluid
- 3) aerosols: spray paints, nonstick coating substance, deodorants, hair sprays, and glass chillers

Various studies indicate that 10, or even perhaps 20%, of all young people have ever tried inhalants while very few, perhaps 1%, are current users. White males, Hispanic Americans, and native Americans tend to outnumber the blacks and females who use inhalants.

There appear to be two major types of inhalant abusers: (1) experimenters or transitional users who move on to other drugs, and (2) chronic abusers. Chronic inhalant abuse is a phenomenon of the young and very poor. As an established drug problem, inhalant abuse occurs in certain neighborhoods and not in others. Chronic inhalant abusers come from the most unstable, disorganized, and problem-ridden families. Chronic inhalant abuse in children is related to parental alcoholism and child abuse and neglect.

Because inhalation of volatile substances through the lungs carries the chemicals via the bloodstream directly to the brain, effects are almost immediate. By controlling dosage, experiences range from mild intoxication to total unconsciousness. Initial feelings of excitement and loss of inhibitory controls are followed by depression and drowsiness. Sometimes headache and nausea accompany recovery. Other effects include delusions of strength or unusual abilities (like flying), visual and auditory hallucinations, impaired judgment, slurred speech, euphoria, or sensations of numbness or nothingness.

Temporary toxic effects include acute organic brain syndrome characterized by dizziness, loss of memory, inability to concentrate, confusion, and unsteady gait. The most prominent threat to health associated with inhalant abuse is the Sudden Sniffing Death (SSD) syndrome related to sniffing the fluorocarbons contained in aerosols. The SSD is caused when fluorocarbons stimulate the heart, causing erratic heartbeat and increased pulse rate, resulting in heart failure and death.

Since volatile substances are not covered under the Comprehensive Drug Abuse Prevention and Control Act of 1970, there are no federal penalties for the possession or selling of these substances. However, there are three federal

consumer/environmental protection laws that affect their production and distribution by regulating or banning potentially toxic agents and requiring cautionary labels regarding use on consumer products containing the toxic agent. So far, 31 states have laws prohibiting the sniffing of volatile substances. Infraction is usually a misdemeanor punishable by a fine and/or imprisonment but there is considerable variation between the laws.

One current attempt to discourage inhalant abuse involves adding harmless chemicals with obnoxious scents or the ability to produce nausea when the products are abused.

Nitrous oxide

Nitrous oxide, or laughing gas, is a cheap, easily available inhalant. Users can inhale gas (95% nitrous oxide) from an unshaken whipped cream dispenser, or purchase the three-inch long cylinders used to charge them. These "whippets" are commonly available at head shops for well under \$1 each. Both cans and whippets can produce a series of highs, a minute-long rush followed by a minute of tingling sensations. Repeated exposure to high levels of nitrous oxide can depress bone marrow, impair peripheral-nerve function, and kill brain cells. Even a single use can result in death.

Sources:

Report Series 30, No. 2 Inhalants: The Deliberate Inhalation of Volatile Substances, July 1978, National Institute on Drug Abuse.

"Here's the topper: whipped cream cans may be fatal to N₂O abusers", Medical World News, April 16, 1979.

NARCOTICS

Narcotics, opium and opium derivatives or synthetic substitutes are indispensable in the practice of medicine: they are the most effective agents known for the relief of intense pain. They are also used as cough suppressants as well as a centuries old remedy for diarrhea.

Under medical supervision narcotics are administered orally or by intramuscular injection. As drugs of abuse, however, they may be sniffed, smoked, or self-administered by the more direct routes of subcutaneous ("skin-popping") and intravenous ("mainlining") injection.

The relief of suffering, whether of physical or psychological origin, may result in a short-lived state of euphoria. The initial effects, however, are often unpleasant, leading many to conclude that those who persist in their illicit use may have latent personality disturbances. Narcotics tend to induce pinpoint pupils and reduced vision, together with drowsiness, apathy, decreased physical activity, and constipation. A larger dose may induce sleep, but there is an increasing possibility of nausea, vomiting, and respiratory depression--the major toxic effect of the opiates. Except in cases of acute intoxication, there is no loss of motor coordination or slurred speech as in the case of the depressants.

To the extent that the response may be felt to be pleasurable, its intensity may be expected to increase with the amount of the dose administered. Repeated use, however, will result in increasing tolerance: the user must administer progressively larger doses to attain the desired effect, thereby reinforcing the compulsive behavior known as drug dependence.

The intensity of physical symptoms experienced during the withdrawal period is related directly to the amount of narcotic used each day. Deprivation of an addictive drug causes increased excitability of those same bodily functions that have been depressed by its habitual use. With the deprivation of narcotics, the first withdrawal signs are usually experienced shortly before the time of the next scheduled dose.

Complaints, pleas, and demands by the addict are prominent, increasing in intensity and peaking from 36 to 72 hours after the last dose, then gradually subsiding. Symptoms such as watery eyes, runny nose, yawning, and perspiration appear about 8 to 12 hours after the last dose. Thereafter, the addict may fall into a restless sleep.

As the abstinence syndrome progresses, restlessness, irritability, loss of appetite, insomnia, goose flesh, tremors, and finally yawning and severe sneezing occur. These symptoms reach their peak at 48 to 72 hours. The patient is weak and depressed with nausea and vomiting. Stomach cramps and diarrhea are common. Heart rate and blood pressure are elevated. Chills alternating with flushing and excessive sweating are also characteristic symptoms. Pains in the bones and muscles of the back and extremities occur as do muscle spasms and kicking movements, which may be the source of the expression "kicking the habit." At this time an individual may become suicidal.

Without treatment the syndrome eventually runs its course and most of the symptoms will disappear in 7 to 10 days. How long it takes to restore physiological and psychological equilibrium, however, is unpredictable. For a few weeks following withdrawal the addict will continue to think and talk about his use of drugs and be particularly susceptible to an urge to use them again.

The withdrawal syndrome may be avoided by reducing the dose of narcotic over a one-to-three week period. Detoxification of an addict can be accomplished quite easily by substituting oral methadone for the illicit narcotic and gradually reducing the dose. However, the addict's entire pattern of life is built around drug taking and narcotic dependence is never entirely resolved by withdrawal alone.

Since addicts tend to become preoccupied with the daily round of obtaining and taking drugs, they often neglect themselves and may suffer from malnutrition, infections, and unattended diseases or injuries. Among the hazards of narcotics addiction are toxic reactions to contaminants, such as quinidine, sugars, and talcum powder, as well as unsterile needles and injection techniques, resulting in abscesses, blood poisoning, and hepatitis.

Since there is no simple way to determine the purity of a drug that is sold on the street, the potency is unpredictable. A person with a mild overdose may be stuporous or asleep. Larger doses may induce a coma with slow shallow respiration. The skin becomes clammy cold, the body limp, and the jaw relaxed; there is a danger that the tongue may fall back, blocking the air passageway. If the condition is sufficiently severe, convulsions may occur, followed by respiratory arrest and death. Specific antidotes for narcotic poisoning are available at hospitals.

Narcotics of Natural Origin

The poppy Papaver somniferum is the main source of the nonsynthetic narcotics. It was grown in the Mediterranean region as early as 300 BC and has since been cultivated in countries around the world, including Hungary, Yugoslavia, Turkey, India, Burma, China, and Mexico.

The milky fluid that oozes from incisions in the unripe seedpod has since ancient times been scraped by hand and air dried to produce opium gum. A more modern method of harvesting is by the industrial poppy straw process of extracting alkaloids from the mature dried plant. The extract may be in either liquid, solid, or powder form. Most poppy straw concentrate made available commercially is a fine brownish powder with a distinct odor.

More than 400 tons of opium or its equivalent in poppy straw concentrate are legally imported annually into the United States.

Opium

There were no legal restrictions on the importation or use of opium until the early 1900s. In those days patent medicines often contained opium without any warning label. Today there are state, federal, and international laws governing the production and distribution of narcotic substances, and there is little abuse of opium in the United States.

At least 25 alkaloids can be extracted from opium. These fall into two general categories, each producing markedly different effects. The first, known as the phenanthrene alkaloids, represented by morphine and codeine, are used as analgesics and cough suppressants; the second, the isoquinoline alkaloids, represented by papaverine (an intestinal relaxant) and noscapine (a cough suppressant), have no significant influence on the central nervous system and are not regulated under the CSA.

Morphine

The principal constituent of opium, ranging in concentration from 4% to 21%, morphine is one of the most effective drugs known for the relief of pain. It is marketed in the form of white crystals, hypodermic tablets, and injectable preparations. Its licit use is restricted primarily to hospitals. Morphine is odorless, tastes bitter, and darkens with age. It may be administered subcutaneously, intramuscularly or intravenously, the latter method being the one most frequently resorted to by addicts. Tolerance and dependence develop rapidly in the user. Only a small part of the morphine obtained from opium is used medically. Most of it is converted to codeine and, secondarily, to hydromorphone.

Codeine

This alkaloid is found in raw opium in concentrations ranging from 0.7% to 2.5%. It was first isolated in 1832 as an impurity in a batch of morphine. Although it occurs naturally, most codeine is produced from morphine. As compared with morphine, codeine produces less analgesia, sedation, and respiratory depression. It is widely distributed in products of two general types. Codeine for the relief of moderate pain may consist of codeine tablets or be combined with other products such as aspirin or acetaminophen (Tylenol). Some examples of liquid codeine preparations for the relief of coughs (antitussives) are Robitussin AC, Cheracol, and elixir of terpin hydrate with codeine. Codeine is also manufactured to a lesser extent in injectable form for the relief of pain. It is by far the most widely used naturally occurring narcotic in medical treatment.

Semi-Synthetic Narcotics

The following narcotics are among the more significant synthetic substances that have been derived by modification of the chemicals contained in opium.

Heroin

First synthesized from morphine in 1874, heroin was not extensively used in medicine until the beginning of this century. The Bayer Company in Germany first started commercial production of the new pain remedy in 1893. While it received widespread acceptance, the medical profession for years remained unaware of its potential for addiction. The first comprehensive control of heroin in the United States was established with the Harrison Narcotic Act of 1914. Pure heroin is a white powder with a bitter taste. Illicit heroin may vary in color from white to dark brown because of impurities left from the manufacturing process or the presence of additives such as food coloring, cocoa, or brown sugar. Pure heroin is rarely sold on the street. A "bag"--

slang for a single dosage unit of heroin--may weigh about 100 mg, usually containing less than 5% heroin. To increase the bulk of the material sold to the addict, diluents are mixed with the heroin in ratios ranging from 9 to 1 to as much as 99 to 1. Sugars, starch, powdered milk, and quinine are among the diluents used.

Hydromorphone

Most commonly known as Dilaudid, hydromorphone is the second oldest semi-synthetic narcotic analgesic. Marketed both in tablet and injectable form it is shorter acting and more sedative than morphine, but its potency is from two to eight times as great. It is therefore a highly abusable drug, much sought after by narcotic addicts, who usually obtain it through fraudulent prescription or theft. The tablets, stronger than available liquid forms, may be dissolved and injected.

Oxycodone

Oxycodone is synthesized from thebaine. It is similar to codeine, but more potent and with a higher dependence potential. It is effective orally and is marketed in combination with other drugs such as Percodan for the relief of pain. Addicts take Percodan orally or dissolve tablets in water, filter out the insoluble material, and "mainline" the active drug.

Synthetic Narcotics

In contrast to pharmaceutical products derived directly or indirectly from narcotics of natural origin, synthetic narcotics are produced entirely within the laboratory. A continuing search for a product that will retain the analgesic properties of morphine without the consequent dangers of tolerance and dependence has yet to yield a drug that is not susceptible to abuse. The two that are most widely available are meperidine and methadone.

Meperidine (pethidine)

The first synthetic narcotic, produced originally a generation ago, meperidine is chemically dissimilar to morphine but resembles it in its analgesic potency. It is probably the most widely used drug for the relief of moderate to severe pain. Available in pure form as well as in products containing other medicinal ingredients, it is administered either orally or by injection, the latter method being the most widely abused. Tolerance and dependence develop with chronic use, and large doses can result in convulsions.

Methadone and Related Drugs

German scientists synthesized methadone during World War II because of a shortage of morphine. Although chemically unlike morphine or heroin, it produces many of the same effects. It became widely used in the 1960s in the treatment of narcotic addicts. The effects of methadone differ from morphine-based drugs in that they have longer duration of action, lasting up to 24 hours, thereby permitting administration only once a day in heroin detoxification and maintenance programs. Moreover, methadone is almost as effective when administered orally as it is by injection. But tolerance and dependence may develop, and

withdrawal symptoms, though they develop more slowly and are less severe, are more prolonged. Ironically, methadone, designed to control narcotic addiction, has emerged in some metropolitan areas as a major cause of overdose deaths.

Another close relative of methadone is a propoxyphene, first marketed in 1957 under the trade name of Darvon for the relief of mild to moderate pain. Less dependence-producing than the opiates, it is also less effective as an analgesic. Misuse of propoxyphene led to its placement in Schedule IV of the CSA in 1977.

Narcotic Antagonists

The deliberate effort to find an effective analgesic that is not dependence producing has led in recent years to the development of a class of compounds known as narcotic antagonists. These drugs, as the name implies, tend to block and reverse the effects of narcotics, and some of them may in future prove useful in checking recidivist tendencies of former addicts who have undergone treatment.

Source:

Drugs of Abuse, Drug Enforcement Administration, 1979

PHENCYCLIDINE

Phencyclidine hydrochloride, or PCP, is a street drug now conservatively estimated to have been used by more than seven million people in the United States. The drug was associated with more than 300 deaths and over 14,000 emergency room visits in 1978.

Phencyclidine is used legally in veterinary medicine as an animal tranquilizer and general anesthetic. Although it was originally developed as an anesthetic for use with humans, it was later abandoned because of erratic and unpleasant side effects. PCP made its first illicit appearance in 1967 on the West Coast. However, it rapidly developed a bad street reputation and had only limited popularity. Since then there have been sporadic outbreaks of its use.

Phencyclidine is manufactured for street use in illegal basement or garage-type laboratories in both powder and tablet form. It comes in many colors and has no odor, but a metallic taste is sometimes reported.

Although PCP can be swallowed and snorted, it is usually sprinkled on marijuana or parsley and smoked. Phencyclidine has many names including angel dust, embalming fluid, elephant or horse tranquilizer, killer weed, and rocket fuel, and is often sold as THC, LSD, mescaline, and even amphetamine or cocaine.

The amount of PCP used in a marijuana cigarette or "joint" usually varies from 1 to 100 mg. Chronic users might use anywhere from 100 mg to 1 gram in a 24-hour period. The effects of swallowing PCP are longer and less controlled than inhaling and may last four to six hours, with an even longer "coming-down" period. Some users report developing a tolerance, with increasing doses needed at the end of a "run" to achieve the same effects.

While there is a belief among chronic users that PCP ultimately results in a "burned out," dulled intellectual functioning, this has yet to be verified. Because PCP is widely used during adolescence, it is important to know its possible effects on the ability to learn and to acquire other necessary skills.

Lasting biological implications of use, including possible reproductive effects and alterations in the nervous system, are largely unknown. Methods for identifying and treating the overdose victim must be further developed.

While higher doses of this drug are incapacitating, much less is known about the effects of lower doses which may be more typical of recreational use. The wide range of possible dose-related reactions to PCP need further study. Also, since PCP is commonly used with other drugs such as alcohol, marijuana, and barbiturates, it is important to know the effects of these combinations.

Not yet explained is the apparent increase in PCP use despite the poor street reputation of the drug. This increased popularity may reflect a change in attitude toward the drug as a result of increased use by smoking as opposed to oral ingestion, or it may reflect simply the widespread availability of phencyclidine. Motivations for use remain poorly understood.

Source:

PCP: An Overview, National Institute on Drug Abuse, 1978

STIMULANTS

Of all abused drugs, stimulants are the most powerfully reinforcing and can lead to increasingly compulsive behavior.

Two stimulants, caffeine and nicotine, are mild enough to be socially accepted and widely used to reduce fatigue and increase alertness.

The more potent stimulants which have a greater potential of producing dependence are regulated by the CSA and are available by prescription for medical purposes or from illegal sources.

People under the influence of stimulants tend to feel stronger, more decisive, and self-possessed. They experience a "rush" of exhilaration, superabundant energy, wakefulness, and loss of appetite. However, with protracted use of stimulants the rush is followed by an unpleasant "crashing" characterized by depression. This depression is easily dispelled by another dose of the stimulant, making it easy for the user to fall into a pattern of abuse. Thus, "stimulants are recognized as among the most potent agents of reward and reinforcement that underlie the problem of dependence" (Drugs of Abuse, DEA).

Other chronic users may follow a pattern of taking stimulants, "uppers" in the morning and depressants, "downers" at night. This chemical manipulation interferes with normal body processes and can lead to mental and physical illness.

Tolerance develops rapidly, prompting the user to take doses large enough to cause various mental aberrations. Early signs of this may include repetitive grinding of the teeth, touching and picking the face and extremities, performing a task repeatedly, preoccupation with one's thought processes, suspiciousness, and paranoia.

A sublethal overdose can cause dizziness, tremor, agitation, hostility, panic, headache, flushed skin, chest pain with palpitations, excessive sweating, vomiting and abdominal cramps. Without medical attention, high fever, convulsions, and cardiovascular collapse may precede the onset of death.

Source:

Drugs of Abuse, Drug Enforcement Administration

Amphetamines

Amphetamine, dextroamphetamine, and methamphetamine are so similar in the effects they induce that they can be differentiated from one another only by laboratory analysis.

Amphetamine was first used clinically in the mid-1930s to treat narcolepsy, a rare disorder resulting in an uncontrollable desire for sleep. After the introduction of the amphetamines into medical practice, the number of conditions for which they were prescribed multiplied as did the quantities made available. They were sold without prescription for a time in inhalers and other over-the-counter preparations.

Abuse of the inhalers became popular among teenagers and prisoners. Housewives, students, and truck drivers were among those who used amphetamines orally in excessive amounts, and "speed freaks," who injected them, won notoriety in the drug culture for their bizarre and often violent behavior. Whereas a prescribed dose is between 2.5 and 15 mg per day, those on a "speed" binge have been known to inject as much as 1,000 mg every two or three hours.

Recognition of the deleterious effects of these drugs and their limited therapeutic value has led to a marked reduction in their use by the medical profession. The medical use of amphetamines is now limited to narcolepsy, hyperkinetic behavioral disorders in children, and certain cases of obesity--as a short-term adjunct to a restricted diet for patients refractory to other forms of therapy. Their illicit use closely parallels that of cocaine in the range of its short-term and long term effects. Despite broad recognition of the risks, clandestine laboratories produce vast quantities of amphetamines, particularly methamphetamine, for distribution on the illicit market.

Cocaine

Cocaine is commonly regarded as the status recreational drug. Expensive, associated with rock stars and celebrities, capable of producing intense euphoria and exhilaration, and reputed to facilitate social interaction, cocaine is becoming increasingly popular among drug users.

A naturally occurring stimulant, cocaine is extracted from the leaves of the coca plant cultivated in South America. Since prehistoric times Bolivian and Peruvian Indians have chewed the leaves for refreshment and relief from fatigue, as well as for religious reasons. Cocaine was first isolated in the 1880s and was soon found to work well as an anesthetic for eye surgery for which no previously known drug had been suitable. It became particularly useful in surgery of the nose and throat because of its ability to constrict blood vessels and thus limit bleeding. In the early 1900s laws regulating its use were passed and now cocaine has limited therapeutic uses.

Illicit cocaine is sold as a white translucent crystalline powder frequently adulterated ("cut") to about half its volume by a variety of other ingredients. The most common adulterants are various sugars (especially lactose and glucose) and other local anesthetics (lidocaine, procaine, and tetracaine) with similar appearance and taste to cocaine. Other stimulants, amphetamines, are also sometimes used. Given the very high cost of cocaine, the temptation to cut the drug at each level of sale is great. The current street price (1980) may range from \$70 to \$80 (Chicago) a gram (about 1/30 of an ounce).

Cocaine is most commonly administered by inhaling small amounts (snorting) through the nasal passages. Thus deposited on the mucous linings, it is readily absorbed into the bloodstream. Repeated use in this way often results in an irritation to the nostrils and nasal mucous membranes. Symptoms may resemble those of a common cold, i.e., congestion or a "runny nose." To cope with these secondary symptoms, "coke" users often use various cold remedies such as nasal sprays to relieve their chronic congestion. Some users report difficulty in breathing comfortably without habitually using a spray to keep the nasal passages open.

Less commonly, cocaine or a mixture of cocaine and heroin is injected directly into the bloodstream for heightened effect. Besides the added hazards of hepatitis and other infections transmitted by non-sterile needles and drugs, injecting is more dangerous since it introduces unknown quantities of drugs directly and suddenly into the bloodstream. Cocaine deaths from intravenous self-administration are more numerous than from snorting despite the greater prevalence of snorting.

Unlike drugs like LSD and heroin, cocaine is popularly accepted as a recreational drug believed to facilitate social interaction and is erroneously reputed to be relatively safe from undesirable side effects.

Although conclusive evidence is lacking, cocaine does appear to be relatively free from serious physical side effects when used infrequently in low doses. But as the most powerfully reinforcing of all abused drugs, it has the potential for extraordinary psychic dependency. Cocaine and all the other stimulants are recognized as the most potent agents of reward and reinforcement that underlie the problem of dependence.

Experienced users report cocaine produces a euphoria, a sense of intense stimulation and of psychic and physical well being accompanied by reduced fatigue. However, the subjective effects of cocaine and other psychoactive drugs are modified by the circumstances under which the individual takes the drugs. These include the physical surroundings and overall atmosphere of those surroundings as well as the user's expectations. Other influences include dose, method of ingestion, pattern of use, and interaction with other drugs. For example, if a normally somewhat apprehensive person takes cocaine among relative strangers, which may contribute to a feeling of insecurity, it is likely that he will react with more heightened anxiety and suspiciousness (not the reputed relaxed sociability) than with close friends in the relaxed circumstances of his own home.

Tolerance develops quickly to both the euphoric and appetite suppressant effects. Protracted use results in "crashing," an unpleasant period of depression. Since this depression can easily be counteracted by another "toot" of cocaine, a dependent pattern easily develops.

Recurrent users may resort to larger doses at shorter intervals until their lives are largely committed to their habituation. Anxiety, restlessness, and extreme irritability may indicate the onset of a toxic psychosis similar to paranoid schizophrenia. Tactile hallucinations so affect some chronic users that they injure themselves in attempting to remove imaginary insects from under their skin. Others fear they are being watched or followed. Because present American use patterns are characterized by relatively infrequent use of small quantities, these serious adverse effects of cocaine may be quite rare.

Two important verified effects of cocaine's medical uses are its local anesthetic action and ability to constrict blood vessels. Good evidence indicates that cocaine in moderate doses increases both heart rate and blood pressure. Unfortunately, the lack of adequate information is sometimes interpreted as indicating cocaine is "safe." It may be that cocaine poses few hazards when used under conditions of relatively infrequent low doses but entails significantly different effects when widely available and regularly used in larger amounts.

Present knowledge of cocaine is fragmentary. Areas of certainty, when closely examined, are quite modest since much of the anecdotally based information has never been systematically investigated.

Paraphernalia

Numerous utensils accompany the use of cocaine. The most common item is a small (approximately 1" high and ½" wide) vial (usually glass or metal) with tight-fitting lid and tiny long-handled spoon attached to the vial by a short chain. Many times these are often cleverly disguised as jewelry. Other utensils include a mirror on which to spread cocaine, a single-edged razor for pulverizing and arranging "lines" of cocaine, and a straw or rolled dollar bill for inhaling cocaine.

Sources:

Cocaine: An Overview, National Institute on Drug Abuse, July 1977
Drugs of Abuse, Drug Enforcement Administration, 1979

Phenmetrazine (Preludin) and Methylphenidate (Ritalin)

The medical indications, patterns of abuse, and adverse effects of phenmetrazine (Preludin) and methylphenidate (Ritalin) compare closely with those of the other stimulants. Phenmetrazine is medically used only as an appetite suppressant and methylphenidate mainly for treatment of hyperkinetic behavioral disorders in children. They have been subject to abuse in countries where freely available, as they are here in localities where medical practitioners write prescriptions on demand. While the abuse of phenmetrazine involves both oral and intravenous use, most of that associated with methylphenidate results from injection after the drug in tablet form is dissolved in water. Complications arising from such use are common since the tablets contain insoluble materials which upon injection block small blood vessels and cause serious damage, especially in the lungs and retina of the eye.

Anorectic Drugs

In recent years a number of drugs have been manufactured and marketed to replace amphetamines as appetite suppressants. These so-called anorectic drugs include benzphetamine (Didrex), chlorphentermine (Pre-Sate, etc.), clortermine (Voramil), diethylpropion (Tenuate, Tepanil, etc.), fenfluramine (Pondimin), mazindol (Sanorex), phendimetrazine (Plegine, Bacarate, Melfiat, Statobex, Tanorex, etc.), phentermine (Ionamin, Adipex-P, etc.). They produce many of the effects of the amphetamines but are generally less potent. Abuse patterns of some of them have not yet been established, but all are controlled because of the similarity of their effects to those of the amphetamines. Fenfluramine differs somewhat from the others in that at low doses it produces sedation.

Source:

Drugs of Abuse, Drug Enforcement Administration, 1979

UNDERSTANDING DRUG ABUSE PREVENTION

Drug abuse prevention in the United States was first attempted on a national level from a legislative angle. Both the Harrison Narcotic Act of 1914 and the 18th Amendment (Prohibition) were based on the premise that effective enforcement of laws controlling the manufacture and distribution of certain drugs would deter people from using them. Both embodied the concept of "supply reduction" that remains a cornerstone of US drug abuse prevention. Such legal controls on the manufacture and distribution of drugs are unquestionably necessary. Without such controls the extent of drug abuse would probably be even greater than it is.

Supply reduction remained the sole approach to drug abuse prevention until the rising incidence of drug abuse during the 1960s increased the need for treatment facilities for physical and emotional drug-related crises. (Such crisis-oriented prevention efforts--those which occur at later stages of abuse and include treatment, institutionalization maintenance, and detoxification--are considered tertiary prevention techniques.)

Almost overnight, community based counseling centers, crash pads, and more intensive treatment facilities such as increased capacities in hospital psychiatric wards mushroomed all over the country. The number of federally funded treatment "slots"--the equivalent of support for one person in treatment for one year--increased from approximately 20,000 in 1972 to 95,000 in 1974. At present, there are 102,000 federally funded treatment slots, providing approximately 30% of the drug abuse treatment in the US. According to one estimate, 98% of the drug abuse funds are spent on 2% of the population, those hardcore addicts in need of treatment who easily cost this country \$10 billion per year in social costs of crime, health care, and lost productivity. The remaining 2% of the funds are allocated to prevention efforts which attempt to reach 98% of the population.

With the initial outbreak of the drug abuse "epidemic" during the 1960s, it became very clear that law enforcement alone was not enough to control drug abuse. And the tertiary, crash pad approach obviously did nothing to prevent abuse. As the Drug Abuse Task Force stated in 1975, "...treatment alone is not enough. Once someone reaches the point at which he needs treatment, a serious problem has already developed and permanent improvement is extremely difficult. It is far better to prevent the problem before it develops." The possibility of reducing demand was raised, and parents, educators, and teachers were soon providing young people with information about drugs and their effects in hopes that youngsters, armed with accurate information and common sense, would choose not to use drugs.

Evidence quickly began to accumulate, however, that detailed lectures on which drugs should be avoided and why served to stimulate curiosity and increase experimentation with those very drugs. The source of the information--often a school teacher who lectured young people about drugs in a highly moralistic fashion--frequently detracted from its credibility. And the information itself bred distrust as much as it instilled fear. A study of informational materials on drugs found that "about 80% of them contained factual errors. More than a third contain so many errors we label them scientifically unacceptable, and some are so bad we think they are more dangerous than drugs."

During this time, various primary prevention strategies (types of activities) were developed to promote the healthy growth of individuals and discourage the use of drugs as a way to solve (or avoid) problems. Many of these activities may not seem to be directly related to drug abuse since their immediate goal is stimulating individuals to reach a high level of functioning which, when achieved, will prevent problems associated with drug use. The assumption is that this enriched personal and social development will serve as a sort of immunization against problems and negative consequences associated with drug use. This approach, which is implemented through the six strategies listed below, is widely accepted by prevention professionals.

- 1) Information
Educating parents and children
- 2) Affective Education
Values clarification
Self-esteem building
Role playing
Classroom discussion
Improving decision making and problem solving skills
- 3) Peer and cross-age tutoring and counseling
- 4) Life/career planning
classroom
experiential
- 5) Alternatives
- 6) Parenting and Family Communication

These various strategies can be used in programs based in the school, family or community. Summaries of programs in these three areas, some of which were conducted by auxiliaries, contain directions for obtaining additional information desired.

SCHOOL-BASED PROGRAMS

The following projects and descriptions are taken from the AMA Auxiliary Project Bank Catalog. Details on these projects can be ordered from the Project Bank, AMA Auxiliary, 535 N. Dearborn St., Chicago, IL 60610.

Hazards of Drug Abuse and Smoking Essay Contest. Principals of grade schools, and junior and senior high schools are urged to have their students participate in an essay contest. The auxiliary supplies some background information to students, suggests other information sources, and awards cash prizes to winners in various age groups. 8-HE-1-1.

Seminar on Drug Abuse Prevention. Auxilians familiarize teachers with drug abuse prevention materials available and encourage their use. Also, a day long city-wide seminar for adults and professionals featured experts on addiction, interpersonal communication, and drugs. 8-HE-1-4.

"Drugs Are Like That" film and discussion period. After training, auxilians show film to grade school children and lead classroom discussions afterward. 8-HE-1-8.

Alcoholism and Drug Abuse School Policy. Auxiliary initiated and guided development of school district policy on dealing with students suspected of or actually using drugs. Also involved education of teachers and students. 8-HE-1-10.

Learning Center on Body Pollution. This portable learning center for 5th and 6th graders, designed and built by auxilians, contains a smoking machine, computer quizzes, information wheels and games. It covers drugs, smoking, alcohol, and poor nutrition and emphasizes the students' responsibility and freedom of choice in using body pollutants, 8-HE-1-12.

"Before You Solo, Pack Your Parachute." This Wisconsin Work Week of Health consisted of two day-long seminars for high school seniors, high school principals, guidance counselors, nurses, and health teachers. Aimed at preparing seniors for life after graduation, experts, movies, and discussion groups covered alcoholism, smoking, drugs, love, coping, and decision making. 8-HE-1-14.

"Drugs Are a Drag" Puppet Show. This professionally developed and copyrighted puppet show for 3rd and 4th graders includes a song and emphasizes the importance of a healthy self image. Teachers are provided with educational information and discussion guides as follow-up to the puppet show. 0-HE-1-17.

Additional programs concerning smoking and alcohol are listed in the AMA Auxiliary's Smoking and Alcoholism Package Programs. Single copies are available free from AMA Auxiliary, 535 N. Dearborn St., Chicago, IL 60610.

COMMUNITY-ORIENTED PROGRAMS

Mid-America Teen Challenge. Through financial contributions, donations of material goods, and other supportive activities, the auxiliary supports a religiously oriented center for the rehabilitation of alcoholics, drug abusers, and other disturbed young men. 8-HE-1-2.

Standing In the Shoes of A Recovered Addict. To inform auxiliaries about drug abuse, a panel of recovered addicts (including a physician and a physician's wife) addressed the auxiliary and answered questions. 8-HE-1-5.

Many communities have developed programs especially suited to their own needs.

Innovative Youth Services of Racine, Inc. This community program is designed to provide preventive counseling for youth. It offers a positive climate for growth and learning in the areas of problem-solving techniques, constructive team formation, and talent appreciation. It offers a 24-hour hotline, counseling, discussion groups, peer group activities, referrals, and crisis prevention.
Write to: Innovative Youth Services of Racine, Inc., R.U.S.H.
826 Park Ave., Racine, WI 53403.

Common Ground. Common Ground is a community program which serves as a resource to young people, the general public, and community organizations by providing direct service to identify and publicize community activities, educational programs, and speakers. Young people founded Common Ground and still participate in its operation. It offers counseling and legal consultation, a free medical clinic and a drugs alternative program.
Write to: Common Ground, 1090 S. Adams, Birmingham, AL 48011.

Drug Abuse Update '79. Professionals and laymen heard experts in education, medicine, law enforcement, and community relations discuss growing teen drug use. Participants at the auxiliary-sponsored seminar also attended the premier showing of the new film "Women and Alcohol: Through the Looking Glass" narrated by actress Carol Burnett.

FAMILY CENTERED PROGRAMS

Drug Awareness for Parents. Auxiliary developed and researched a presentation to inform parents of the drug problem, detecting use in their children, and what to do if they suspect drug use. Accompanied by a display of photos, drug paraphernalia. Sample speech included. 8-HE-1-16.

Families in Action. Formed by a parent concerned by her children's drug use, Families In Action stresses unification of parents as a peer group, strengthening family ties, improving family communication, elimination of drug paraphernalia by banning sales, and providing accurate drug information for both parents and children. Copies of their excellent manual, How to Form a Families In Action Group in Your Community, are \$10 each, 2 to 5 copies \$9 each. Write to DeKalb Families In Action, 1436 Cornell Rd., NE, Atlanta, GA 30306.

Families Involved in Nurture and Development. Adapted from the Parents are Responsible material of the Minneapolis Health Department's Metro Drug Awareness program, this six session course is based upon the belief that healthy families are the most promising of all of society's institutions for reversing the trend toward increased dependence on chemical substances. The sessions include factual information on drug use and employ several kinds of learning experiences, with emphasis on honest sharing of ideas, attitudes, and feelings in group discussions. Single copies of both the participants' handbooks and group facilitators guides for A Family Response to the Drug Problem are available free from NIDA.

PUBLICATIONSGeneral Audience

NIDA Capsules, NIDA. These brief leaflets are available on a wide range of subjects, some of which are listed below. Order single free copy from Press Office of the National Institute on Drug Abuse, Room 10A56, 5600 Fishers Lane, Rockville, MD 20857.

Marijuana and Chemotherapy	PCP: An Overview
Narcotics: Some Questions and Answers	Cocaine: An Overview
Sleeping Pills, Insomnia, and Medical Practice	26 Most Reported Drugs
Women and Prescription Drugs	
Marijuana: What It Is and What It Does	

Drugs and You, Channing L. Bete. This brief, illustrated, easy to read booklet dispels myths, offers facts on drugs, and the consequences of their abuse. Copies of order no. C523-1114 are 75¢ each for quantities of 1-24, 50¢ each for quantities of 25-99, and similar discounts for larger quantities. Order from Channing L. Bete Co. Inc., 45 Federal St., Greenfield, MA 01301.

What Everybody Should Know About Drug Abuse, Channing L. Bete. This brief booklet defines drug abuse, drug categories, types of drug abusers, contains a chart of commonly abused drugs and their dangers, and lists the hazards of drug abuse. Copies of order no. C836-1122 are 75¢ each for quantities of 1-24, 50¢ each for quantities of 25-99, with similar discounts for larger quantities. Order from Channing L. Bete Co. Inc., 45 Federal St., Greenfield, MA 01301.

Psychoactive Drugs, AMA. This businesslike brochure briefly describes types of drug users and the major types of abused drugs, slang terms, their appearance, and effects. Copies of OP-455 are 75¢ each for 1-99 copies, 40¢ each for quantities of 100-499. Order from AMA Order Dept., PO Box 821, Monroe, WI 53566.

Drug Abuse and Misuse, Drug Enforcement Administration. Very similar to the AMA's Psychoactive Drugs but contains information on less widely used drugs. Single copies free from: United States Dept. of Justice, Drug Enforcement Administration, 1405 "I" Street, Washington DC 20537.

Drugs and Driving, NIDA. This flyer covers the effects of each major type of drug on driving ability. Free from NCDIAI, Room 10A56 Parklawn Bldg., Rockville, MD 20857.

For Parents

Parents Peers and Pot, NIDA. Based on the experiences of a parent involved in Families in Action, Atlanta, Ga., this hard hitting, no-nonsense book offers suggestions and guidance to parents of teens and preteens who aren't sure just how to deal with drug use in their family, community and schools. Single copies free from: National Clearinghouse for Drug Abuse Information, Room 10A56, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

What Every Parent Should Know About Drugs and Drug Abuse, Channing L. Bete. This booklet helps parents determine if their children are using drugs and tells them what they can do about it. Copies of order no. C836-1135 are 75¢ each for quantities of 1-14, 50¢ each for quantities of 25-99, and similar discounts for larger quantities. Order from Channing L. Bete Co. Inc., 45 Federal St., Greenfield, MA 01301.

A Family Response to the Drug Abuse Problem, NIDA. These two publications, the group facilitators guidelines and participants' handbook, make up a very complete group discussion program.
Group facilitator guidelines: Offers tips on leading group discussions, and special instructions (visual aid ideas, role playing situations) for each class session.
Participants handbook: Discusses the interaction of drugs, society, and families, and contains a brief history of drugs and drug use, glossary of medical/scientific terms, reading list, summary of federal drug laws, and lists alternatives.
 Single copies available from: NCDIAI, PO Box 416, Kensington, MD 20795.

Points for Parents Perplexed about Drugs, Hazelden Foundation. After discussing societal influences and pressures to take drugs, the booklet offers ways to react when teen drug use is suspected. Copies are 40¢ each plus handling. Write to: Hazelden Foundation, Consultation and Education Services, Box 176, Center City, MN 55012.

How to Form A Families In Action Group in Your Community, Sue Rusche. Written by the president of Families In Action, Inc., in Atlanta, Ga., a group of concerned parents who turned around the drug abuse problem among their teens, this 155 page manual tells you how they did it, plus it offers facts on the drug paraphernalia industry, effects of marijuana on youth, symptoms of drug abuse, and offers guidelines for talking with your child about drug use, a glossary of terms and paraphernalia products, and further reading for parents. Copies \$10 each, \$9 for 2-5 copies, and \$8 each for 6 or more copies. Write to: DeKalb Families In Action, Inc., 1436 Cornell Rd., NE, Atlanta, GA 30306.

Parents/Teachers

How to Talk to Kids About Drugs. This 32 page booklet offers practical suggestions for what to say--and what not to say--to pre-teens and teenagers. It includes chapters on how to evaluate attitudes about drug use, how to communicate better, how to avoid negative messages, and a section on information about drugs and their effects. Copies are \$2.50 each including postage and handling. Bulk rates available for quantities over 100. Make check payable to: Prevention Materials Institute. Write to Pacific Institute for Research and Evaluation, 7101 Wisconsin Ave., Suite 1006, Bethesda, MD 20014.

A Better High, 1978. In this book's 50 brief chapters, the concept of "alternatives" to drug use is defined and much food for thought offered to young people. Copies are \$2.50 each. Write to Research and Education on Alcohol and Drugs, 505 N. Sixth St., Springfield, IL 62702.

Prevention Resources. This quarterly newsletter contains articles on the latest developments in drug abuse prevention, critiques of new programs, publications, and films, and idea exchanges. Copies available from Pyramid, 39 Quail Court, Suite 201. Walnut Creek, CA 94596.

Youth

This Side Up, NIDA. This workbook for junior high students has a "fun" format, but contains very factual information and encourages the student to form values concerning drug use and make decisions. Single copies available free from: NCDIAI, PO Box 416, Kensington, MD 20795.

Soozie says "Only Sick People Need Drugs!", Drug Enforcement Administration. This coloring book for pre-school and grade school children, to be used by parents or teachers, contains a study guide for adults.

Women

A Woman's Choice: Deciding About Drugs, NIDA. Written for women by women, this booklet discusses stress and drugs; when drugs may be helpful in dealing with stress and when using drugs may only add to the problems. Single free copy available from: Women, Box 1701, Washington, DC 20013 or NCDIAI, PO Box 416, Kensington, MD 20795

FILMS

General Audience

Reading, Writing, and Reefer, NBC-TV Documentary, 1978. This film on adolescent marijuana use is available at no charge for copying by non-profit educational institutions. To obtain off-air taping permission, write to Films Incorporated, 1144 Wilmette Ave., Wilmette, IL 60091. A four-page study guide for teachers is available through local NBC-TV affiliated stations, NBC in New York, and Films Incorporated.

Marijuana: The Facts, 1978. Young people ask a physician questions in this low-key, straightforward film that offers the facts with no propaganda. This 25-minute 3/4" U-matic videocassette rents for \$25 and sells for \$95. Write to Addiction Research Foundation, Dept. NM 7/78, Marketing Services, 33 Russell St., Toronto, Ontario, Canada, M5S 2S1.

Alcohol, Drugs, and You. Case histories are used to illustrate the hazardous effects of mixing alcohol with prescription and illicit drugs. For maximum effectiveness, use supportive print material and drug interaction charts. This 15-minute color, slide/sound show rents for \$2.50, sells for \$50 and may be previewed free of charge. Write to Texas Pharmaceutical Assn., 1624 Highway 183 East, Austin, TX 78701.

Psychoactive, 1976. This is a good informational film for audiences seeking sound factual information about drugs and their effects. This 16 mm 28 minute film rents for \$20 and sells for \$250. Write to Pyramid Films, Box 1048, Santa Monica, CA 90406.

The PCP Story, 1976. Attitudes of users, effects on users, danger of bad effects, and treatment for chronic use and overdose of the drug are covered. Price \$375. For audiences senior high and up. Write to: Film Tree Distributors, PO Box 84346, Los Angeles, CA 90073.

Angel Death, 1979. In dramatic scenes, the film shows the many effects of PCP --including violent acts and loss of memory on a wide variety of users. Experts testify on the risks and hazards of use. In the longer version, the family problems of a young PCP user are explored. Paul Newman and Joanne Woodward narrate. Price \$675 (long version), \$425 (short version); rental, \$50 (short version only). For audiences high school and up. Write to: Media Five, 3211 Cahuenga Boulevard West, Hollywood, CA 90068.

For Parents Only: What Kids Think About Marijuana, 1980. This 29-minute film discusses the widespread and increasing use of marijuana, what youngsters think of their own marijuana use. Youngsters discuss why they smoke (or quit smoking) marijuana, and experts comment on youthful pot use.

Films in Review. This biannual publication gives synopsis of films, and information on cost, length, producer, and suggested audience. Available from Pyramid or The Media Center, Pyramid East.

Drug Abuse Films. This booklet lists the year of production, running time, sale or rental price, name and address of distributor, plus a brief synopsis and the suggested audience. Available from National Clearinghouse for Drug Abuse Information, PO Box 416, Kensington, MD 20795.

Youth--elementary-intermediate

Dope Is for Dopes, 1975. Fat Albert, played by Bill Cosby, uncovers a pusher and goes from "dope" to hero after a dangerous motorcycle chase, involvement with the police and a lot of all's-well-that-ends-well sentiments. This 14-minute film rents for \$20 and sells for \$195. Write to McGraw-Hill Films, 1221 Avenue of the Americas, New York, NY 10020.

For Parents Only: What Kids Think About Marijuana, (1980). This 29-minute film discusses the widespread and increasing use of marijuana, what youngsters think of their own marijuana use. Youngsters discuss why they smoke (or quit smoking) marijuana, and experts comment on youthful pot use. Write to National Audiovisual Center (NAC), General Services Administration, Washington, DC 20409.

Parents/Teachers

Using Values Clarification. Part of a series of 12 films on new approaches to high school learning and discipline, this film is an excellent introduction to values clarification. It offers an overview of the theory and practice of this strategy that works in school, family, and community settings. Good for high school teachers, PTA groups, and community groups. This 16mm, 19-minute film rents for \$45 (one week) and sells for \$375. Write to Media Five, 10011 N. Cole Ave., Hollywood, CA 90038.

Youth--Jr. and sr. high

Alcohol and Drugs....Making the Decision, 1978. Hosts Paul Williams and Meredith Baxter offer techniques for avoiding or overcoming dependence on drugs and alcohol. Vignettes offer the viewer ways of coping, using creative decision making, alternatives exploration, etc. This 26-minute film rents for \$30 and sells for \$345. Write to Sandler Reflections, 7449 Melrose Ave., Hollywood, CA 90046. For senior high audiences.

Good Vibes Van, 1977. A documentary of one community's efforts to prevent drug abuse, this film explores the "alternatives" approach to prevention. Some alternatives pictured: sky diving, water skiing, ballooning, and motorcycle racing. This 29-minute film is available in 16 mm, 35 mm, super 8, videocassette, and videotape. For price information, write to Film Originals, Box 5072, Boise, ID 83705. For junior high audiences.

Alcohol, Tobacco, and Drugs Vs. Physical Fitness, 1972. Scenes of young people engaging in popular forms of exercise demonstrate the message "Turn on with exercise, not drugs" and are accompanied by substantial scientific proof. Good for physical fitness and health classes. This 24-minute film rents for \$30 (1-3 days) and sells for \$325. Write to AIMS Instructional Media Services, Inc., 626 Justin Ave., Glendale, CA 91201.

Alcohol, Drugs, or Alternatives, 1973. Tommy Smothers assumes his unfavored brother role in this humorous film that explores the problems of poor self image, peer pressure, and identity. This 25-minute, 16 mm film rents for \$30 (five days) and sells for \$330. Write to Sandler Institute Films, 1001 N. Poinsetta Pl., Hollywood, CA 90046.

Almost Everyone Does. 1970. Young people need models to show them how to deal with their feelings as they grow up in a "drug society." Although somewhat dated, this film can be used with an appropriate introduction or updated review. This 16 mm, 14-minute film rents for \$18 (1 day), \$25 (2-3 days), \$40 (1 week), and sells for \$185. Write to: Wombat Productions, Little Lake, Glendale Rd., PO Box 70, Ossining, NY 10562 For junior high audiences.

Women

Born Hooked, March of Dimes. This 13-minute, color film features women who have been addicted to methodone or heroin during pregnancy and the impact on the unborn child. The film stresses the positive effects of proper pre- and post-natal care of the health of the baby born to a drug-addicted mother. Free loan. Write to: March of Dimes, 4660 Kenmore Ave., Alexandria, VA 22304.

ORGANIZATIONS

American Council on Marijuana and Other Psychoactive Drugs
521 Park Ave.
New York, NY 10021

Citizens for Informed Choices on Marijuana
300 Broad St.
Stamford, CT 06901

Families Anonymous
Box 344
Torrance, CA 90501

Hazelden Foundation, Inc.
Box 176
Center City, MN 55012
(800) 328-9288 Toll-free in Continental US only

National Clearinghouse for Drug Abuse Information
5600 Fishers Lane
Rockville, MD 20857

National Council on Drug Abuse
571 W. Jackson Blvd.
Chicago, IL 60606

Parents' Resource Institute for Drug Education (PRIDE)
Georgia State University
Atlanta, GA 30303

Phoenix House
Director of Information Services
154 West 74th St.
New York, NY 10023

Pyramid
39 Quail Court
Suite 201
Walnut Creek, CA 94596

United States Dept. of Justice
Drug Enforcement Administration
1405 "I" Street, N.W.
Washington, DC 20537

Wisconsin Substance Abuse Clearinghouse
420 North Lake
Madison, WI 53706

The Media Center
Pyramid East
7101 Wisconsin Ave.,
Suite 1006
Bethesda, MD 20014

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