National Institute on Drug Abuse

Opiates

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

What are opiates?

Opiates, sometimes referred to as narcotics, are a group of drugs which are used medically to relieve pain, but also have a high potential for abuse. Some opiates come from a resin taken from the seed pod of the Asian poppy. This group of drugs includes opium, morphine, heroin, and codeine. Other opiates, such as meperidine (Demerol), are synthesized or manufactured.

Opium appears as dark brown chunks or as a powder and is usually smoked or eaten. Heroin can be a white or brownish powder which is usually dissolved in water and then injected. Most street preparations of heroin are diluted, or "cut," with other substances such as sugar or quinine. Other opiates come in a variety of forms including capsules, tablets, syrups, solutions, and suppositories.

Which opiates are abused?

Heroin ("junk," "smack") accounts for 90 percent of the opiate abuse in the United States. Sometimes opiates with legal medicinal uses also are abused. They include morphine, meperidine, paregoric (which contains opium), and cough syrups that contain codeine.

What are the effects of opiates?

Opiates tend to relax the user. When opiates are injected, the user feels an immediate "rush." Other initial and unpleasant effects include restlessness, nausea, and vomiting. The user may go "on the nod," going back and forth from feeling alert to drowsy. With very large doses, the user cannot be awakened, pupils become smaller, and the skin becomes cold, moist, and bluish in color. Breathing slows down and death may occur.

Does using opiates cause dependence or addiction?

Yes. Dependence is likely, especially if a person uses a lot of the drug or even uses it occasionally over a long period of time. When a person becomes dependent, finding and using the drug often becomes the main focus in life. As more and more of the drug is used over time, larger amounts are needed to get the same effects. This is called tolerance.

What are the physical dangers?

The physical dangers depend on the specific opiate used, its source, the dose, and the way it is used. Most of the dangers are caused by using too much of a drug, the use of unsterile needles, contamination of the drug itself, or combining the drug with other substances. Over time, opiate users may develop infections of the heart lining and valves, skin abscesses, and congested lungs. Infections from unsterile solutions, syringes, and needles can cause illnesses such as liver disease, tetanus, and serum hepatitis.

What is opiate withdrawal?

When an opiate-dependent person stops taking the drug, withdrawal usually begins within 4-6 hours after the last dose. Withdrawal symptoms include uneasiness, diarrhea, abdominal cramps, chills, sweating, nausea, and runny nose and eyes. The intensity of these symptoms depends on how much was taken, how often, and for how long. Withdrawal symptoms for most opiates are stronger approximately 24-72 hours after they begin and subside within 7-10 days. Sometimes symptoms such as sleeplessness and drug craving can last for months.

What are the dangers for opiate-dependent pregnant women?

Researchers estimate that nearly half of the women who are dependent on opiates suffer anemia, heart disease, diabetes, pneumonia, or hepatitis during pregnancy and childbirth. They have more spontaneous abortions, breech deliveries, caesarean sections, premature births, and stillbirths. Infants born to these women often have withdrawal symptoms which may last several weeks or months. Many of these babies die.

What treatment is available for opiate addiction?

The four basic approaches to drug abuse treatment are: detoxification (supervised withdrawal from drug dependence, either with or without medication) in a hospital or as an outpatient, therapeutic communities where patients live in a highly structured drug-free environment and are encouraged to help themselves, outpatient drug-free programs which emphasize various forms of counseling as the main treatment, and methadone maintenance which uses methadone, a substitute for heroin, on a daily basis to help people lead productive lives while still in treatment.

How does methadone treatment work?

Methadone, a synthetic or manufactured drug, does not produce the same "high" as illegal drugs such as heroin, but does prevent withdrawal and the craving to use other opiates. It often is a successful treatment for opiate dependence because it breaks the cycle of dependence on illegal drugs such as heroin. When patients are receiving methadone in treatment, they are not inclined to seek and buy illegal drugs on the street, activities which are often associated with crime. Patients in methadone maintenance programs also receive counseling, vocational training, and education to help them reach the ultimate goal of a drug-free normal life.

What are narcotic antagonists?

Narcotic antagonists are drugs which block the "high" and other effects of opiates without creating physical dependence or producing a "high" of their own. They are extremely useful in treating opiate overdoses and may prove useful in the treatment of opiate dependence.

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National Institute on Drug Abuse

Sedative-Hypnotics

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

What are sedative-hynotics?

Sedative-hypnotics are drugs which depress or slow down the body's functions. Often these drugs are referred to as tranquilizers and sleeping pills or sometimes just as sedatives. Their effects range from calming down anxious people to promoting sleep. Both tranquilizers and sleeping pills can have either effect, depending on how much is taken. At high doses or when they are abused, many of these drugs can even cause unconsciousness and death.

What are some of the sedative-hypnotics?

Barbiturates and benzodiazepines are the two major categories of sedative-hypnotics. The drugs in each of these groups are similar in chemical structure. Some well-known barbiturates are secobarbital (Seconal) and pentobarbital (Nembutal). Diazepam (Valium), chlordiazepoxide (Librium), and chlorazepate (Tranxene) are examples of benzodiazepines.

A few sedative-hypnotics do not fit in either category. They include methaqualone (Quaalude), ethchlorvynol (Placidyl), chloral hydrate (Noctec), and mebrobamate (Miltown).

All of these drugs can be dangerous when they are not taken according to a physician's instructions.

Can sedative-hypnotics cause dependence?

Yes. They can cause both physical and psychological dependence. Regular use over a long period of time may result in tolerance, which means people have to take larger and larger doses to get the same effects. When regular users stop using large doses of these drugs suddenly, they may develop physical withdrawal symptoms ranging from restlessness, insomnia and anxiety, to convulsions and death. When users become psychologically dependent, they feel as if they need the drug to function. Finding and using the drug becomes the main focus in life.

Is it true that combining sedative-hypnotics with alcohol is especially dangerous?

Yes. Taken together, alcohol and sedative-hypnotics can kill. The use of barbiturates and other sedative-hypnotics with other drugs that slow down the body, such as alcohol, multiplies their effects and greatly increases the risk of death. Overdose deaths can occur when barbiturates and alcohol are used together, either deliberately or accidentally.

Can sedative-hypnotics affect an unborn fetus?

Yes. Babies born to mothers who abuse sedatives during their pregnancy may be physically dependent on the drugs and show withdrawals symptoms shortly after they are born. Their symptoms may include breathing problems, feeding difficulties, disturbed sleep, sweating, irritability, and fever. Many sedative-hypnotics pass through the placenta easily and have caused birth defects and behavioral problems in babies born to women who have abused these drugs during their pregnancy.

What are barbiturates?

Barbiturates are often called "barbs" and "downers." Barbiturates that are commonly abused include amobarbital (Amytal), pentobarbital (Nembutal), and secobarbital (Seconal). These drugs are sold in capsules and tablets or sometimes in a liquid form or suppositories.

What are the effects of barbiturates when they are abused?

The effects of barbiturates are, in many ways, similar to the effects of alcohol. Small amounts produce calmness and relax muscles. Somewhat larger doses can cause slurred speech, staggering gait, poor judgment, and slow, uncertain reflexes. These effects make it dangerous to drive a car or operate machinery. Large doses can cause unconsciousness and death.

How dangerous are barbiturates?

Barbiturate overdose is a factor in nearly one-third of all reported drug-related deaths. These include suicides and accidental drug poisonings. Accidental deaths sometimes occur when a user takes one dose, becomes confused and unintentionally takes additional or larger doses. With barbiturates there is less difference between the amount that produces sleep and the amount that kills. Furthermore, barbiturate withdrawal can be more serious than heroin withdrawal.

What other sedative-hypnotics are abused?

All the other sedative-hypnotics can be abused, including the benzodiazepines. Diazepam (Valium), chlordiazepoxide (Librium), and chlorazepate (Tranxene) are examples of benzodiazepines. These drugs are also sold on the street as downers. As with the barbiturates, tolerance and dependence can develop if benzodiazepines are taken regularly in high doses over prolonged periods of time.

Other sedative-hypnotics which are abused include glutethimide (Doriden), ethchlorvynol (Placidyl), and methaqualone (Sopor, Quaalude).

What is methaqualone?

Methaqualone ("Sopors," "ludes") was originally prescribed to reduce anxiety during the day and as a sleeping aid. It is one of the most commonly abused drugs and can cause both physical and psychological dependence. The dangers from abusing methaqualone include: injury or death from car accidents caused by faulty judgment and drowsiness, and convulsions, coma, and death from overdose.

What are sedative-hypnotic "look-alikes"?

These are pills manufactured to look like real sedative-hypnotics and mimic their effects. Sometimes look-alikes contain over-the-counter drugs such as antihistamines and decongestants, which tend to cause drowsiness. The negative effects can include nausea, stomach cramps, lack of coordination, temporary memory loss, becoming out of touch with the surroundings, and anxious behavior.

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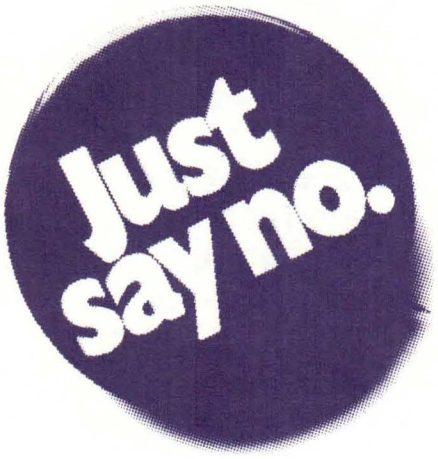
National Institute on Drug Abuse

Marijuana



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

What is marijuana?

Marijuana (grass, pot, weed) is the common name for a crude drug made from the plant *Cannabis sativa*. The main mind-altering (psychoactive) ingredient in marijuana is THC (delta-9-tetrahydrocannabinol), but more than 400 other chemicals also are in the plant. A marijuana "joint" (cigarette) is made from the dried particles of the plant. The amount of THC in the marijuana determines how strong its effects will be.

The type of plant, the weather, the soil, the time of harvest, and other factors determine the strength of marijuana. The strength of today's marijuana is as much as ten times greater than the marijuana used in the early 1970s. This more potent marijuana increases physical and mental effects and the possibility of health problems for the user.

Hashish, or hash, is made by taking the resin from the leaves and flowers of the marijuana plant and pressing it into cakes or slabs. Hash is usually stronger than crude marijuana and may contain five to ten times as much THC. Hash oil may contain up to 50 percent THC. Pure THC is almost never available, except for research. Substances sold as THC on the street often turn out to be something else, such as PCP.

What are some of the immediate effects of smoking marijuana?

Some immediate physical effects of marijuana include a faster heartbeat and pulse rate, bloodshot eyes, and a dry mouth and throat. No scientific evidence indicates that marijuana improves hearing, eyesight, and skin sensitivity.

Studies of marijuana's mental effects show that the drug can impair or reduce short-term memory, alter sense of time, and reduce ability to do things which require concentration, swift reactions, and coordination, such as driving a car or operating machinery.

Are there any other adverse reactions to marijuana?

A common bad reaction to marijuana is the "acute panic anxiety reaction." People describe this reaction as an extreme fear of "losing control," which causes panic. The symptoms usually disappear in a few hours.

What about psychological dependence on marijuana?

Long-term regular users of marijuana may become psychologically dependent. They may have a hard time limiting their use, they may need more of the drug to get the same effect, and they may develop problems with their jobs and personal relationships. The drug can become the most important aspect of their lives.

What are the dangers for young people?

One major concern about marijuana is its possible effects on young people as they grow up. Research shows that the earlier people start using drugs, the more likely they are to go on to experiment with other drugs. In addition, when young people start using marijuana regularly, they often lose interest and are not motivated to do their schoolwork. The effects of marijuana can interfere with learning by impairing thinking, reading comprehension, and verbal and mathematical skills. Research shows that students do not remember what they have learned when they are "high."

How does marijuana affect driving ability?

Driving experiments show that marijuana affects a wide range of skills needed for safe driving—thinking and reflexes are slowed, making it hard for drivers to respond to sudden, unexpected events. Also, a driver's ability to "track" (stay in lane) through curves, to brake quickly, and to maintain speed and the proper distance between cars is affected. Research shows that these skills are impaired for at least 4-6 hours after smoking a single marijuana cigarette, long after the "high" is gone. If a person drinks alcohol, along with using marijuana, the risk of an accident greatly increases. Marijuana presents a definite danger on the road.

Does marijuana affect the human reproductive system?

Some research studies suggest that the use of marijuana during pregnancy may result in premature babies and in low birth weights. Studies of men and women who use marijuana have shown that marijuana may influence levels of some hormones relating to sexuality. Women may have irregular menstrual cycles, and both men and women may have a temporary loss of fertility. These findings suggest that marijuana may be especially harmful during adolescence, a period of rapid physical and sexual development.

How does marijuana affect the heart?

Marijuana use increases the heart rate as much as 50 percent, depending on the amount of THC in the cigarette. It can cause chest pain in people who have a poor blood supply to the heart—and it produces these effects more rapidly than tobacco smoke does.

How does marijuana affect the lungs?

Scientists believe that marijuana can be especially harmful to the lungs because users often inhale the unfiltered smoke deeply and hold it in their lungs as long as possible. Therefore, the smoke is in contact with lung tissues for long periods of time, which irritates the lungs and damages the way they work. Marijuana smoke contains some of the same ingredients in tobacco smoke that can cause emphysema and cancer. In addition, many marijuana users also smoke cigarettes; the combined effects of smoking these two substances creates an increased health risk.

Can marijuana cause cancer?

Marijuana smoke has been found to contain more cancer-causing agents than is found in tobacco smoke. Examination of human lung tissue that had been exposed to marijuana smoke over a long period of time in a laboratory showed cellular changes called metaplasia that are considered precancerous. In laboratory tests, the tars from marijuana smoke have produced tumors when applied to animal skin. These studies suggest that it is likely that marijuana may cause cancer if used for a number of years.

How are people usually introduced to marijuana?

Many young people are introduced to marijuana by their peers—usually acquaintances, friends, sisters, and brothers. People often try drugs such as marijuana because they feel pressured by peers to be part of the group. Children must be taught how to say no to peer pressure to try drugs. Parents can get involved by becoming informed about marijuana and by talking to their children about drug use.

What is marijuana "burnout"?

"Burnout" is a term first used by marijuana smokers themselves to describe the effect of prolonged use. Young people who smoke marijuana heavily over long periods of time can become dull, slow moving, and inattentive. These "burned-out" users are sometimes so unaware of their surroundings that they do not respond when friends speak to them, and they do not realize they have a problem.

How long do chemicals from marijuana stay in the body after the drug is smoked?

When marijuana is smoked, THC, its active ingredient, is absorbed by most tissues and organs in the body; however, it is primarily found in fat tissues. The body, in its attempt to rid itself of the foreign chemical, chemically transforms the THC into metabolites. Urine tests can detect THC metabolites for up to a week after people have smoked marijuana. Tests involving radioactively labeled THC have traced these metabolites in animals for up to a month.

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National Institute on Drug Abuse

Stimulants and Cocaine

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

What are stimulants?

Stimulants ("uppers") refer to several groups of drugs that tend to increase alertness and physical activity. Some people use stimulants to counteract the drowsiness or "down" feeling caused by sleeping pills or alcohol. This up/down cycle is extremely hard on the body and dangerous. Amphetamines, cocaine; and caffeine are all stimulants.

Amphetamines

What are amphetamines?

Amphetamines include three closely related drugs—amphetamine, dextroamphetamine, and methamphetamine. Their street names include: "speed," "white crosses," "uppers," "dexies," "bennies," and "crystal." In pure form, they are yellowish crystals that are manufactured in tablet or capsule form. Abusers also sniff the crystals or make a solution and inject it.

Are amphetamines used for medical purposes?

Amphetamines are used for treating narcolepsy (a rare disorder marked by uncontrolled sleep episodes) and minimal brain dysfunction (MBD) in children. They also are prescribed for short-term treatment of obesity.

What are the physical effects of amphetamines?

Amphetamines increase heart and breathing rates and blood pressure, dilate pupils, and decrease appetite. In addition, the user can experience a dry mouth, sweating, headache, blurred vision, dizziness, sleeplessness, and anxiety. Extremely high doses can cause people to flush or become pale; they can cause a rapid or irregular heartbeat, tremors, loss of coordination, and even physical collapse. An amphetamine injection creates a sudden increase in blood pressure that can cause death from stroke, very high fever, or heart failure.

How do amphetamine users feel?

In addition to the physical effects, users report feeling restless, anxious, and moody. Higher doses intensify the effects, and the user can become excited and talkative and have a false sense of self-confidence and power.

People who use large amounts of amphetamines over a long period of time also can develop an amphetamine psychosis: seeing, hearing, and feeling things that do not exist (hallucinations), having irrational thoughts or beliefs (delusions), and feeling as though people are out to get them (paranoia). People in this extremely suspicious state frequently exhibit bizarre—sometimes violent—behavior. These symptoms usually disappear when people stop using the drug.

What about long-term effects?

Long-term heavy use of amphetamines can lead to malnutrition, skin disorders, ulcers, and various diseases that come from vitamin deficiencies. Lack of sleep, weight loss, and depression also result from regular use. Frequent use of large amounts of amphetamines can produce brain damage that results in speech and thought disturbances. In addition, users who inject amphetamines intravenously can get serious and life-threatening infections from nonsterile equipment or self-prepared solutions that are contaminated. Injecting them can cause lung or heart disease and other diseases of the blood vessels, which can be fatal. Kidney damage, stroke, or other tissue damage also may occur.

Can people become dependent on amphetamines?

Yes. Some people report a psychological dependence, a feeling that the drug is essential to their normal functioning. These users frequently continue to use amphetamines to avoid the "down" mood they get when the drug's effects wear off.

In addition, people who use amphetamines regularly may develop tolerance, the need to take larger doses to get the same initial effect.

When people stop using amphetamines abruptly, they may experience fatigue, long periods of sleep, irritability, hunger, and depression. The length and severity of the depression seems to be related to how much and how often the amphetamines were used.

What are "look-alike" stimulants?

Look-alike stimulants are drugs manufactured to look like real amphetamines and mimic their effects. The drugs usually contain varying amounts of caffeine, ephedrine, and phenylpropanolamine. These three legal substances are weak stimulants and often are found in over-the-counter preparations, such as diet pills and decongestants. More recently, new drugs called "act-alikes" have been manufactured to avoid new State laws that prohibit look-alikes. The act-alikes contain the same ingredients as the look-alikes but don't physically resemble any prescription or over-the-counter drugs. These drugs are sold on the street as "speed" and "uppers" and are expensive, even though they are not as strong as amphetamines. They often are sold to young people who are told they are legal, safe, and harmless. This is one reason they are being increasingly abused.

What are the effects of look-alikes?

Some negative effects of look-alikes, especially when taken in large quantities, are similar to the effects of amphetamines. These effects include anxiety, restlessness, weakness, throbbing headache, difficulty breathing, and a rapid heartbeat. There have been several reports of severe high blood pressure, leading to cerebral hemorrhaging and death. Often, in an emergency, look-alike drug overdose cases are misidentified by physicians and poison control centers. This can cause a problem in determining the proper treatment.

What are the dangers of look-alikes?

One of the greatest dangers is that these drugs are easily available and are being used by young people and others who do not normally abuse drugs. Once people start using these drugs, they may be at high risk for using other drugs.

Because look-alikes are not as strong as real amphetamines, they are extremely dangerous for people who—deliberately or accidentally—take the same amount of real amphetamines as they would take of the look-alikes. For example, people who buy look-alikes on the "street" may, unknowingly, buy real amphetamines and take enough to cause an overdose. On the other hand, people who have abused amphetamines may underestimate the potency of the look-alike drugs and take excessive amounts that can result in a toxic reaction.

Cocaine

What is cocaine?

Cocaine is a drug extracted from the leaves of the coca plant which grows in South America. Like the amphetamines, it is a central nervous system stimulant. Cocaine appears in several different forms. Cocaine hydrochloride is the most available form of the drug and is used medically as a local anesthetic. It is usually a fine white crystal-like powder, although at times it comes in larger pieces which on the "street" are called "rocks." Cocaine is usually sniffed or snorted into the nose, although some users inject it or smoke a form of the drug called freebase.

Another form of the drug is coca paste. It is a crude product that is smoked in South America. It may be especially dangerous because it also consists of contaminants such as kerosene which can cause lung damage.

What are the immediate effects of cocaine?

When cocaine is "snorted," the effects begin within a few minutes, peak within 15 to 20 minutes, and disappear within an hour. These effects include dilated pupils and increases in blood pressure, heart rate, breathing rate, and body temperature. The user may have a sense of well-being and feel more energetic or alert, and less hungry.

What is freebase?

Freebase is a form of cocaine which is made by chemically converting "street" cocaine hydrochloride to a purified, altered substance that is then more suitable for smoking. Smoking freebase produces a shorter and more intense "high" than most other ways of using the drug because smoking is the most direct and rapid way to get the drug to the brain. Because larger amounts are getting to the brain more quickly, smoking also increases the risks associated with using the drug. These risks include confusion, slurred speech, anxiety, and serious psychological problems.

What are the dangers of cocaine use?

The dangers of cocaine use vary, depending on how the drug is taken, the dose, and the individual.

Some regular users report feelings of restlessness, irritability, anxiety, and sleeplessness. In some people, even low doses of cocaine may create psychological problems. People who use high doses of cocaine over a long period of time may become paranoid or experience what is called a "cocaine psychosis." This may include hallucinations of touch, sight, taste, or smell.

What are some physical dangers of cocaine use?

Occasional use can cause a stuffy or runny nose, while chronic snorting can ulcerate the mucous membrane of the nose. Injecting cocaine with unsterile equipment can cause hepatitis or other infections. Furthermore, because preparation of freebase involves the use of volatile solvents, deaths and serious injuries from fire or explosion can occur. Though few people realize it, overdose deaths can occur when the drug is injected, smoked, or even snorted. Deaths are a result of multiple seizures followed by respiratory and cardiac arrest.

Can people become dependent on cocaine?

Yes. It is a very dangerous, dependence-producing drug. People use cocaine repeatedly because they like its effects and can get to the point of centering their lives around seeking and using the drug. Smoking freebase increases this risk of dependence. Sometimes people who have been using the drug over a period of time continue to use it in order to avoid the depression and fatigue they would feel if they stopped using the drug.

Are there cocaine "look-alikes"?

Yes. The growing demand for cocaine, its high price, and limited supply have led to the widespread use of substitute drugs that resemble cocaine and may have stimulant effects. Cocaine look-alikes contain ingredients that are legal and that also appear as impurities in samples of street cocaine. Substances which are used to "cut" or dilute cocaine include household items such as flour, baking soda, talc, and sugar. Local anesthetics, caffeine, and other chemicals also are sold as substitutes.

Caffeine

Is caffeine a drug?

Yes. Caffeine may be the world's most popular drug. It is a white, bitter, crystal-like substance found in coffee, tea, cocoa, and cola. It also is found in some products such as aspirin, nonprescription cough and cold remedies, soft drinks, diet pills, and some street drugs.

What are the effects of caffeine?

As with all drugs, the effects vary depending on the amount taken and the individual. When a person drinks two cups of coffee (150-300 milligrams of caffeine), the effects begin in 15-30 minutes. The person's metabolism, body temperature, and blood pressure may increase. Other effects include increased urine production, higher blood sugar levels, hand tremors, a loss of coordination, decreased appetite, and delayed sleep. Extremely high doses may cause nausea, diarrhea, sleeplessness, trembling, headache, and nervousness. Poisonous doses of caffeine have occurred occasionally and may result in convulsions, breathing failure, and death. Although it is almost impossible for death to occur from drinking coffee or tea, deaths have been reported through misuse of tablets containing caffeine.

Can a person become dependent on caffeine?

Tolerance to caffeine (the need for a larger dose to get the same effect) may develop with the use of over 500-600 milligrams (for example, 4-6 cups of coffee) of caffeine per day. A regular user of caffeine who has developed a tolerance also may have a craving for the drug's effects, particularly to "get going" in the morning. Some researchers have found a withdrawal-like syndrome among people who suddenly stop using caffeine. The symptoms include headache, irritability, and mood changes.

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National Institute on Drug Abuse

Hallucinogens and PCP

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

What are hallucinogens?

Hallucinogens, or psychedelics, are drugs that affect a person's perceptions, sensations, thinking, self-awareness, and emotions. Hallucinogens include such drugs as LSD, mescaline, psilocybin, and DMT. Some hallucinogens come from natural sources, such as mescaline from the peyote cactus. Others, such as LSD, are synthetic or manufactured.

PCP is sometimes considered an hallucinogen because it has some of the same effects. However, it does not fit easily into any one drug category because it also can relieve pain or act as a stimulant.

What is LSD?

LSD is manufactured from lysergic acid which is found in ergot, a fungus that grows on rye and other grains. LSD was discovered in 1938 and is one of the most potent mood-changing chemicals. It is odorless, colorless, and tasteless. LSD is sold on the street in tablets, capsules, or occasionally in liquid form. It is usually taken by mouth but sometimes is injected. Often it is added to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose.

What is mescaline?

Mescaline comes from the peyote cactus and although it is not as strong as LSD, its effects are similar. Mescaline is usually smoked or swallowed in the form of capsules or tablets.

What are some other psychedelic drugs?

Psilocybin comes from certain mushrooms. It is sold in tablet or capsule form so people can swallow it. The mushrooms themselves, fresh or dried, may be eaten. DMT is another psychedelic drug that acts like LSD. Its effects begin almost immediately and last for 30-60 minutes.

What are the effects of psychedelics like LSD?

The effects of psychedelics are unpredictable. It depends on the amount taken, the user's personality, mood, and expectations, and the surroundings in which the drug is used. Usually, the user feels the first effects of the drug 30-90 minutes after taking it. The physical effects include dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, and tremors.

Sensations and feelings change too. The user may feel several different emotions at once or swing rapidly from one emotion to another. The person's sense of time and self change. Sensations may seem to "cross over," giving the user the feeling of "hearing" colors and "seeing" sounds. All of these changes can be frightening and can cause panic.

What are "bad trips"?

Having a bad psychological reaction to LSD and similar drugs is common. The scary sensations may last a few minutes or several hours and be mildly frightening or terrifying. The user may experience panic, confusion, suspiciousness, anxiety, feelings of helplessness, and loss of control. Sometimes taking a hallucinogen such as LSD can unmask mental or emotional problems that were previously unknown to the user. Flashbacks, in which the person experiences a drug's effects without having to take the drug again, can occur.

What are the effects of heavy use?

Research has shown some changes in the mental functions of heavy users of LSD, but they are not present in all cases. Heavy users sometimes develop signs of organic brain damage, such as impaired memory and attention span, mental confusion, and difficulty with abstract thinking. These signs may be strong or they may be subtle. It is not yet known whether such mental changes are permanent or if they disappear when LSD use is stopped.

PCP

What is PCP?

PCP (phencyclidine) is most often called "angel dust." It was first developed as an anesthetic in the 1950s. However, it was taken off the market for human use because it sometimes caused hallucinations.

PCP is available in a number of forms. It can be a pure, white crystal-like powder, or a tablet or capsule. It can be swallowed, smoked, sniffed, or injected. PCP is sometimes sprinkled on marijuana or parsley and smoked.

Although PCP is illegal, it is easily manufactured. It is often sold as mescaline, THC, or other drugs. Sometimes it may not even be PCP, but a lethal by-product of the drug. Users can never be sure what they are buying since it is manufactured illegally.

What are the physical effects of PCP?

Effects depend on how much is taken, the way it is used, and the individual. Effects include increased heart rate and blood pressure, flushing, sweating, dizziness, and numbness. When large doses are taken, effects include drowsiness, convulsions, and coma. Taking large amounts of PCP can also cause death from repeated convulsions, heart and lung failure, or ruptured blood vessels in the brain.

Why is PCP dangerous?

PCP can produce violent or bizarre behavior in people who are not normally that way. This behavior can lead to death from drownings, burns, falls (sometimes from high places), and automobile accidents. Regular PCP use affects memory, perception, concentration, and judgment. Users may show signs of paranoia, fearfulness, and anxiety. During these times, some users may become aggressive while others may withdraw and have difficulty communicating. A temporary mental disturbance, or a disturbance of the user's thought processes (a PCP psychosis), may last for days or weeks. Long-term PCP users report memory and speech difficulties, as well as hearing voices or sounds which do not exist.

How do PCP users feel?

Users find it difficult to describe and predict the effects of the drug. For some users, PCP in small amounts acts as a stimulant, speeding up body functions. For many users, PCP changes how users see their own bodies and things around them. Speech, muscle coordination, and vision are affected; senses of touch and pain are dulled; and body movements are slowed. Time seems to "space out."

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GPO : 1986 O - 162-579 (Item 2) QL 3

National Institute on Drug Abuse

Inhalants

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

What are inhalants?

Inhalants are breathable chemicals that produce psychoactive (mind-altering) vapors. People do not usually think of inhalants as drugs because most of them were never meant to be used that way. They include solvents, aerosols, some anesthetics, and other chemicals. Examples are model airplane glue, nail polish remover, lighter and cleaning fluids, and gasoline. Aerosols that are used as inhalants include paints, cookware coating agents, hair sprays, and other spray products. Anesthetics include halothane and nitrous oxide (laughing gas). Amyl nitrite and butyl nitrite are inhalants that also are abused.

What is amyl nitrite?

Amyl nitrite is a clear, yellowish liquid that is sold in a cloth-covered, sealed bulb. When the bulb is broken, it makes a snapping sound; thus they are nicknamed "snappers" or "poppers." Amyl nitrite is used for heart patients and for diagnostic purposes because it dilates the blood vessels and makes the heart beat faster. Reports of amyl nitrite abuse occurred before 1979, when it was available without a prescription. When it became available by prescription only, many users abused butyl nitrite instead.

What is butyl nitrite?

Butyl nitrite is packaged in small bottles and sold under a variety of names, such as "locker room" and "rush." It produces a "high" that lasts from a few seconds to several minutes. The immediate effects include decreased blood pressure, followed by an increased heart rate, flushed face and neck, dizziness, and headache.

Who abuses inhalants?

Young people, especially between the ages of 7 and 17, are more likely to abuse inhalants, in part because they are readily available and inexpensive. Sometimes children unintentionally misuse inhalant products that are often found around the house. Parents should see that these substances, like medicines, are kept away from young children.

How do inhalants work?

Although different in makeup, nearly all of the abused inhalants produce effects similar to anesthetics, which act to slow down the body's functions. At low doses, users may feel slightly stimulated; at higher amounts, they may feel less inhibited, less in control; at high doses, a user can lose consciousness.

What are the immediate negative effects of inhalants?

Initial effects include nausea, sneezing, coughing, nosebleeds, feeling and looking tired, bad breath, lack of coordination, and a loss of appetite. Solvents and aerosols also decrease the heart and breathing rate and effect judgment.

How strong these effects are depends on the experience and personality of the user, how much is taken, the specific substance inhaled, and the user's surroundings. The "high" from inhalants tends to be short or can last several hours if used repeatedly.

What are the most serious short-term effects of inhalants?

Deep breathing of the vapors, or using a lot over a short period of time may result in losing touch with one's surroundings, a loss of self-control, violent behavior, unconsciousness, or death. Using inhalants can cause nausea and vomiting. If a person is unconscious when vomiting occurs, death can result from aspiration.

Sniffing highly concentrated amounts of solvents or aerosol sprays can produce heart failure and instant death. Sniffing can cause death the first time or any time. High concentrations of inhalants cause death from suffocation by displacing the oxygen in the lungs. Inhalants also can cause death by depressing the central nervous system so much that breathing slows down until it stops.

Death from inhalants is usually caused by a very high concentration of inhalant fumes. Deliberately inhaling from a paper bag greatly increases the chance of suffocation. Even when using aerosol or volatile (vaporous) products for their legitimate purposes, i.e., painting, cleaning, etc., it is wise to do so in a well-ventilated room or outdoors.

What are the long-term dangers?

Long-term use can cause weight loss, fatigue, electrolyte (salt) imbalance, and muscle fatigue. Repeated sniffing of concentrated vapors over a number of years can cause permanent damage to the nervous system, which means greatly reduced physical and mental capabilities. In addition, long-term sniffing of certain inhalants can damage the liver, kidneys, blood, and bone marrow.

Tolerance, which means the sniffer needs more and more each time to get the same effect, is likely to develop from most inhalants when they are used regularly.

What happens when inhalants are used along with other drugs?

As in all drug use, taking more than one drug at a time multiplies the risks. Using inhalants while taking other drugs that slow down the body's functions, such as tranquilizers, sleeping pills, or alcohol, increases the risk of death from overdose. Loss of consciousness, coma, or death can result.

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GPO : 1986 O - 162-579 (Item 1) QL 3

Cocaine
ADDICTION

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

Many people think they know the facts about cocaine. Some even think it is safe to use. Actually, as many have found out, cocaine is a dangerous, addictive drug.

What is cocaine?

Cocaine in its pure form is a white crystalline powder extracted from the leaves of the South American coca plant. The drug sold on the street is a mixture of the pure substance (cocaine hydrochloride) and various adulterants added to increase the quantity, for the seller's profit.

How is cocaine being used?

Most users "snort" cocaine, that is, they sharply inhale the powdered mixture. Another form of the drug called "freebase" is made by chemically converting the street drug into a basic form that can be smoked. Smoking freebase is an especially dangerous practice.

Which type of use is most dangerous?

The use of cocaine is risky in all forms. As with any drug, the risks vary depending on the amount, how it is used, the setting of use, and individual sensitivity. Risks increase as the amount and frequency of use increase. When cocaine is smoked, very large doses reach the brain within seconds, increasing the risks. Injecting cocaine carries the additional hazards of serious infection and possible adverse reactions to the impure injected mixture. When "snorted," even small amounts of cocaine in sensitive individuals may be enough to cause convulsions that can result in heart and respiratory failure, and death.

Do adulterants increase the risks in cocaine use?

Yes. Cocaine adulterants and cocaine substitutes in common use increase the hazards of taking an already risky drug. The user cannot monitor the dosage of the drug taken. The cocaine that ends up in the hands of the consumer ranges widely from 30% to 95% pure and some of the adulterants are dangerous as well.

Do withdrawal symptoms occur when people stop using cocaine?

Yes. The withdrawal effects from stopping cocaine use are not as easy to see as heroin withdrawal symptoms, but they are just as real. Symptoms of cocaine withdrawal include exhaustion, irritability, sleepiness, loss of energy, depression, and an intense craving for more cocaine.

Is there a cure for cocaine dependence?

Most severely dependent cocaine users require help in order to stop using cocaine. Cocaine dependence is a persistent and devastating experience. No one can predict which cocaine users will run into serious trouble. Users may be unaware of or deny the negative effects of the drug because they are addicted. Treatment can be prolonged and costly and craving may persist for long periods. The most common reasons given for entering treatment are financial and family problems.

How much does a cocaine habit cost?

The cost of a cocaine habit ranges from $200 to $3,000 weekly. Users can also pay the additional price of damaged health, career, and personal life. No matter who you are, cocaine costs too much!

Can people become dependent on cocaine?

Yes. Cocaine is an addictive drug. Researchers have found that an addicted animal will prefer cocaine to food even if starved. Sometimes people who have been using the drug over a period of time continue to use it just to feel "normal," or to avoid the severe depression and fatigue that occurs when they try to stop using the drug. Virtually no one who becomes addicted to cocaine ever thought they would.

What are the immediate effects of cocaine?

When cocaine is "snorted," the effects begin within a few minutes, peak in 15 to 20 minutes, and disappear within an hour. The immediate effects include dilated pupils, increases in blood pressure, heart rate, breathing rate, and body temperature. The user usually feels a sense of well-being and may feel more energetic or alert.

Does cocaine get rid of depression?

Once the initial euphoria wears off, in about 30 minutes, users are likely to feel more down, more depressed than when they started. The higher the high, the lower the low. There's even a name for the low: the "coke blues." People often get caught in "binge and crash" cycles when they use cocaine and take other drugs to get rid of the depression that follows the short-lived cocaine "high." Users often get caught in a down cycle of needing more and more of the drug just to feel "normal."

Does cocaine improve concentration and performance?

Some users report that cocaine, like other stimulants, increases their concentration and improves performance on a variety of tasks. No objective evidence supports these reports. Moreover, cocaine is a short-acting drug, and within an hour, a person not only feels less alert, but more anxious, tired, or depressed than before.

Does cocaine enhance sexual pleasure?

Cocaine may initially seem to act as an aphrodisiac, probably because of its initial psychological effects as well as its actions on the sympathetic nervous system. However, when used on a regular basis, cocaine can produce complete sexual dysfunction.

What about long-term psychological effects?

After weeks and months of regular binging, the user is "coked out." Depression can become chronic, and hallucinations and signs of psychosis may appear. Earlier signs of trouble are increased irritability, short temper, and paranoia. Some users have difficulty concentrating or remembering things, lose interest in sex, or have panic attacks.

How does cocaine affect the heart?

A large dose, or even a moderate dose under some conditions, can overtax the heart and may be fatal. Regular use of cocaine can cause heart palpitations, angina, arrhythmia, and even a heart attack.

What are the effects of cocaine on the brain?

Cocaine use results in an overstimulation of neurotransmitters in the brain. These neurotransmitters act as chemical messengers controlling behavior and mood and are responsible for the drug's effects.

Is it dangerous to use cocaine in combination with other drugs?

Yes. Alcohol and marijuana are the most common substances used with cocaine, either simultaneously or consecutively. Combining cocaine with depressants such as heroin, barbiturates or sedatives, as in a cocaine-heroin "speedball," may result in the build-up of either drug to seriously toxic levels. Since cocaine has stimulant effects itself, combining it with other stimulants can be especially dangerous. Local anesthetics, hazardous in themselves, are common cocaine adulterants.

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

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857

U.S. GOVERNMENT PRINTING OFFICE : 1985 O - 486-501

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Printed 1985

IMPAIRED PROFESSIONALS' RESOURCE GUIDE

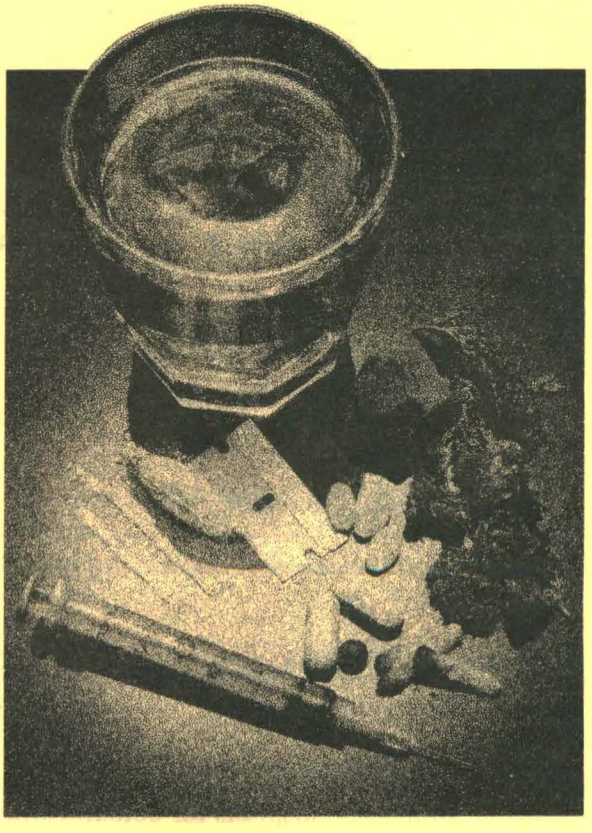
EMPLOYEE COUNSELING SERVICE PROGRAM (ECSP) SEPTEMBER 1986

In the Employee Counseling Service Program's (ECSP) effort to respond to the increasing concern about impaired professionals, the following information and attached list of resources are available.

Chemical dependency, including alcohol abuse, alcoholism, and drug addiction, is a serious national health problem. The suffering of those affected, their families, coworkers, and friends, and the terrible consequences for society, are well-documented. Chemical dependency is a disease that does not discriminate between the young and the old, or between the professional and the nonprofessional. It is believed that chemical dependency is a disease suffered by many health care providers, especially as they have easy access to drugs. Substance abuse is often used as a coping mechanism for dealing with this high stress environment.

Chemical dependency or impairment among health professionals is troublesome, not only because of the personal tragedy, but because of the potential for harm to the patients served by the impaired professional.

Health care professionals have most often been reacting to their colleagues who fall victim to alcohol and other drug addictions by denial to minimize its impact on the health care profession as a whole. Health care providers, when caught diverting drugs for personal use, are often covered up and "rescued" by their peers until the disease has progressed to the point of crisis. The sick professional may be reported to a State board, but seldom is he/she referred for treatment, rehabilitation and reinstatement to their job. Recently, professional organizations have attempted to respond to the problem in a more effective way.



NURSES (cont.)

Patricia Green Chairperson of the National Nurses Society on Addictions (NNSA) Impaired Nurse Committee 1020 Sunset Drive Lawrence, KS 66044	(816) 254-3652/ Ext. 271	Nursing Network of Resources and Support Groups in All Geographic Areas
Eleanor Sullivan, Ph.D., R.N. Chairwoman, Peer Assistance Committee Missouri Nurses Association 206 East Cunkin Jefferson City, MO 65102	(314) 636-4623	Program for Chemically Dependent Nurses in Missouri

RESOURCES FOR IMPAIRED SOCIAL WORKERS

John Bland Chairman, Impaired Social Workers Medical and Chirurgical Faculty of the State of Maryland 1211 Cathedral Street Baltimore, MD 21201	(301) 225-6541	Resource Information
Social Workers Helping Social Workers Box 3765 Grand Central Station New York, NY 10163		Mutual Support Groups; Workshops; Weekend Conferences
Peter Mazzella Social Workers Helping Social Workers Room 16A-23, Parklawn Building 5600 Fishers Lane Rockville, MD 20857	(301) 443-HELP	Resource Information and Referrals

RESOURCES FOR IMPAIRED PHARMACISTS

Medical and Chirurgical Faculty of Maryland Attention: Harry Fink Pharmacist Rehabilitation Committee 1211 Cathedral Street Baltimore, MD 21201	(301) 727-0746	Resource Information
American Pharmaceutical Association Impaired Pharmacist Program 2215 Constitution Ave., N.W. Washington, DC 20037	(202) 628-4410	Information and Assistance

Further resource information is available through ECSP by calling FTS 443-HELP.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Care Delivery and Assistance

Division of Federal Occupational and Beneficiary Health Services
5600 Fishers Lane
Rockville, Maryland 20857

Amy Claire Barkin, M.S.W., M.P.H., C.A.C.
Director, Employee Counseling Service Program

WARNING SIGNS

OF SUBSTANCE ABUSE

1. PERFORMANCE DETERIORATES

   ---- Inconsistent work quality

   ---- Lowered productivity

   ---- Poor concentration

   ---- Spasmodic work pace

   ---- Signs of fatigue

   ---- Shifting of responsibility

2. POOR ATTENDANCE AND ABSENTEEISM

   ---- Absenteeism and lateness increase, particularly after weekends

   ---- Often family members call about the absence rather than the employee. Often the illness is flu, stomach distress, headache, and other vaguely defined illness.

   ---- Early leaving and extended lunch periods become more frequent. Unexplained disappearances from the job occur.

3. ATTITUDE AND PHYSICAL APPEARANCE CHANGES

   ---- Details are often neglected, assignments are handled sloppily.

   ---- Others are blamed for the individual's shortcomings.

   ---- Colleagues and the supervisor are often deliberately avoided.

   ---- Personal appearance deteriorates.

   ---- Ability to get along with others is sporadic. Mood swings from elation to depression and from happiness to irritability occur.

---- Poor morale and reduced productivity occur in the work group because of the time spent "covering up" for the substance abuser.

4. HEALTH AND SAFETY HAZARDS INCREASE

---- Careless handling and maintenance of equipment.

---- Taking of needless risks or expenditure of energy in order to make up for periods of low productivity.

---- Disregard for safety of self or others.

---- Increase in number of accidents, both at work and after work.

5. DOMESTIC PROBLEMS

---- Complaints about problems at home increase. There is talk of separation, divorce, family squabbles, family violence, delinquent behavior on the part of the children.

---- Financial problems begin to occur.

---- There is an episode of loss of driver's license due to driving while intoxicated.

AMERICA, THE BEAUTIFUL

Oh beautiful, for spacious skies
For amber waves of grain
For purple mountain's majesties
Above the fruited plains
America, America, God shed His grace on thee
And Crown thy good, with brotherhood
From sea to shining sea.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DRUG AWARENESS DAY

October 27, 1986
11:00 A.M. - 12:00 P.M.

THE GREAT HALL
HUBERT H. HUMPHREY BUILDING

PROGRAM

Mistress of Ceremonies ..... The Honorable Stephanie Lee-Miller
Assistant Secretary for Public Affairs

Interpreter ..... Mr. Michael Hartman
Office of the Assistant Secretary for Personnel Administration

Invocation ..... The Reverend Tony Torain
Office of the Assistant Secretary For Personnel Administration

America the Beautiful ..... Audience
Led by the Robert Brent Elementary School pupils

Greetings ..... Miss Shamai Carter
Student, Robert Brent Elementary School

Opening Remarks ..... The Honorable Otis R. Bowen, M.D.
Secretary of Health and Human Services

THEME: DRUGS — A THREAT TO THE WHOLE FAMILY

Introduction of Speakers ..... The Honorable Stephanie Lee-Miller

Speakers:

Erin ..... A Young Person's Perspective

Mrs. Lonise Bias ..... A Parent's Perspective

The Honorable
Donald Ian Macdonald, M.D.
Administrator, ADAMHA ..... A Physician's Perspective

Questions from the Audience

Closing Remarks ..... The Honorable Stephanie Lee-Miller

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Directory of Employee Counseling Services Program Administrators

Department of Health and Human Services

Phillip Boyle, Director
Office of the Assistant Secretary for Personnel Administration
Washington, D.C.
245-6757

Social Security Administration

Frederica Harrison
Baltimore, Maryland
FTS 934-3620

Health Care Financing Administration

Beverly Moore
Baltimore, Maryland
FTS 934-9253

Southwest Washington

Geri Cooperman (Acting)
Washington, DC
FTS 472-5290

Region II

Robert Mazzochi
New York, NY
FTS 264-5505

Region IV

Marilyn Montgomery
Atlanta, GA
FTS 242-2713

Region VI

Mary Perkins
Dallas, TX
FTS 729-3616

Region VIII

Donna Keeling
Denver, CO
FTS 564-6391

Region X

John Murphy
Seattle, WA
FTS 399-8033

Pubic Health Service

Amy Barkin
Rockville, Maryland
FTS 443-4357

National Institutes of Health

Evelyn Joy
Bethesda, Maryland
FTS 496-3164

Region I

Corinne Reppucci
Boston, MA
FTS 835-1389

Region III

Beverly Janda
Philadelphia, PA
FTS 596-6712

Region V

Ken Haycock
Chicago, IL
FTS 886-5491

Region VII

John McClay
Kansas City, MO
FTS 758-5848

Region IX

Sage Kataoka
San Francisco, CA
FTS 556-3437

10/1986

Dr B. — 10/24

Will you attend?
I gave Bob Sweet a
copy. Lee Rm 522A
facsimile
Fran

Fran -
Pls send copies to Carlton, Dick Williams,
Rich Davis, Al Kingon.
send 10/27 Thx RCB

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

OCT 23 1986

Dr. Ralph C. Bledsoe
Special Assisant to the President
Old Executive Office Building
Room 200
Wahington, D.C. 20500

Dear Dr. Ralph Bledsoe:

I thought you might be interested in seeing what the Department is doing to begin implementation of the President's initiative for a drug-free Federal workplace. First, the Secretary has sent the President's memorandum to every employee in the Department, along with an accompanying personal message from him. I have attached a copy for your information.

Second, the Secretary has proclaimed October 27 as Drug Awareness Day in HHS, to commemorate National Drug Awareness Month. He will hold the first of a series of HHS Drug Awareness Programs in the Great Hall of the Humphrey Building at 11:00 a.m. on Monday, October 27. The program will feature an address by the Secretary, and presentations by Mrs. Lonise Bias; Dr. Donald Ian Macdonald, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration within HHS; and the daughter of one of our executives, a recovered teen-age drug user.

The theme for this inaugural program is Drugs: A Threat To The Whole Family. We plan to videotape this program and make it available to our headquarters and regional offices for use in similar programs throughout the Department. The program will also feature exhibits from the Department's Employee Assistance Programs and from national and local organizations involved in drug abuse treatment and education. We have issued a press release on this program, a memorandum from the Secretary to our top managers encouraging their support, and a personal message from the Secretary to our headquarters employees inviting them to attend this program. Copies of these are also attached.

If you or any of your staff would like to attend our program, please give me a call on 245-7284.

Sincerely,

Thomas S. McFee
Assistant Secretary for
Personnel Administration

Attachment

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 22 1986

MEMORANDUM TO HHS EMPLOYEES

The President has recently approved several new initiatives designed to achieve our nation's goal of a drug-free America. The President has also written to all employees in the Executive Branch, sending us his personal message about his concern for the effects of illegal drug use on employees, their families, and their communities. I am forwarding the President's memorandum for you to read personally. This Department, as the country's leader in drug abuse education, research, and treatment, has played a prominent role in helping to bring about the President's initiative. I am writing to you today to express my hopes for how we, as the "People's Department," can help achieve this goal.

Let me state clearly that this is no small undertaking. It will require the commitment and cooperation of all of us, as well as our families, our friends, and our neighbors. We can start by helping to achieve a drug-free workplace in HHS. I want employees in this Department who may have drug-related problems to know that we care and we can help. This Department has an Employee Assistance Program throughout all of its headquarters and regional offices. This program is designed to provide all HHS employees assistance with personal problems, including drug-related problems, which prevent them from working to the best of their ability. I intend to make sure that our HHS Employee Assistance Program is available to all employees and that we can offer rehabilitation to all employees who may need it. This program is also available to you should a drug-related problem arise among members of your family.

Other Federal agencies, as well as employers around the country, will be looking to us as an example of how to achieve a drug-free workplace. I join with President Reagan in asking for your assistance in this vital national effort.

Otis R. Bowen, M.D.
Secretary

Attachment

THE WHITE HOUSE

WASHINGTON
October 4, 1986

MEMORANDUM FOR ALL EXECUTIVE BRANCH EMPLOYEES

As you know, I recently approved several new initiatives with an overriding goal of a drug-free America. This is no easy task, requiring as it does the commitment and support of all Americans. I am asking you, as citizens, parents, friends, and colleagues, to take a leading role.

As members of the Nation's largest work force, you can continue to set an example for other American workers. I know an overwhelming majority of Federal employees have never had trouble with illegal drugs, but our goal is a safe and drug-free workplace for all employees and the American public. Certainly the issue of drug testing has caused some concern, but I want to assure you that my Executive Order contains provisions to ensure that any testing program will be fair and will protect your rights as citizens.

Our intention is not to punish users of illegal drugs, but to help rehabilitate them. When you see colleagues or friends struggling with a drug problem, encourage them to seek help from your Employee Assistance Program or from some other organization or person skilled in drug counseling and treatment. Together we can send a message that illegal drug use in every office, shop, and laboratory simply will not be tolerated. The combined efforts of all of us will make it easier for Federal as well as private sector employees to "Just Say No."

Your efforts to increase public awareness and prevention of drug abuse are also crucial. Illegal drug use is not a "victimless crime," nor is it glamorous or a matter of personal choice. Drug abuse victimizes everyone in productive time lost, lives shattered, and families and communities torn apart. We must send this message beyond the workplace to friends and neighbors and especially to our young people.

I have called upon you many times in the past, and your support and dedication have already helped us achieve so much. Now I am asking you to get personally involved in ridding our offices, schools, homes, and communities of drugs and making them better places to live and work. I know I can count on your personal help.

Ronald Reagan

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Thursday, October 23, 1986

Contact: Chuck Kline
(202) 245-6343

Health and Human Services Secretary Otis R. Bowen, M.D., today announced an "HHS Employees Drug Awareness Day" program for Oct. 27 during which special guests and departmental officials will talk to employees and their families about drugs.

The program, in conjunction with President Reagan's designation of October as "National Drug Awareness Month," will be held in the Great Hall of the Humphrey Building, 200 Independence Ave. S.W., from 11 a.m. until noon. Its theme is, "Drugs - A Threat to the Whole Family."

Special guests participating are Mrs. Lonise Bias, mother of former University of Maryland basketball star Len Bias, and Erin, a high school senior who is a recovering alcohol and drug abuser.

HHS officials joining Dr. Bowen on the anti-drug program are Donald Ian Macdonald, administrator of the Alcohol, Drug Abuse, and Mental Health Administration, and Stephanie Lee-Miller, assistant secretary for public affairs.

In addition to hearing remarks from the perspective of a mother, a youth and a physician, HHS employees are invited to ask questions related to the problem of the illegal use of drugs.

An exhibition featuring informational and educational anti-drug material from HHS components and private businesses and organizations will be displayed in the Great Hall throughout the day.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MEMORANDUM TO HEADS OF OPERATING AND STAFF DIVISIONS

SUBJECT: HHS Drug Awareness Day

President Reagan has proclaimed the month of October as National Drug Awareness Month. As part of this Department's efforts to support the President's initiatives for achieving a drug-free Federal workplace, I have designated October 27 as HHS Drug Awareness Day.

I plan to hold an HHS Drug Awareness Program on October 27 at 11:00 a.m. in the Great Hall of the Hubert H. Humphrey Building. Dr. MacDonald of ADAMHA and Mrs. Bias, mother of former University of Maryland student Len Bias, will be joining me in the program. This program will highlight our commitment to achieving a drug-free workplace in HHS and to the HHS Employee Counseling Services (ECS) Program, our employee assistance program for helping all employees who are experiencing personal problems, including those which may be drug-related. The program will also feature exhibits from the headquarters ECS programs as well as from several national and local drug treatment and prevention organizations.

I would like to invite you to join me at this program. It is important that employees recognize your commitment and leadership as the heads of the organizations for which they work. I would also like to ask you to personally invite your senior managers and supervisors to attend this program. In his Executive Order on the use of illegal drugs, the President recognized the role of supervisors in dealing with drug use in the workplace by calling for a renewed emphasis on supervisory training in this area. One of the goals of this program is to convey to our managers and supervisors how vital their help will be in achieving a drug-free workplace in HHS.

Please join me, along with your senior managers and supervisors, in sponsoring a successful HHS Drug Awareness Day.

Otis R. Bowen, M.D.
Secretary

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 21 1986

MEMORANDUM TO HHS HEADQUARTERS EMPLOYEES

SUBJECT: HHS Drug Awareness Day

As one of his initiatives to achieve a drug-free Federal workplace, the President has proclaimed the month of October as National Drug Awareness Month.

As part of this Department's efforts to support the President's initiatives, I am designating October 27 as HHS Drug Awareness Day, and inviting all HHS Headquarters employees to attend. The HHS Drug Awareness Program will be held on October 27 at 11:00 a.m. in the Great Hall of the Hubert H. Humphrey Building. Our featured guest speaker will be Mrs. Bias, the mother of former University of Maryland student Len Bias, who died earlier this year in a drug-related incident.

This program will highlight our commitment to achieving a drug-free workplace in HHS and our Department's Employee Counseling Services (ECS) Program, which is available to assist all employees with a wide variety of problems, including those which may be drug-related.

Exhibits will be set up in the Great Hall representing the Department's headquarters ECS programs, as well as several national and community organizations involved in drug abuse treatment and prevention. Pamphlets, brochures, films, and other materials will be available at these exhibits.

Please accept my personal invitation to attend this important program, and join with me in the Great Hall of the Humphrey Building on October 27.

Otis R. Bowen, M.D.
Secretary

Problems on the Job

A Supervisor's Guide to Coping

Office of Personnel Management
Washington, D.C. 20415

Sometimes, Supervision is

an uphill battle.

Because supervising means getting work done through other people. And working through people has its own set of problems. . . the kind that get in the way of getting work done, whether it's processing mounds of paperwork, or building a highway or coming up with a drug abuse policy.

An employee who's drunk by noon

whose leave record looks like a crossword puzzle

who is hooked on "downers"

whose financial problems are bordering on disaster

has to be coped with.

By you.

You got to be a supervisor because you had special abilities. You're paid for the quality of your decisions about programs, and priorities and people.

Sometimes those decisions aren't easy.

Bettmann Archive prints

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Stock No. 006–000–01067–9

When you consider that there are an estimated ten million alcoholics in the country, that many drugs are commonly abused, and that 10 percent of our population suffers from some form of mental illness at one time or another, the odds are that these problems are going to show up on the job.

And one of the joys of supervision is this: whether an employee is abusing leave, alcohol, drugs, credit or your other workers' patience, you are going to have to cope with the situation.

Coping is part of your job description. An important one of the skills you need to be a supervisor is the ability to focus on troubled employees, discuss the situation with them and refer them somewhere they can get the help they need.

We hope this booklet will help.

No Man Woman Job Problem is an Island

NOTE: In this booklet, the troubled employee is usually referred to as "he." This is for brevity only. All kinds of employees have problems on the job... even supervisors!

Where to Step In

As a general rule,* the only time you have a right to approach an employee who may be having problems of one kind or another is when that trouble interferes with his or her job performance.

Since many of a person's waking hours are spent on the job, the chances are that problems will affect job performance sooner or later. That's when you have not only the authority but the *responsibility* to step in.

The following signs are like the 10% of an iceberg that's above water. What you see is what you deal with.

1. Job performance is down when it had been previously satisfactory, when no change has taken place in the work situation.
2. Deteriorating relationships with other employees—especially a marked change in behavior.
3. Chronic absenteeism or lateness.

The 90% below the surface is not quite so directly your problem. More on that later.

*Exceptions, as you know , prove the rule.
There may be times when an employee whose work record is fine will approach you for assistance. Or you may observe an employee who seems troubled, and be able to steer him toward help before job performance deteriorates How you would handle this kind of motivation would depend on your relationship with the employee, but even in this situation, *DON'T DIAGNOSE. . . REFER.*

Be Ready to Follow Through

Covering up for poor job performance is copping out; it doesn't help your organization and it doesn't help the employee. A worker who senses that you aren't going to lower the boom is extremely unlikely to improve the situation. Once you have observed the warning signals:

1. Contact the person designated by your installation to advise you about employees with problems. (See "Referral," page 5 .) Check with him on your obligations under the negotiated agreement, if one exists. Then, with his assistance, you can proceed.

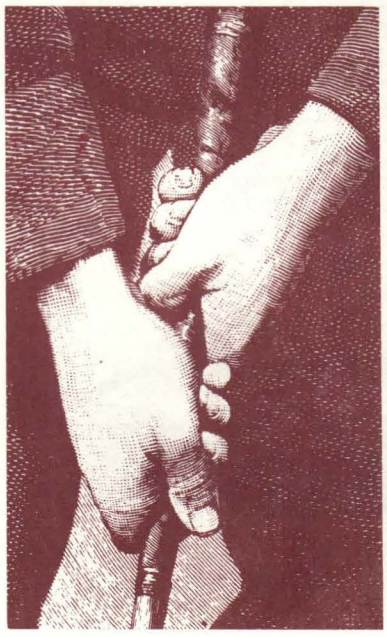
2. Keep a record of the employee's work performance—good points as well as bad. (You should be doing this for all of your employees, anyway.) When you speak with him you can't operate on the basis that you have a "vague feeling" his work is slipping.

3. Don't delay or beat about the bush. An employee has a right to know what you expect of him. And you have a right to expect that an employee will do what he or she was hired to do. The sooner you confront an employee, the sooner he can be given the opportunity for help.

4. Have an informal talk. Tell the employee that his job performance is unsatisfactory, using the documentation you have.
Describe, don't evaluate. For example, you might say, "John (or Jane), I see that you have taken sick leave every Monday for seven weeks," rather than, "John, you must be drinking a lot on week ends to have a hangover every Monday."
Tell him that if he has a health or personal problem which may be causing this poor performance, you can refer him to someone who can help him. Whether he gets help or not is entirely up to him—but with or without help, his job performance must improve or more formal action will have to be taken.

5. Be consistent. Once you have confronted an employee, following through is extremely important. If you say that additional action will be taken unless improvement is made, *it must be taken*. An employee's commitment to help himself hinges very strongly on your commitment to follow through at your end.

6. Don't wait for the last straw; by then you may be too late.



Why This is not a Do-It-Yourself Book

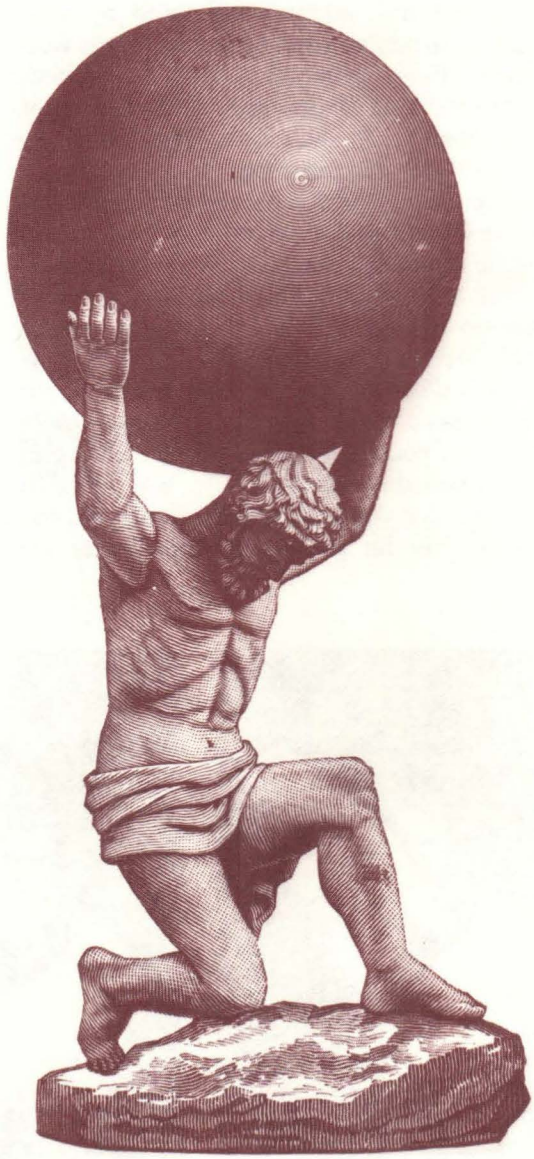
If you haven't been professionally trained to treat the kinds of problems that crop up on the job, you shouldn't try. For unqualified people to try to help seriously troubled employees is at the least a waste of time (both yours and the employee's) and at worst dangerous.

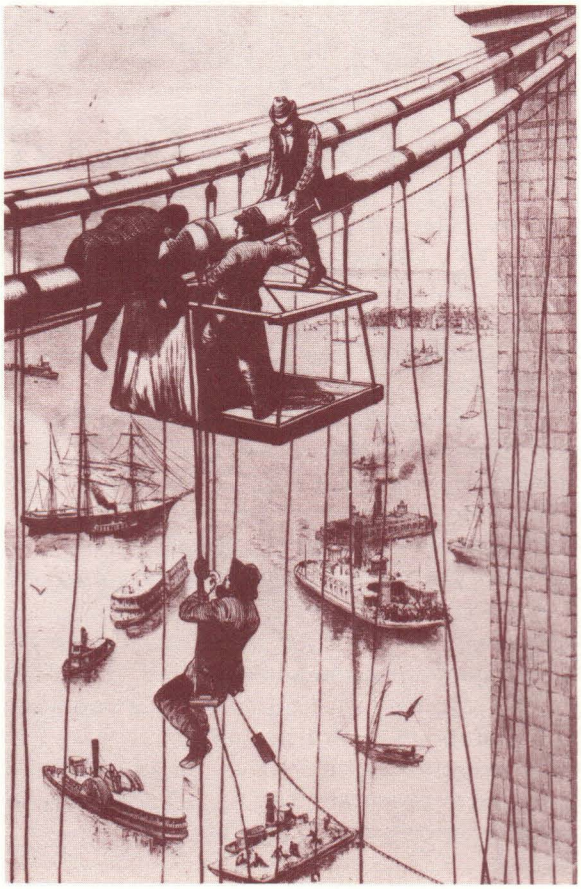
Helping an employee is not so much a question of *being* the right one, but of *finding* the right one to work with the person most effectively.

Following is an example of what can happen when misguided help is offered an employee:

> A Federal employee was becoming a problem on the job and in general seemed to be in trouble. After a discussion with the employee in which the employee revealed that he was in bad financial difficulties, the supervisor loaned the employee money in an attempt to help him get back on his feet. The employee's situation did not improve. At this point a loan was arranged to consolidate the employee's debts and get him off to a fresh start. When even this did not help, it became clear that the problem was not basically financial; the employee was an alcoholic. (It's estimated that about half of employee problems involve alcohol.) By becoming personally involved in a problem he was not equipped to handle, the supervisor not only lost time (and money!) but delayed treatment for the employee in trouble.

Diagnosis is not one of the skills you should be using as a supervisor. What you need is empathy—the ability to put yourself in another's shoes, to see things through that person's eyes, but not to lose your own objectivity.





Referral
The Bridge Over Troubled Waters

If not you, who?

Getting an employee lined up with the right kind of help will involve different routes, depending upon the facilities in the agency where you work.

Federal agencies and departments operate their own programs and services for job-related employee problems. Although all programs are set up under general Office of Personnel Management guidelines, they vary a lot, depending upon agency facilities and priorities. For example, an agency having a large medical unit might have in-house programs for alcoholism education and counseling located in the medical unit; another might have someone designated in the personnel office as a referral point for all types of problems on the job. Still another might have a cooperative arrangement with another agency as a channel to community treatment centers for drug abuse.

Generally, the pattern is this: Your agency will have stated policies for alcoholism, drug abuse, and other problems which cause trouble on the job. There will be someone designated who has access to counseling and treatment resources—either in the agency, a neighboring larger agency, or in the community. That person can help you by providing advice on handling your initial confrontation with a problem employee and by actually referring the employee to a facility where help is available.

An employee who is having problems should be referred to the designated program coordinator. Referral is not a cop-out; it's a question of good management. Look at it this way: any time you need a specialist—whether it's to fix a typewriter, program a computer or paint a corridor—you get one. Helping a troubled employee is one of those times.

Maybe that sounds hard-boiled. But you're an employee yourself. Wouldn't you want the same consideration? Would you want a supervisor to become too involved in your personal life, or would you rather have him refer you where you can get constructive professional help?

Letting professionals do their job is part of your job.

Completing the Circuit

What kind of feedback can you expect, once you've referred an employee for assistance?

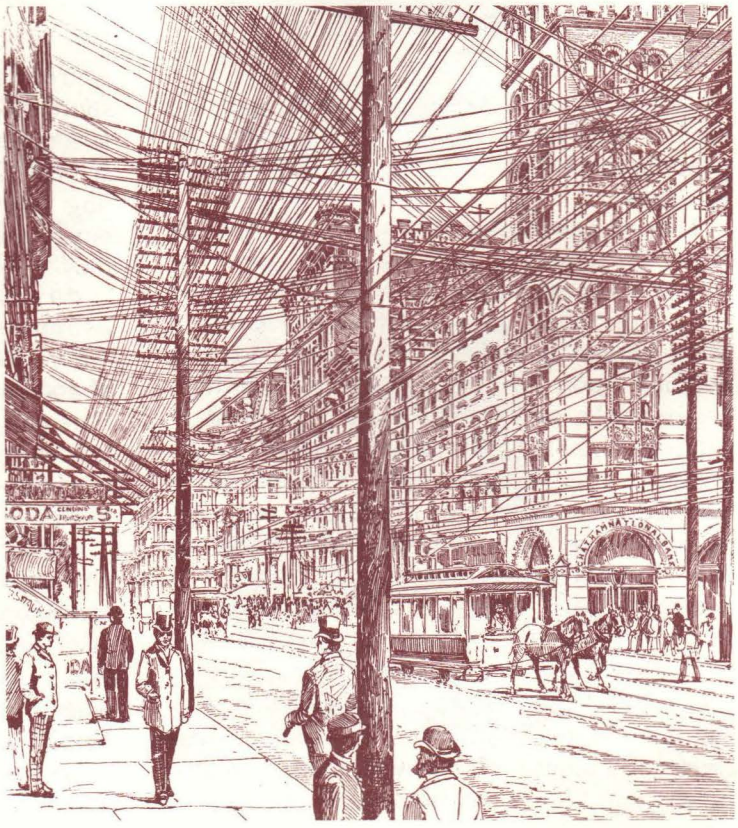
Because the confidentiality between the employee and counselor must be maintained, specific details or a definition of the problem may never reach you. That information is confidential in the same way an employee's medical record is confidential.

However, with the employee's signed consent, you can generally expect answers to the following questions:

Did the employee keep his appointment?
Will additional sessions be needed?
Is the employee cooperating?
What are the prospects for improvement?

While the feedback you get from the counselor will give you a general idea of the kind of progress an employee may be making, your best indicator will always be whether or not the employee's job performance improves. Often, it will. If it doesn't, the decision on when to move into official disciplinary action should be made jointly with the counselor. So keep in touch.

If the employee doesn't give the counselor written consent, the counselor will be unable to release any information about him. In that relatively rare event, you must proceed as if the employee has not tried to get help, basing any decision you make *solely on job performance*. The decision to take administrative action is never an easy one. But sometimes it's necessary. Sometimes the kindest thing to do is to pursue administrative disciplinary action *when it's appropriate*. With some employees, this may be necessary before they fully understand the need to cooperate with the program coordinator or the community resource.



Where to Turn

Meanwhile, back in reality...

Your agency is required to have a designated person or office for counseling and referral services. At this point, these facilities in Federal agencies are at an uneven stage of development, ranging from complete, permanently staffed Employee Assistance Programs to no facilities of any kind.

Where there are agency resources, contacts with community facilities are, usually, well developed. But if your agency doesn't have facilities, or when the designated program coordinator isn't available, you may have to refer an employee directly to a community agency.

If assistance is not available, and you need help, call one of the following for assistance:

1. *Occupational Health Representatives* (OHRs), located at OPM regional offices in the following cities: *Boston* (Maine, New Hampshire, Vermont, Massachusetts, Connecticut, and Rhode Island); *New York* (New York, Puerto Rico, New Jersey, and Virgin Islands); *Philadelphia* (Pennsylvania, Delaware, Maryland, Virginia, and West Virginia); *Atlanta* (North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee, and Kentucky); *Chicago* (Minnesota, Michigan, Wisconsin, Illinois, Indiana, and Ohio); *St. Louis* (Kansas, Missouri, Iowa, and Nebraska); *Denver* (Wyoming, Montana, North Dakota, South Dakota, Colorado, and Utah); *Seattle* (Alaska, Washington, Oregon, and Idaho); *San Francisco* (California, Nevada, Hawaii, and Arizona); *Dallas* (Texas, Arkansas, Louisiana, New Mexico, and Oklahoma).

or (for Washington, D.C. metropolitan area):

2. *Alcoholism and Drug Abuse Program*
   Occupational Health Division, Room 233K
   Office of Personnel Management
   1900 E Street, N.W.
   Washington, D.C. 20415

Back on the Job

When the employee returns to the job, both you and he will share something in common . . . a feeling of apprehension. If the employee has been away for a period of time for intensive treatment, this apprehension may be even greater. You'll probably be concerned about how to "handle" him. Should you be sympathetic and protective? Should you overlook problems and performance deficiencies for awhile?

On the other side of the coin, the employee will probably be experiencing feelings of guilt, low self-esteem, and considerable concern over how others view him.

To smooth the re-entry process, the following suggestions should prove useful:

1. Sympathy and overprotectiveness should play no part in handling the returning employee. He already feels different and such an approach will only intensify those feelings.

2. While, with some employees, there may be significant improvement in performance almost immediately, in other cases the recovery process will be slower and gains less evident. The important thing to note is the general trend of performance.

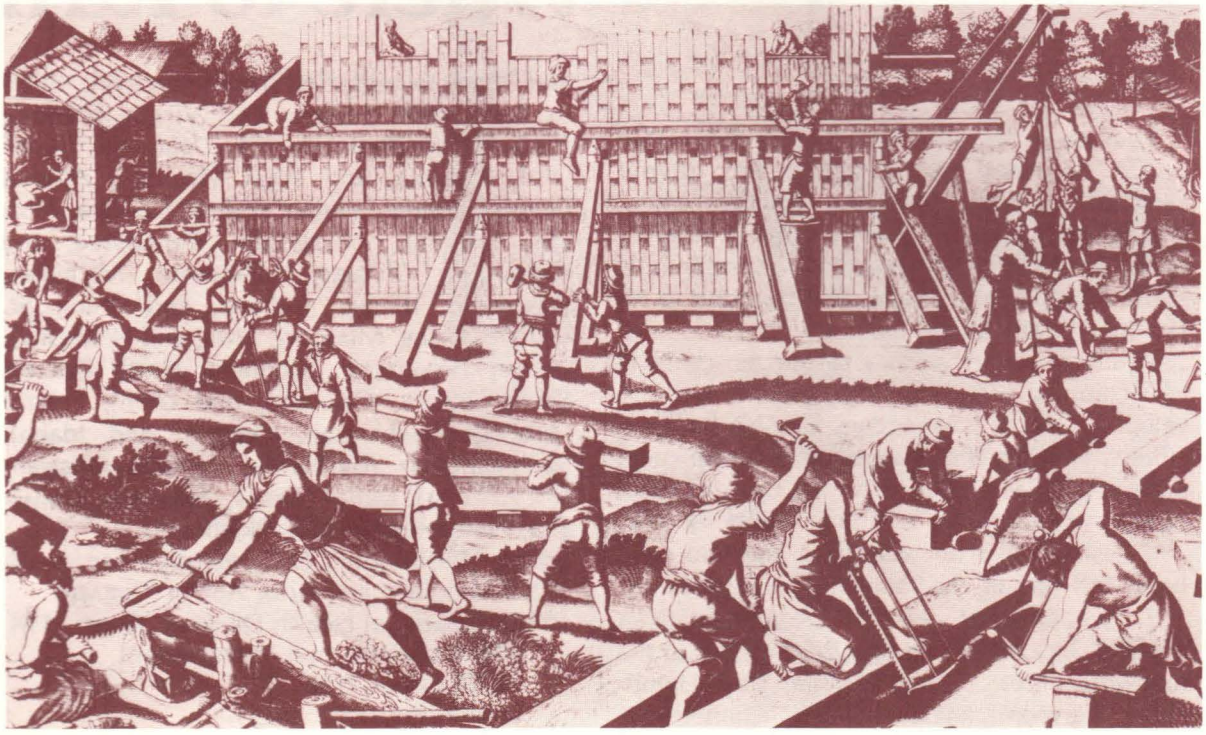
Work toward an "out front" relationship with the employee. Poor performance should not be passed over or ignored, nor should good performance. A word of encouragement when improvement is made can provide strong reinforcement to the recovery process.

3. Be sensitive to changes later on . . . mood swings, difficulty in handling routine situations, lack of interest or a return to old withdrawal patterns. These could be warning signs of a possible relapse. Discuss them with the coordinator or counselor at your installation.

4. A relapse doesn't mean failure. But you need to act quickly and firmly to insure appropriate treatment follow-up.

5. Encourage the employee's involvement in long-term supportive therapy (e.g. Alcoholics Anonymous, group therapy, etc.). Aftercare is an essential ingredient in long-term, stable recovery from alcoholism, drug addiction or emotional illness.

6. Most importantly . . . if you are concerned, talk to someone now . . . the coordinator, counselor or your boss.



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THE WHITE HOUSE

WASHINGTON

August 30, 1986

MEMORANDUM FOR RALPH BLEDSOE

FROM: BOB SWEET, JR. BSR

SUBJECT: Legislative Strategy/Drug Policy

On Friday I met with Sharon Lumpkins and Carlton Turner to discuss the progress of the Working Group report to the DPC and what I could do to assist in preparing a decision memo for DPC discussion on September 8. We agreed that the decision paper should be developed at the same time as the working group report, with our task to identify the critical policy issues that needed the immediate attention of the DPC.

I then called Becky Dunlop in order to determine what the Attorney General wanted the DPC to focus on at the September 8 meeting. She indicated that in her conversation with him on Thursday, that he wanted an update on the Democratic drug package, any administration bill(s), and any Republican initiatives in either the House or Senate. I then spoke with Henry Gandy in Legislative Affairs and set up a 4:30 p.m. meeting on Friday, where Dan Bensing from the Civil Division at Justice, Sharon Lumpkins, Chuck Kubic and I met in Henry's office to compare notes on the current status of the legislative aspects of the drug issue. Henry Gandy welcomed the meeting because he has felt that so many people were involved that it was time to take account of where we are and develop a plan of action. He provided us with an analysis of the House bill and we gave him a summary of the draft legislative package prepared by Justice.

I also spoke with Carol Crawford, Barbara Selfridge, and Jim Muir from OMB to get an update on where the Education Zero Tolerance Act and the law enforcement bill from Justice stood in the clearance process. The education bill has been cleared and the Justice bill is nearly complete as well. OMB has made preliminary cost estimates for the Democratic House bill and although it is a "moving target" the cost would be nearly 2 billion dollars. The Democratic Senate bill would cost nearly 1 billion dollars.

The legislative task force under the Working Group on Drug Policy has combined a number of draft legislative proposals from various agencies and will be submitting an omnibus six title bill to the Working Group on Tuesday. Each title of the bill corresponds to one of the six goals the President announced on August 4.

On the basis of these discussions, Chuck Kubic has prepared a draft options paper for the September 8 DPC meeting. This paper should be presented to Carlton Turner for review prior to the Working Group meeting. This paper could be the action item to be presented to the DPC along with the Working Group Report. The Attorney General wants to have the issue paper by COB Wednesday September 3, 1986 for his review.

The Executive Order

The Justice Department has received a Draft Executive Order from OPM and HHS. Staff is working this weekend to resolve any major differences in order to present a draft to the working group on Tuesday. According to Tom Barba in the Civil Division at Justice, agreement between the three department drafts is virtually assured. The Working Group should reach consensus on Tuesday if at all possible in order to get approval from the DPC on September 8.

The Legislative package

It is Henry Gandy's opinion that a Legislative package should be submitted to the Senate as soon as possible in order to give the Republicans a way to include elements of the President's Drug program in any final legislative drug package produced by Congress. Time is extremely short, and the only vehicle available to us is the Senate. Senator Dole is in the process of preparing a bill on the Drug issue, but is very interested in working with the Administration to come up with a comprehensive plan that is consistent with the Presidents goals and yet does not just throw money at the problem.

The Working Group should review the Justice Department proposal on Tuesday, reach consensus on the elements of the bill, and have the Justice Department submit it to OMB for expedited clearance. If agreement can be reached on Tuesday, it would also be important that appropriate contact be made with Senator Dole's staff as soon as possible on the principle elements of the draft administration bill in order to make sure that any final Senate bill is consistent with the Presidents six goals.

Conclusion

There have been at least 278 bills on the drug issue introduced in Congress this year. Because the issue is moving through Congress at such a rapid rate, it is necessary for the Domestic Policy Council to address the most pressing issues first, and then move deliberately to implement the President's goals for a drug free society. I believe the following decisions need to be made to keep the President in the lead without being pushed by the Congress into a major spending program: