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For Immediate Release

PRESS BRIEFING

June 24, 1982

BY

CARLTON TURNER

CONCERNING THE DRUG ABUSE PROGRAM

The Briefing Room

11:36 A.M. EDT

MR. SPEAKES: The President has finished about a 20 minute meeting with an inter-agency group that will now constitute a new task force on the part of the administration. The meeting the President had emphasizes his attention to the drug problem and a new approach to it through, for the first time, a thorough coordination effort of the federal endeavor to combat drug abuse.

We have with us the person who will head this inter-agency office and it is Dr. Carlton Turner, and you have a biographical sketch of him. So if you can wade through his Mississippi accent I will let him come forward. This is on the record and he will take your questions.

DR. TURNER: Thank you, Larry, Perhaps my accent is a little bit more than yours; I haven't been here as long.

As you know, the President, the Vice President, the First Lady, and other members of the administration just met with heads of 17 agencies with responsibilities in the drug area. And the President charged us with the task of coming up with new approaches, new ideas, a more coordinated approach to solve the problems of drug abuse. The problems of drug abuse, as all of you know, reach the fabric of American life and affect every individual in one way or the other. Probably it can be summarized best by, in the last 20 years the death rate for the young people in this country between 15 and 24 has increased 14 percent. No other age has shown an increase, and this increase has been caused by an increase in the number of accidents, suicidal and homicidal death, but the key thing was that those using drugs had a higher increase than the others.

The President has basically told us that he feels that drug abuse is one of the gravest problems facing this country internally and that we are at the risk of losing a generation if we do not address this issue.

Ninety percent of the illegal drugs we use in this country come in from other countries. It is a problem that we must address down at the local level and we must come up with a program that will have every individual in this country involved. It will have every element, the local, the community, the state, and the national effort involved. To give you a magnitude of the coordination effort, we have nine departments, twenty-nine agencies, and four independent agencies involved in the drug area.

The President, by signing the executive order making me responsible also says that the coordination must be more acute, more well-defined, and more agencies must be brought into play in the drug area than in the previous --

We have addressed this issue and we have looked at the international area, the whole spectrum, and we have looked at five broad areas that would do exactly what the President has asked us to do. And those areas are international initiatives, law enforcement initiatives, research and development, detoxification treatment, education and prevention. And we want to bring every individual in the U.S. into this program. Thank you.

Q Can you tell us what has happened to the budget in the Department of Justice, DEA, and the other agencies since

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administration took office? It is our understanding that the budget for drug enforcement and for some of the other programs has been reduced, not increased, under this administration.

DR. TURNER: It would be presumptive for me to discuss existing budgets. We have nearly \$1 billion in the federal drug program and after the President met this morning I can assure you that the drug issue will have a higher priority in the agencies. We are getting more agencies involved that have never been involved before, and by changing the priorities, getting new agencies involved with better coordinations, we can do much more than we have been within existing resources.

Q Is \$1 billion less than it was?

DR. TURNER: More. \$1 billion is more.

Q More than what?

DR. TURNER: It was approximately \$800 million before. Now we are approaching \$9.5 million -- somewhere in that neighborhood.

Q Are you talking about the difference between FY '82 and FY '83?

DR. TURNER: I am talking about the difference between FY '81 and FY '82. It is premature to talk about FY '83 right now.

Q What about '80?

DR. TURNER: Let me tell you

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in the last five years there has been a steady increase in the enforcement budget.

Q Hasn't there been a decrease -- hasn't there been a decrease in the Justice Department's money for enforcement?

DR. TURNER: In the DEA's budget, there's been an increase. I can't answer the questions on the other individual agencies that may not be involved in the drug issues.

Q DEA's is up?

DR. TURNER: Yes.

Q Dr. Turner, do you agree with the President that marijuana is a real threat, and what are you going to do to curb it?

DR. TURNER: Yes, I agree with the President. I have to worry about 60,000 beds each year for young people under the age of 18 because of marijuana. And it requires approximately 11 and a half months to get these young people off of marijuana. I agree with the President wholeheartedly, but that doesn't mean that we don't have concern about the other drugs. It just means that we must be concerned about all drugs.

Q What are they in the hospital for?

DR. TURNER: In treatment.

Q For marijuana?

DR. TURNER: For problems with marijuana, yes.

Q Such as?

DR. TURNER: Such as the problems that we're getting with marijuana; we get distorted thinking; we get the amotivational syndrome with heavy use; we get problems with learning; we get problems with coordination; we have a series of problems now where the young people cannot cope with the normal procedures of growing up and cope with the problems of drug abuse at the same time.

Q And they're hospitalized --

DR. TURNER: They're in treatment facilities. That doesn't mean that they are hospitalized -- bed facilities. When you look --

Q How many beds?

DR. TURNER: What?

Q How many beds?

DR. TURNER: Approximately 60,000 according to -- survey are required for that treatment. That's been known --

Q That's not beds? I mean, that's not in the sense that we think in beds?

DR. TURNER: Not in the sense of a hospital bed that you put a patient in, no.

Q Are you talking about people then -- 60,000 people?

DR. TURNER: We're talking about people.

Q People. Okay.

Q You say 60,000 beds required. How many in use for that purpose now?

DR. TURNER: I was mistaken when I said the word "bed." We have to worry about treatment for 60,000 young people under the ages of 18 because of marijuana each year. And it is a threat.

Q Under the age of 18?

DR. TURNER: Under the age of 18.

Q Is that an unmet need currently or is that 60,000 --

DR. TURNER: That is the current need, and I think the need is being met. Most of the places -- you've got to look at our treatment facilities in 1968. We had approximately 183 treatment facilities in the United States that dealt with drug abuse. Today we've got over 3,440.

Q Wait a minute. Wait. Go back over what you just said. Slowly please. Say that again.

DR. TURNER: I said that you have to look at the treatment facilities. In 1968, we had 183 treatment facilities in the United States that dealt with drug abuse issues or treatment. Today we have over 3,449 facilities. And certain treatment facilities are expanding to meet the needs in the communities to where they haven't previously been there. I think the need is being met.

Q Is it your view, sir, that marijuana and cocaine use are increasing?

DR. TURNER: Yes, in certain elements of society, but the daily high school -- if you use a daily -- the annual high school senior survey, there is a decrease in marijuana use among those. In 1978, it was one in nine high school seniors. This year it's one in 14 in 1981.

Q What about alcohol though? Is that --

DR. TURNER: Alcohol use -- if you look at the monthly alcohol use, the monthly alcohol use of the young people under 18 stands now at 8.6 million on a monthly basis. And that's 8.6 million young people under 18 on a monthly basis.

Q Using what kind of alcohol?

DR. TURNER: Using alcohol.

Q Do you mean beer or wine or --

DR. TURNER: An alcoholic beverage -- let's put it like that.

Q Is this part of the program -- alcohol?

DR. TURNER: We will address in the Education and Prevention Program the two drugs that are causing the young people the most problem, and that is alcohol and marijuana according to the young people that we've talked to in the treatment facilities.

Q Sir, if there's so much progress being made, why did they up their budget?

DR. TURNER: I'm sorry. Maybe I misunderstood the question. Could you repeat it?

Q You seem to indicate that there's great progress being made. The figures seem to be going down, so why should the budget go up?

DR. TURNER: The figures are going down for daily use of marijuana among high school seniors. That is a fact. There has been an increase in the Drug Enforcement Administration's budget -- that's for Justice for enforcement. That is a fact.

Q May I follow that up, please? What are you doing about educating the youngsters in schools?

DR. TURNER: You're talking to something that's very dear to my heart. We're approaching that from a two-pronged approach: Number one, education; and number two, prevention. We're taking the view that we must educate the parents of this country about drug abuse, and we're having those private sector initiatives -- those agencies of the government to mobilize, to educate the parents -- to get the literature available for the parents. The second -- where the parents can then take an active role in preventing the young people from getting into the drug scene or at least delay their entry into the drug scene.

Q Do we know how to do that? Do you know how to do that?

DR. TURNER: We've learned some things -- very positive. We've seen, since there's been a massive educational program geared around the entry of the drug of marijuana, that more young people are perceiving it as a problem. We've also seen that the average age of heroin addict

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has been going up.

Q Don't you talk too fast.

DR. TURNER: I am sorry. I thought, with a southern accent, I would be talking too slow.

Q No; wrong.

Q Dr. Turner, what effect will this have on the Navy's ongoing drug program?

DR. TURNER: The Navy's ongoing program will continue. It is following the directives of the Navy, and we are working very closely with the people in the military.

Q Will there be any change with the Navy's working with the Coast Guard?

DR. TURNER: I see no change in that.

Q You said that the two most troublesome drugs for the young people, am I correct, are marijuana and alcohol, right?

DR. TURNER: According to the young people.

Q Now then, but you also said that 90 percent of these drugs are coming from other countries. Well, how can that possibly be true? I mean, we are not importing that much Russian vodka, and I think Anheiser Busch --

DR. TURNER: I said illegal drugs coming in from outside the country -- illicit drugs from coming outside the country -- 90 percent.

Q There is one thing I do not understand. On this fact sheet it says by the end of this summer, you are going to announce your strategy. But yet, you laid out these five categories and is that not it. I mean, what more? You seem to know exactly what you are doing.

DR. TURNER: We will have the formal document, which will dictate the ongoing problems and set the program for the future, available by late summer in a publishable form that can be handed out to you. That does not mean that we are not having an active program underway now. We have had an active program underway.

Q So you are really doing now everything you are going to do. You just have not written it down.

DR. TURNER: We are basically doing everything that we think is needed for a comprehensive, well thought out, practical program. And that will be put in the form of writing which will be guiding our policies and our programs long-term.

Q What about the use of other drugs besides marijuana? What are the drugs that are on the increase: cocaine, heroin?

DR. TURNER: Cocaine is on the increase. Amphetamine-like drugs are on the increase, and there is some reported increase in heroin in particular corridors of the U.S.

Q In urban areas; predominantly, the Northeast corridor.

Q What would you say is the administration's number one priority when it comes to this problem?

DR. TURNER: In terms of enforcement, or what?

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Q Overall; I mean, what would you say is going to get the most money, is going to get the most attention, is going to get the most manpower?

DR. TURNER: Our priority is to reduce the flow of drugs coming into this country, at the same time, gear up those initiatives from the private sector that will reduce the demand for drugs by our people.

Q So it is educational?

Q Dr. Turner, are most of these drugs coming in from Florida and southern ports, or just what is the percentage there?

DR. TURNER: The percentage prior to the Vice President's Task Force which the President set up was approximately 80 percent of those drugs were coming through Florida. The Vice President has stated publicly that the flow of cocaine and marijuana coming in through Florida is now down to a trickle. I think we have been very successful. The Vice President's program has shown that good cooperation, good coordination can make a major impact.

Q Where are they coming from now?

Q What about foreign policy initiatives?

Excuse me.

Q Where are they coming from now?

DR. TURNER: Our information says that they are waiting; they are not coming. There has been no data to show that they are coming in other areas.

Q Wait, wait, wait.

Q You say it is a trickle. The problem is not a trickle.

DR. TURNER: I did not say the problem is now a trickle.

Q We only now have about 20 percent, maybe 25 percent of the marijuana and cocaine coming into this country.

DR. TURNER: I said through the Florida area, but there is no known diversion. Drug smuggling takes a trend. Right now, we are not in the trend.

Q -- 80 percent of the marijuana and cocaine coming through the country was coming in through Florida. You said that that drug traffic through Florida has now come down to a trickle.

DR. TURNER: It has now been greatly reduced.

Q To a trickle; to a trickle.

DR. TURNER: Yes.

Q Okay. You are suggesting that the inflow of drugs into the country is now a real trickle. I mean, that -- 20 percent of them, 25 percent, 30 percent, let us say, of the drugs coming into the country that we had before the south port of passage. Is that what you meant to say?

DR. TURNER: In that particular area, yes.

Q How about the country itself?

DR. TURNER: The country?

Q Yes.

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DR. TURNER: I do not have recent figures on that, but if you would like to get them after this, I can get with the agency and get them for you.

Q What I want to know is is it still a big, major problem of the inflow of drugs?

DR. TURNER: We still have a problem with the inflow of drugs in this country. But that problem has been greatly reduced by the Vice President's task force in a coordinated, positive effort in Florida.

Q What countries are mainly sending it in? Is it Venezuela or Bolivia or where?

DR. TURNER: Your countries that were mainly responsible for the drugs coming in through Florida: Columbia, Bolivia, Peru. Your primary source of cocaine, marijuana, and qualudes are also included in Columbia.

Q Is it being stopped at the source?

DR. TURNER: That is our initiative, to stop the drugs at their source before they get into the distribution chain.

Q Well, what about foreign policy initiatives? Previous administrations have had programs in Mexico and programs in Turkey. What does

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this administration plan to do as part of your coordination?

DR. TURNER: We will continue those programs that are on-going in Mexico and in Turkey. And we will explore every avenue to ensure that the proper international agreements are reached to do the same in other producing countries.

Q Can I ask you some -- question about how you've gone about this today? Why didn't you come out and announce this enormous success of the program instead of coming out this other way by saying we've got to have this new program and why wasn't that the first thing you told us? You seem to have stopped the in-flow to a great extent. It seems to me that that's a pretty good --

DR. TURNER: It is a very significant achievement, yes. But we're talking today --

Q Why do we have to drag that out of you?

DR. TURNER: We're talking today about a presidential discussion with the agency heads that not only include the enforcement people but also includes the health people. It includes the prevention and education people to pull this total package together.

Q I'm a little confused as to why you're not sort of bragging about this and making a big deal out of it?

DR. TURNER: I think the Vice President's Task Force -- the Vice President has talked very cognizantly and has done a good job with the task force in communicating that.

Q Do they think they can hold it down now or do they think -- you said it's a trendy --

DR. TURNER: The President said we will keep the pressure on.

Q -- Coast Guard interception? I mean, what is --

DR. TURNER: We have the Coast Guard out in the choke points. You have the Yucatan, the Windward or the Mona Passages. We have Coast Guard cutters out there. And the Coast Guard cutters will stay out there to reduce the flow.

Q But you just cut the budget on the Coast Guard?

DR. TURNER: Not in the enforcement areas. There's been a change on priority in enforcement area.

Q I mean, if their overall budget is cut so that they can't maintain their ships and they can't pay good salaries, I mean, what --

DR. TURNER: If you change -- yes, I feel like that -- if you change the priority and raise the priority -- if you ask the people in the Coast Guard, the efforts in the drug area have received a higher priority -- the efforts in the drug area will continue in the Southeast United States under the Vice President's Task Force which has been very successful in doing what it was set up to do.

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Q Dr. Turner, following up on Lesley's -- if I understand what you're telling us, the Reagan administration is on the verge or is looking to be able to say in some period of time here, "We have dramatically reduced drug use. We've stopped all these drugs from coming in." Are we on the brink of that kind of a breakthrough or are we misreading what you seem to be telling us?

DR. TURNER: What I'm putting forth is that we have a drug -- have a federal drug prevention strategy that includes different elements than in the past. And we are under the pressure from the American people to come up with a positive approach and by uniting all these elements that we have -- by bringing all of these agents together in a coordinated, organized approach, we can have major impact on the drug problem.

Q Can you quantify that in any way? Can we reduce the drug problem to half of what it is today or a third? I mean --

DR. TURNER: There is no way that we can quantify exactly how much you're going to reduce any particular problem when you have such a pervasive one because the drug issue is such that when you control one thing, there may be another drug that will come up.

Q But you must have some target, don't you --

DR. TURNER: Sure, we've got a target, a goal of reducing the supply of drugs coming into the country and at the same time reducing the demand. We intend to follow demand by the things that we have -- the DAW -- the Drug Abuse Warning System, the annual high school senior survey, the annual household survey, and we intend to monitor the others on the amount of seizures and the amount of drugs coming into the country being exported from other countries.

Q How will we know it's a success? What will be the measurement that if somebody from some news organization in this room wanted to measure it a year from now or any period of time that you set, what would constitute a success -- so vague.

DR. TURNER: You would measure the high school senior survey to give you an idea how the Education Prevention Program is going. You would measure the involvement on the public level of initiatives such as you have in certain states now. You would measure it on the number of seizures involved, the number of drug eradication programs in other countries. You would measure it on those ideas. And we can give you a list of those and we'll have those ready the next time we get together.

Q Are there any other problems, related problems, when you cut off the flow, let's say, through the Southeast Corridor. Do you then have an increase in other types of drugs or do you have an increase in violence as the drug market becomes more competitive?

Q Or alcohol abuse?

Q Or do you have an increase in the price of drugs as they become scarcer and therefore more violence and burglaries and that sort of thing?

DR. TURNER: Drug issue is always one of flexibility. When you reduce one drug, there may well be a demand for another and that's the reason our research people, our treatment detoxification people looking at these

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possibilities. That's the reason we're looking at areas of coordination of bringing everyone together where, if we do, we'll be able to control the problem.

Q -- to ask, what have you experienced since you have reduced the flow through Florida? What change in the drug pattern have you experienced elsewhere in the country?

DR. TURNER: I do not know what the trends are elsewhere in the country now. I talked with Admiral Murphy and he has been keeping his fingers on that and so far, there have been no trends of the smuggling nature.

Q Dr. Turner, you seem to be talking largely about enforcement. The NIDA budget hasn't fared very well the last two go arounds. Are you going to change that and get into treatment -- put more money into that?

DR. TURNER: The treatment money is going back to the states. We believe that the states and the local people have the best idea of what they should have. There are different treatment modalities and much of that money is going back to the states and they will handle the distribution of that.

Q So, you're getting out of it, then?

DR. TURNER: We're not getting out of --

Q -- the federal government are, isn't that what you're saying?

DR. TURNER: We're making the monies available to the states that where the state can then choose what modality they want to use. The drug problem in one area of the country will not be the drug problem in another and they can use the money -- if you look at the alcohol, drug abuse, and mental health budgets going back to the states, there's very little there that the states cannot use. In fact, 66 percent of all the treatment facilities now are supported by state and local money rather than federal money.

Q Is it in block grants or earmarked?

Q -- are you going to make it more available? Is the amount still going to go down or are you going to increase the budget?

DR. TURNER: I have not looked at the budget for 1983 but I think the block grant monies are basically the same, is it not Bill?

Q But the money doesn't have to be spent on drug -- if it's in a block grant, the states can spend it any way they want, right?

DR. TURNER: That's right. That's up to the states to make the decision on how they want to spend that money.

Q How does the one billion dollars break down? Can you give us a rough --

DR. TURNER: Obviously, I don't have the one million

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dollar -- or one billion dollar breakdown at my fingertips. But a cross cut of the budgets can be provided.

Q The President seemed to indicate that one of the most serious problems is the drug abuse among school-age children and you say there's going to be -- and perhaps a stepped-up education program. Is there any thought in this new approach -- you emphasize new -- towards screening school children or testing them seeing if they're on drugs?

DR. TURNER: That would be a local initiative and that would be left up to the local people. We have no plans whatsoever at the federal level to be involved in that.

Q I wonder if I could ask a philosophical question? The President became President on the grounds that government tells people how to run their lives too often. Why can't adults use drugs? Why doesn't the President feel that if an adult wants to make a decision on his own or let's say marijuana usage or something like that, that he ought to be allowed to use it? What's the President's thinking on that?

DR. TURNER: You would have to ask the President. I cannot speak for the President there.

Q What is your idea of that?

Q -- his thinking on it.

DR. TURNER: My idea is that this society we live in today has a responsibility and when you have a situation where we have 26,000 people killed on the highway each year because of alcohol, that should give you an answer.

Q Dr. Turner --

DR. TURNER: Yes.

Q -- you said something about the schools. You keep mentioning high school ages. What about the little elementary ones who are getting drawn into this drug program?

DR. TURNER: The average age of first drug use is down to around 13, 13½ years old now. And we will be concentrating on all elements there. They're in the process of being developed -- certain procedures, coloring books, comic books, to educate those young people about the problems of drugs.

Q What have you learned from the Navy's drug policy as far as methods of enforcement and the type of drugs that are being used, the number of people that are using them, and how will that be included in the new program?

DR. TURNER: The Navy and the DOD is evaluating their programs and that evaluation will be a nation-wide evaluation of all the DOD functions and when we get those in, we'll know.

Q Is the percentage of drug abuse in the military down and if so by how much?

DR. TURNER: -- briefing this morning, Dr. John Johns was telling us and I think a copy of his prepared remarks will be there, is that the opiate use is down. Their biggest problem now deals with marijuana and alcohol and they're addressing that issue and that survey this summer, late summer, will tell us whether it's down or up.

THE PRESS: Thank you.

END

12:00 P.M. ED

THE WHITE HOUSE

WASHINGTON

June 25, 1982

AMENDMENT TO THE DATA CONTAINED IN TRANSCRIPT OF PRESS CONFERENCE

BY CARLTON E. TURNER, Thursday, June 24, 1982

REGARDING: BUDGET FIGURES

The following are the official dollar figures for all Federal drug programs:

(Dollars in Millions)

	<u>FY79</u>	<u>FY80</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
FEDERAL DRUG EFFORT	\$885	\$963	\$1015	\$924	\$968

ATTACHMENT to transcript of remarks by Carlton E. Turner, Press Conference, June 24, 1982, White House Press Office.

PREPARED BY:

Drug Abuse Policy Office
The White House
456-6554

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

October 5, 1982

The 1982 Federal Strategy for Prevention of Drug Abuse and Drug Trafficking was today released by Dr. Carlton Turner, Director of the Drug Abuse Policy Office in the White House Office of Policy Development. The 75 page document, one of a series of Federal strategies issued by the White House since 1973, outlines President Reagan's campaign to reduce drug abuse in the United States.

The 1982 Federal Strategy will be vigorously implemented in five major areas:

- o International Cooperation
- o Drug Law Enforcement
- o Drug Abuse Education and Prevention
- o Detoxification and Treatment
- o Research

The Strategy also supports Department of Defense programs to reduce drug abuse among the Armed Forces.

With Dr. Turner in releasing the 1982 Federal Strategy were:

Mr. Rudolph Guiliani, Associate Attorney General.

Dr. William Mayer, Administrator, Alcohol, Drug Abuse and Mental Health Administration.

Mr. Jon Thomas, Deputy Assistant Secretary of State for International Narcotics Matters.

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ACQUIRED IMMUNODEFICIENCY SYNDROME

Relationship Between Intravenous Drug Use and AIDS

The linkage between AIDS and intravenous drug use is clearly established. The human immunodeficiency virus (HIV), the virus that causes AIDS, is transmitted among intravenous drug users primarily through shared use of needles and other paraphernalia used in the injection of drugs.

Intravenous drug users constitute one of the two groups at highest risk for AIDS in the United States. Of the 22,000 cases of adult AIDS reported to date, individuals with a history of intravenous drug use comprise approximately 25 percent. Intravenous drug use is the only risk factor for 17 percent, and an additional 8 percent are homosexual or bisexual males who also admit to intravenous drug use.

There is considerable geographic variability in the extent to which AIDS cases are related to intravenous drug use. For example, over half of all AIDS patients in New Jersey are intravenous drug users, compared with 35 percent of AIDS cases in New York State and 12 percent of AIDS cases in California. Similarly, there is considerable variability in the extent to which intravenous drug users have been infected with the AIDS virus. Research funded by the National Institute on Drug Abuse (NIDA) found that over 50 percent of a sample of opiate addicts in treatment in New York City were positive for HIV. In a study conducted by the National Cancer Institute and NIDA in New Jersey, 56 percent of a sample of addicts in treatment within five miles of lower Manhattan/Jersey City were positive, compared with 2 percent of addicts living more than 100 miles from there. Also, NIDA-funded research in New Orleans found minimal levels of infection.

While rates of infection can be expected to vary geographically due to differences in needle-sharing practices, much of the geographic variation in AIDS and HIV prevalence appears to be related to historical factors--how recently the virus has been introduced into the communities. As more communities are exposed to the virus, rates of infection and disease among intravenous users can be expected to increase across the United States.

How Is AIDS Spread?

The AIDS virus is spread through the exchange of blood, semen, and, perhaps, breast milk. Sexual contact is the primary mode of transmission. HIV infection can be transmitted homosexually between men and heterosexually from men to women and from women to men. In addition to transmission through shared intravenous drug injection equipment, other major modes of transmission include transfusions with contaminated blood or blood products and perinatal infection from mother to child.

While spread of infection among drug users through needle-sharing is one public health issue, also of concern is the transmission of infection from intravenous drug users to the general population. Infected intravenous drug users can transmit AIDS to their sexual partners. Over 75% of the cases of heterosexually transmitted AIDS are sexual partners of intravenous drug users. This potential danger for transmission to the general population is heightened since many female intravenous users are prostitutes. In addition, AIDS can also be transmitted perinatally, and the majority of pediatric AIDS cases involve mothers who are intravenous drug users or whose heterosexual partners use drugs intravenously.

Drugs and Immunity

AIDS is an acquired immunodeficiency disease, and there is evidence linking marijuana, opiates, alcohol, and nitrites with immunity. Also, the rates of non-intravenous drug use (marijuana, alcohol, inhalants) are unusually high among AIDS patients. Whether the relationship between AIDS and the use of various substances is real or spurious is now unclear, and additional research is needed to clarify this issue. Both the possible role of drug use in increasing risk of infection with the AIDS virus and the possible role of drug use in the development of AIDS among infected individuals must be explored. Related to the second point is the possible role of drug use in determining risk for specific AIDS-related diseases. For example, several studies suggest that the inhalant butyl nitrite may be a cofactor in the development of Kaposi's Sarcoma, a cancer associated with AIDS. Whether or not there is a direct relationship between non-intravenous drug use and AIDS, there does appear to be an association between the action of psychoactive drugs as disinhibitors of a constellation of behaviors, including sexual practices, that are particularly dangerous to the individual and might foster the spread of the virus to others.

How can we channel intravenous drug users into treatment?

The importance of treatment to reducing intravenous drug use, and therefore the risk of AIDS transmission is strongly supported by the literature on treatment effectiveness. Three major conclusions emerge from these studies: (1) the majority of addicts in community-based treatment dramatically reduce their drug use after treatment, (2) for those addicts having legal status (charges, parole, probation), both retention in treatment and large reductions in narcotic use are associated with supervision, and (3) retention in treatment beyond 90 days leads to substantially better outcomes.

Many addicts are forced into treatment primarily through the criminal justice system, usually when there is the actual or potential threat of incarceration as an alternative. Examples of such "forcing" are civil commitment, as practiced under the civil commitment provisions of the Narcotic Addict Rehabilitation Act (NARA), diversion into community-based treatment programs through sentencing provisions, and pre-trial diversion

through organized programs--e.g., Treatment Alternative to Street Crime (TASC). Longer treatment tenure has also been shown to produce better treatment outcomes, with 90 days to be the apparent minimum period for substantial benefit from treatment. Thus, while short-term detoxification has some clear utility, clients should be encouraged to remain in treatment at least 90 days. Increasing retention should be considered. In methadone maintenance, for example, individualized dosage is likely to be more useful than a standardized low-dose which is common in many jurisdictions.

Intravenous drug users could be channeled into treatment by: enhancing linkages between probation/parole authorities and drug abuse treatment programs; using some variant of the civil commitment process; expanding treatment in correctional facilities; linking civil advantages to drug-free status; (e.g., fines, suspension of automobile registration) for possession of small quantities; and/or referring drug abusing employees or students into treatment.

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Recommendations of Advisory Panel
on
AIDS and the IV Drug Abuser:
Strategies for Combating the Epidemic

National Institute on Drug Abuse

July 10-11, 1986

The acquired immunodeficiency syndrome (AIDS) is a serious medical disorder caused by the human immunodeficiency virus (HIV). Most individuals infected with the virus are asymptomatic, and infection can only be determined by antibody tests. It is estimated that 20-30 percent of individuals currently infected will develop AIDS within the next five years. While some limited forms of treatment are available for AIDS symptoms, no treatment with proven clinical efficacy is available for the underlying immunodeficiency. Approximately 80 percent of AIDS cases die within two years of diagnosis. Health care costs of persons with AIDS are growing rapidly, and are expected to be between \$8 and \$16 billion in 1991.

AIDS and the virus that causes AIDS have been found in all socioeconomic and racial groups in the world's population. Transmission of the virus is principally by exchange of contaminated blood/blood products during transfusion or intravenous drug use, and by semen during intimate sexual contact. Since intravenous drug abuse is a principal means by which the AIDS virus is transmitted, the National Institute on Drug Abuse (NIDA) has a special responsibility in developing strategies for combating the AIDS epidemic.

To assist the Institute in formulating its AIDS strategy, the advisory panel offers the following consensus recommendations. These recommendations were developed following the guidelines proposed for controlling and preventing the spread of AIDS outlined in the report of the Coolfont Planning Conference ("Public Health Service Plan for the Prevention and Control of AIDS and the AIDS Virus"), held on June 4-6, 1986.

1. As part of its mission to reduce drug abuse and its consequences, NIDA should act decisively to reduce the spread of AIDS associated with intravenous drug use. The primary focus of NIDA's strategy should be on preventing and reducing intravenous drug use and the behavior of intravenous drug users that may result in the spread of the HIV to their sexual partners, offspring, and other drug users.
2. Treatment should be available for every intravenous drug user who desires treatment, and intravenous drug users should be aggressively recruited to enter treatment. Treatment expansion must be provided in areas where treatment capacity is inadequate. Treatment services should be provided in a manner consistent with the goal of effecting changes in intravenous drug-use behavior.
3. Existing treatment modalities, including methadone maintenance, therapeutic communities and drug-free outpatient settings, have proven effective in the treatment of intravenous drug use. These modalities should be further strengthened to enhance their impact in the treatment of intravenous drug use.

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4. Methadone treatment resources should be expanded and more communities should make this treatment available, as there is good evidence that it reduces intravenous opioid use. To encourage greater patient enrollment and retention in treatment, current administrative regulations restricting methadone maintenance and detoxification should be revised.
5. New approaches should be developed for the treatment of intravenous drug use. The effectiveness of a variety of newer treatment approaches currently implemented should be evaluated. These include short-term drug-free residential programs, self-help networks, and aftercare programs. Continued efforts should be made in the development of buprenorphine in the treatment of heroin addiction. The effectiveness of pharmacotherapies for the treatment of non-opioid drug use should also be explored.
6. NIDA should explore ways for coordinating treatment delivery with health, social service, and criminal justice agencies, to facilitate the referral of intravenous drug users from these agencies into drug-abuse treatment.
7. HIV antibody testing should be available to all present and past intravenous drug users who desire it. All testing should be coupled with pre- and post-test counseling, along with guarantees of confidentiality and prompt reporting of results to the individual. In addition, support services should be available within and outside the drug abuse treatment program. Programs have a responsibility to educate intravenous drug users about the role and process of HIV testing. It is recognized that clinical application of HIV antibody testing requires further study.
8. Since the majority of heterosexual and perinatal transmission of HIV in the United States has been associated with intravenous drug users, it is part of NIDA's responsibility to support culturally appropriate education and prevention efforts that are aimed at reducing heterosexual and perinatal transmission of the virus in geographical areas with significant intravenous drug use. This includes direct efforts with persons who do not themselves inject drugs (e.g., spouses and offspring of affected persons).
9. In addition to providing mandatory education about AIDS risk reduction, treatment programs should encourage anyone with a history of intravenous drug use, and anyone likely to become a parent with someone who has a history of intravenous drug use, to be HIV tested. High priority should be given to drug-abuse treatment of intravenous drug-using women. Within drug abuse treatment programs (or other community agencies), family counseling should be available to individuals concerning HIV seropositivity.

10. NIDA should explore the sources of differences in AIDS prevalence among various groups of intravenous drug users.
11. In the development of educational material concerning risk reduction, attention should focus on the relationship between needle-sharing and AIDS, on encouraging intravenous drug users to enter treatment, and on avoiding drug use in general. Each message should be tailored towards the appropriate audience. Regional differences should be considered in the planning of educational campaigns.
12. Since the majority of intravenous drug users will not be in treatment, educational outreach efforts should be directed towards this population. The efforts should include information about HIV transmission, advice to avoid needle sharing, and advice on effective means for sterilizing needles.
13. All of the actions recommended here should be subject to evaluation to determine their effectiveness in reducing HIV transmission among intravenous drug users.

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National Institute on Drug Abuse

AIDS Priorities

Over the past several years, the drug-abuse aspects of AIDS transmission have become painfully clear. One of the principal modes of transmission of the Human Immunodeficiency Virus (HIV) is needle sharing by intravenous drug users. By recent estimates, 25 percent of all AIDS cases involve intravenous drug use, which is the second most common means of transmission of the virus. Drug users may be particularly susceptible to HIV infection, due to the suppressive effects of some abused drugs on the immune system. In addition, intravenous drug users are a special concern for public-health officials, who believe such users are the most likely avenue for spreading the virus into the heterosexual population.

The National Institute on Drug Abuse (NIDA) has a strong commitment to help curb the spread of AIDS among intravenous drug users. Our technical and professional expertise lies primarily in having worked with drug abuse problems for a number of years. As a result, we have amassed a considerable amount of information on the nature of drug problems, the effectiveness of various approaches for treating drug problems, as well as strategies for preventing the development of drug problems. Networks of State and local organizations have been established to provide direct access to drug abusers and to personnel working in the drug-abuse field. Similarly, parents groups and community organizations have been established for the dissemination of drug-abuse information at the grass-roots level.

In curbing the spread of the AIDS virus, NIDA focuses on reducing unsafe injection practices and intravenous drug use as its primary objectives. This will be accomplished by (1) supporting research that will improve efforts at treating and preventing intravenous drug use, (2) expanding the availability of drug abuse outreach and treatment services and to provide HIV antibody testing, and (3) developing educational materials and training programs relevant to AIDS prevention and drug abuse treatment. NIDA will also support research on the clinical epidemiology and natural history of HIV infection and AIDS in intravenous drug users, in their sexual partners, and offspring, and basic research to determine the effects of abused drugs on the immune system.

Specific NIDA initiatives in the AIDS area will include:

- (a) Development of information on unsafe injection practices. Information on risk factors in the spread of HIV infection will be disseminated to intravenous drug users. Information will include the possibility of viral transmission by sharing of needles and other injection paraphernalia, inadequate needle sterilization procedures, etc. Various methods for increasing awareness of these risk factors and for motivating intravenous drug users to change their injection practices will be tested.

- (b) Reducing intravenous drug use. For opiate addicts, methadone maintenance is a highly effective means of reducing intravenous opiate use (and thereby for reducing exposure to a known risk factor for AIDS). However, only a limited number of opiate addicts are enrolled in methadone-maintenance programs and those that are enrolled tend to enter such programs relatively late in their addiction careers. NIDA will seek additional funds for drug abuse treatment in order to expand outreach efforts to encourage intravenous drug users to enter drug abuse treatment. NIDA will also seek additional funds to expand the number of drug abuse treatment slots in order to eliminate waiting lists of intravenous drug users currently seeking treatment and to provide treatment services for those intravenous drug users recruited through outreach activities. Thus, expanding community-based programs to encourage more opiate addicts to enter methadone treatment, and to encourage opiate addicts to enter methadone treatment at an earlier age, will be a primary strategy implemented by NIDA for reducing the spread of AIDS.

Research efforts to improve the effectiveness of drug abuse treatment (e.g., the use of contingency contracting in methadone maintenance and the use of other pharmacological agents such as buprenorphine) will be pursued. Also, since methadone maintenance is not effective in reducing the intravenous use of non-opiate drugs (e.g., cocaine), development of specific treatment strategies for reducing intravenous use of these drugs will be encouraged. In addition to controlled research studies, drug abuse treatment demonstration projects will be undertaken in an effort to evaluate recruitment and treatment strategies on a broader scale and, thus, involve more intravenous drug users in drug abuse treatment, thereby reducing the spread of AIDS.

Other efforts to improve the effectiveness of drug abuse treatment will include participation with the Food and Drug Administration in the review and, where appropriate, revision of methadone maintenance and detoxification regulations. Initiatives will also be undertaken to increase the coordination of drug abuse treatment delivery with other health, social service, and criminal justice agencies to facilitate drug abuse treatment referrals.

- (c) Establishing HIV screening within drug abuse treatment programs. Intravenous drug users should be encouraged to participate in HIV antibody testing so that individuals who are infected with the AIDS virus can take appropriate precautions to prevent further transmission of the virus and can take steps to enhance their own health status. Since intravenous drug users are suspicious of many community agencies, drug abuse treatment programs are appropriate testing sites. NIDA will seek additional funds to establish HIV screening capacity within drug abuse treatment programs in order to encourage intravenous drug users to participate in HIV testing and to provide pre- and post-test counseling to intravenous drug users regarding test interpretation and risk reduction.

- (d) Preventing intravenous drug use. Prevention activities will focus on identifying individuals at high risk for becoming intravenous drug users, and developing educational materials and intervention strategies for halting the progression from initial experimentation to intravenous injection that may occur in drug users.
- (e) Clinical epidemiology of AIDS in intravenous drug users. For at least the next several years, NIDA will monitor HIV seropositivity among intravenous drug users in selected U.S. cities to determine trends in prevalence of the viral infection. Research will also be supported to determine natural history of infection in intravenous drug users, and to identify risk factors for transmission of infection among drug users and from drug users to members of their families and the general population.
- (f) Identification of co-factors to AIDS in drug users. Research will be supported to determine activating factors for AIDS in intravenous drug users who are seropositive for HIV infection. Particular attention will be paid to the effects of drugs on immune function, with special attention given to those drugs that are used in drug abuse treatment, e.g., methadone and buprenorphine. The effects of various drugs of abuse as co-factors among homosexuals will also be explored. Since some drugs of abuse are known to impair immune functioning, it can be hypothesized that users of those drugs may be more susceptible to HIV infection.
- (g) Sexual partners and children of intravenous drug users. Three quarters of cases of heterosexual AIDS transmission are related to intravenous drug use as are approximately two-thirds of the cases of perinatal transmission. Research will be supported to determine the extent of HIV infection among these groups and to explore cofactors related to infection and disease progression. Educational materials and training programs will be developed to focus on heterosexual and perinatal transmission. Research will also evaluate the efficacy of informational/educational strategies targeted toward intravenous drug user's spouses/cohabitants and toward intravenous drug users/spouses who are pregnant or contemplating pregnancy.

WAITING LISTS IN NEW YORK

Treatment programs in many parts of the nation typically operate above their funded capacity; that is they care for more clients in a month than they have been funded to serve. Waiting lists are sometimes maintained and may appear to indicate need for additional treatment capacity. However, it is important to add a cautionary note about what a waiting list may represent. For instance, in New York waiting lists can typically be a measure of the number of persons in a detoxification program who are waiting to enter a long-term rehabilitation program. Since programs providing detoxification services usually provide a relatively short-term service, ranging from 30 to 120 days, their clients may apply to enter a residential program or a methadone maintenance clinic upon completion of detoxification. In these instances the waiting list represents clients wishing to transfer from one clinic to another. Waiting lists maintained in this manner do provide an indication of the relative demand for inter-program transfer, however, may not truly measure the need for treatment in the broadest sense. Perhaps a better measure is the difference between the number of clients in treatment and the estimated number of users of a particular substance in a given location.

In New York, the nation's largest drug abuse treatment system was operating at 105 percent capacity at the end of March according to State officials. The funded capacity in New York is nearly 41,000 treatment slots, and approximately 43,000 clients were reported by New York clinics as active patients in March. Among residential drug free programs, 3,956 clients were reported by clinics with an aggregate funded capacity of 3,837. In methadone maintenance programs with a funded capacity of 26,663, some 28,124 patients were reported to be actively engaged in treatment. In addition to the overcrowding in these two environments, New York residential and methadone programs report that nearly 1500 potential clients are currently waiting to enter treatment. The size of the waiting list in New York pales in comparison to the great disparity between the estimated number of heroin addicts (175,000) and the available treatment slots (30,000).

PUBLIC HEALTH SERVICE PLAN FOR THE
PREVENTION AND CONTROL OF AIDS AND THE AIDS VIRUS

Report of the Coolfont Planning Conference
June 4 to 6, 1986

Foreword

In 1985, the Public Health Service's Executive Task Force on AIDS published a comprehensive plan that included a set of objectives to control and prevent the spread of acquired immune deficiency syndrome by the year 2000. In the year since the plan was developed, considerable progress has been made. Our knowledge base has expanded many fold, and our cumulative 5 years of experience with AIDS and HTLV-III/LAV (HIV)* infection has provided new information that permits tentative long-range demographic projections, a better understanding of pathogenesis, a refined approach to research and development of vaccines and therapeutic agents, a refocus of prevention and control efforts, and the incorporation of patient care issues.

The Public Health Service (PHS) convened a meeting at the Coolfont Conference Center in Berkeley Springs, WV., June 4-6, 1986. Eighty-five experts in various aspects of AIDS, including clinicians, epidemiologists, public health policy makers, and basic research scientists were invited to review and modify the plan according to current information, needs, and demographic projections through 1991. The following plan is the result of that meeting; it represents a renewed commitment by the Public Health Service to prevent and control HTLV-III/LAV infection and its sequelae.

Purpose

This document provides a framework for the steps that must be taken in five broad areas--pathogenesis and clinical manifestations; therapeutics; vaccines; public health control measures; and patient care and health care needs--to achieve prevention and control of AIDS. The current plan is based on estimated changes in the demographics of AIDS through 1991. It calls for concerted action by Federal agencies, State and local health departments, professional organizations, and volunteer groups.

*HTLV-III/LAV = Human T Cell Lymphotropic Virus Type III/Lymphadenopathy Associated Virus. The name human immunodeficiency virus (HIV) has been proposed for these viruses by the International Committee on the Taxonomy of Viruses.

Goals

The following goals were first published in the 1985 plan and remain valid for guiding the continuing National effort.

- o By 1987, reduce the transmission of the HTLV-III/LAV infection.
- o By 1990, reduce increase in the incidence of AIDS.
- o By 2000, eliminate transmission of HTLV-III/LAV infection with a decline in the incidence of AIDS thereafter.

Background

Five years have elapsed since the initial report of Pneumocystis carinii pneumonia from Los Angeles marked the recognition of what has become known as AIDS. By 1984, a human retrovirus, HTLV-III/LAV, had been determined to be the etiologic agent of AIDS and, by early 1985, serologic tests for antibody to the virus were licensed and widely available.

In retrospect, when AIDS was initially reported in June 1981, some 5 years already had elapsed since the introduction of HTLV-III/LAV into the United States, and 3 years had elapsed since the first clinical cases had occurred. AIDS cases have been reported from all 50 States, the District of Columbia, and four Territories. Cases have been reported from more than 100 foreign countries.

The rapid development and implementation of sensitive and specific assays for HTLV-III/LAV antibodies have permitted screening of donated blood and plasma, and the research use of these and other assays has elucidated the modes of transmission, the natural history of infection, and a better understanding of the clinical manifestations of HTLV-III/LAV infection .

The predominant defect in AIDS is a profound and, so far, irreversible immune dysfunction that results when HTLV-III/LAV preferentially infects the helper-inducer subset of T-lymphocytes. Although the virus can also infect other cells of the immune system, as well as cells of the central nervous system, it is the infection of these T-lymphocytes that ultimately leads to a breakdown in the ability of an infected individual to mount an immune response. In the past 5 years, more effective therapies for some of the opportunistic infections that accompany AIDS have been found, but no cure for AIDS is yet available.

Studies of the molecular biology of HTLV-III/LAV have revealed that a copy of the viral genetic material becomes an integral and permanent component of the DNA of an infected individual. As a result, such an individual is likely a carrier of the virus for the rest of his life and, for purposes of public health control, is assumed to be capable of transmitting the virus to others.

The HTLV-III/LAV genome has been completely sequenced and the function of several of its genes are known. Considerable differences in some genes have been found among various isolates. In addition, related viruses have been identified in man and nonhuman primates. These related viruses cause a range of different diseases. Studies in animals indicate the feasibility of vaccination against retroviruses, and one veterinary vaccine is available for the prevention of feline leukemia virus. Although some promising approaches are under way, as yet no effective vaccine for AIDS exists.

HTLV-III/LAV is transmitted by sexual, parenteral, and perinatal contact with the virus. Although this infection has been most often recognized in homosexual men and intravenous (IV) drug abusers, it is clear that this virus does not discriminate by sex, age, race, ethnic group, or sexual orientation. Behaviors which are high risk for the acquisition of HTLV-III/LAV infection include sexual contact or sharing of drug injection equipment with an infected person. Studies now clearly demonstrate that AIDS is not spread by casual contact, such as sneezing, coughing or sharing meals with an AIDS patient.

There are 21,517 cases of AIDS reported in the United States as of June 1986. Blacks and Hispanics represent 39 percent of total cases. Women who report no history of IV drug abuse represent half of the 1400 cases in women. Approximately 304 cases of AIDS occurred in infants and children under age 13. Between 2 and 3 percent of the cases have occurred in transfusion recipients or hemophiliacs. With the routine use of the HTLV-III antibody test to screen donated blood and plasma, use of chemical and heat treated clotting factors, and donor deferral practices, we can expect to see this percentage reduced in future years..

Projected Cases of AIDS*
United States

CATAGORY	1986	1991	1991 Range
<u>Cases Diagnosed</u>			
Cumulative cases at start of year	19,000	196,000	155,000 to 220,000
Diagnosed during year	16,000	74,000	46,000 to 91,000
Alive at start of year	10,000	71,000	50,000 to 83,000
Alive during year	26,000	145,000	96,000 to 180,000
<u>Deaths</u>			
Cumulative deaths at start of year	9,000	125,000	103,000 to 137,000
Deaths during year	9,000	54,000	37,000 to 64,000
Cumulative deaths at end of year	18,000	179,000	142,000 to 201,000
<u>Infections</u>			
Persons with HTLV-III/LAV infection	1,000,000 to 1,500,000 (estimate)		

*These numbers refer only to those cases that meet the CDC definition for AIDS (see Morbidity and Mortality Weekly Report, 1985: 34: 373-5) and do not include other manifestations of infection, such as AIDS-related complex and lymphadenopathy syndrome.

Projections

The following projections, as well as those in the table, are based on the Centers for Disease Control (CDC) surveillance data and epidemiologic studies of populations at high risk to infection with the virus.

- o Twenty to 30 percent of the estimated 1 to 1.5 million Americans infected with HTLV-III/LAV as of June 1986 are projected to develop AIDS by the end of 1991. The latency period between infection and overt AIDS averages 4 or more years in adults, therefore, most persons who will develop AIDS between 1986 and 1991 will be those who are already infected with HTLV-III/LAV.
- o Based on an empirical model that uses reported cases of AIDS, by the end of 1991, the cumulative cases of AIDS in the U.S. meeting the CDC surveillance definition will total more than 270,000. During 1991 alone, more than 145,000 cases of AIDS will require medical care and over 54,000 AIDS patients are predicted to die, bringing the cumulative number of deaths due to AIDS to over 179,000.
- o The empirical model may underestimate by at least 20 percent the serious morbidity and mortality attributable to AIDS, because of underreporting or underascertainment of cases.
- o In 1985, 9,000 cases of AIDS were diagnosed in the United States and reported to the Centers for Disease Control. The empirical model predicts that cases will continue to increase through 1991, that there will be nearly 16,000 cases reported in 1986, and more than 74,000 cases projected for 1991. The estimates for 1991 range from 46,000 to 90,000.
- o More than 70 percent of the cases will be diagnosed among homosexual or bisexual men, and 25 percent of the cases will occur among IV drug abusers with some overlap to continue between the groups. Because the periods between infection and disease are long and variable, cases will continue to be reported among transfusion recipients and persons with hemophilia.
- o Additional cases in heterosexual men and women are projected, the 1,100 (7 percent of the total) for 1986 will increase to nearly 7,000 (more than 9 percent) by 1991. This group includes patients who reported heterosexual contact with an infected person or someone in a risk group, as well as cases in groups in which epidemiologic studies suggest heterosexual transmission as the major risk factor. By 1991, more than 3,000 cases will have been diagnosed in infants and children.

- o Through 1985, fewer than 60 percent of cases were diagnosed in persons outside New York City and San Francisco, but by 1991 more than 80 percent of cases are predicted to be reported from other States and localities.
- o Homosexual-bisexual men and men and women who use drugs of abuse intravenously will continue to be the populations at highest risk for HTLV-III/LAV infection during the next 5 years. Using estimates published by Kinsey, over 2.5 million (4 percent) of U.S. men between 16 and 55 years of age are exclusively homosexual throughout their life; an estimated 5-10 million more will have some homosexual contact. An estimated 750,000 Americans inject heroin or other drugs intravenously at least once a week; a similar number inject drugs less often.
- o The prevalence of HTLV-III/LAV seropositivity among homosexual men and IV drug users parallels the frequency of AIDS in various cities. In 1984-85, 20 to 50 percent of homosexual men participated in research studies had evidence of HTLV-III/LAV infection. Similarly, seroprevalence estimates among IV drug abusers ranged from 10 to more than 50 percent in various U.S. cities. By extrapolating all available data, we estimate that there are approximately 1 to 1.5 million infected persons in those groups at the present. Thus estimates of a 20 to 30 percent progression to AIDS by 1991 in this group are consistent with the total number of AIDS cases predicted by the empirical model.
- o Uninfected homosexual men have continued to acquire HTLV-III/LAV infections during the past year, but at a lower rate than would be predicted from the increases in previous years and from the increase in the number of potentially infectious persons. This observation is consistent with changes reported in sexual behavior and declines in other sexually transmitted infections in homosexual men. Nonetheless, due to the large present and future populations at risk, hundreds of thousands of additional homosexual men, IV drug abusers, and others may become infected during the next 5 years.
- o Because of heat and chemical treatment of clotting factor concentrates, donor deferral, and serologic screening of donated blood and plasma, only a very small number of additional infections are likely to occur through blood and plasma transfusions.

- o Current information is insufficient to predict the future incidence of HTLV-III/LAV infection in heterosexual populations, but increases in heterosexual transmission are likely. Those at highest risk will be heterosexual sexual partners of infected persons and those who have sexual contact with past or present IV drug abusers, bisexual men, prostitutes, or others at increased risk for HTLV-III/LAV infection. As is true for homosexual men, sexual contact with multiple partners will increase one's risk for HTLV-III/LAV infection.
- o Additional increases in HTLV-III/LAV infection in infants are expected as more women in child-bearing years become infected.

The following five sections are the deliberations and recommendations made by the work groups at the Coolfont meeting.

I. PATHOGENESIS AND CLINICAL MANIFESTATIONS

Infection with HTLV-III/LAV results in a broad range of clinical manifestations including an acute retroviral syndrome, asymptomatic disease, chronic lymphadenopathy, and serious diseases including Kaposi's sarcoma and other malignant neoplasms, fatal opportunistic infections, and neurological and psychiatric disorders.

The factors that determine the expression and progression of disease in an individual are largely unknown. Techniques are available to diagnose and treat many of these opportunistic diseases, although they often recur. However, once Kaposi's sarcoma or certain opportunistic infections occur, an ultimately fatal outcome for the patient has been the rule.

Conclusions

Clinical and epidemiologic studies need to be conducted to:

- o Clarify the natural history of infection including the role which may be played by exogenous or endogenous factors in determining which clinical manifestations occur; and
- o Continue to expand the spectrum of clinical manifestations.

Basic scientific studies need to be expanded on the virology and immunopathogenesis of HTLV-III/LAV, especially to:

- o Assess target cell susceptibility;

- o Identify viral and host cell determinants of transmissibility and pathogenicity including portals of viral entry, mechanisms of cytopathic effects, and dysfunction;
- o Further elucidate mechanisms of viral latency and activation;
- o Identify and assess direct and indirect immunopathogenic mechanisms;
- o Further delineate the pathogenesis of neurologic and psychiatric abnormalities; and
- o Ascertain more fully the functions of viral gene products and determine the meaning and mechanisms of genetic heterogeneity.

More suitable animal models for HTLV-III/LAV infection need to be developed to allow more comprehensive understanding of pathogenesis and rapid evaluation of treatment and prophylaxis. Dedicated efforts must be made to maximize efficiency of use of limited animal resources.

Improved methodologies are needed to detect infected and infectious individuals and to identify and quantitate virus, viral antigen, and viral antibody.

II. THERAPEUTICS

No drug with proven clinical efficacy for AIDS is currently known. Both antiviral agents and immunomodulators are being developed, and several drugs are under clinical investigation at present. The ability of an agent to reverse the disease process or halt its progression may vary depending upon the stage of infection. Research is now in progress to develop new methods to inhibit viral replication and correct the immune deficiencies. A safe and effective antiviral agent is not likely to be in general use for the next several years. Experimental products are also under study for treatment of opportunistic infections and neoplasms associated with HTLV-III/LAV infection.

Conclusions

- o Further expansion of the multi-institutional, multidisciplinary approach to identify and develop agents for the treatment and prevention of HTLV-III/LAV

infection and associated diseases, including central nervous system disease, is necessary. Part of this effort must be the establishment of a large capacity screening program to measure the antiviral, immunomodulators and toxic effects of newly identified natural and synthetic compounds.

- o A system for classifying HTLV-III/LAV associated disease manifestations which is useful in the design, implementation and analyses of therapeutic trials must be developed. Standard clinical criteria for the measurement of efficacy and toxicity must be formulated to facilitate the performance of well organized multicenter clinical trials.
- o The most efficient design of clinical trials of candidate antiviral agents will require the use of placebo controls.
- o New therapeutic approaches must be developed to control or eliminate latent virus and to specifically direct antiviral compounds to the appropriate target tissues. Combination strategies to control viral replication and restore the immune system must be developed and evaluated.
- o Since antiviral drugs currently under development are likely to repress rather than eliminate the AIDS virus infection, long-term therapy is expected and with it the emergence of drug-resistant strains.
- o New and/or existing strategies in the diagnosis, treatment, and prophylaxis of the opportunistic infections and neoplasms associated with AIDS all need to be developed, tested, and improved.

III. VACCINES

A number of vaccine candidates for human beings are currently under development and limited clinical testing for some could begin within 2 years. Field trials to demonstrate efficacy may require additional years. Vaccines are not anticipated to be useful in individuals who are already infected. A vaccine for general use is not anticipated before the next decade and its use would not affect the number of persons infected by that time.

Conclusions

- o Vaccines employing recombinant DNA derived antigen, subunit, killed viruses, synthetic peptide, live recombinant, live-attenuated, and antiidiotypes will need to be evaluated as potential candidates for human trials.
- o Vaccination methods will need to be devised to induce immunity to antigenically distinct strains of HTLV-III/LAV.
- o Reliable in vitro and in vivo systems need to be developed for the evaluation of vaccine immunogenicity safety and efficacy before commencing trials in humans.
- o A program for clinical and field evaluation of vaccine(s) needs to be established, including resolution of difficult aspects of design such as identification of target populations and the definition of parameters of vaccine efficacy.
- o Protocols need to be developed for the in vitro and in vivo evaluation of anti-HTLV-III/LAV immunoglobulin to explore its value in passive immunization.

IV. PUBLIC HEALTH CONTROL MEASURES

In the absence of a vaccine and therapy, prevention and control of HTLV-III/LAV infection depends largely upon effective approaches to decrease sexual transmission, transmission among IV drug users, and perinatal transmission from infected mothers. A strategy to control and prevent AIDS should involve voluntary counseling and testing* for persons at increased risk of HTLV-III/LAV infection and imparting to infected patients those Public Health Service recommendations concerning personal behaviors that must be observed if spread of the virus is to be halted.

Public health activities directed toward the control and prevention of AIDS have required significant funding and staffing at national, State, and local levels. The projected increases in AIDS and HTLV-III/LAV infection over the next 5 years will pose substantial continuing demands for resources for these efforts.

*Throughout this section, serological testing is intended to be voluntary, conducted with confidentiality, and accompanied by appropriate pretest and post-test counseling.

Conclusions

The recommendations of the conference participants concerning public health measures focused on five areas.

1. Information Base

- o Information is needed to better determine the size of the population at greatest risk in the United States, particularly the numbers of homosexual men, bisexual men, IV drug abusers, and heterosexuals who have multiple partners.
- o Better information is needed on the number of persons infected with HTLV-III/LAV. Extensive and repeated seroepidemiologic surveys are needed to determine the incidence and prevalence of infection by age, race, ethnicity, sex, geographic area and sexual preference. States should be encouraged to obtain and report data on incidence and prevalence to CDC for publication.
- o The Public Health Service should encourage and assist in the evaluation and comparison of all interventions for prevention and control of AIDS and HTLV-III/LAV infection.
- o PHS should continue to support key epidemiologic studies, such as modes of transmission.
- o The United States should continue to play a role in understanding and assisting efforts to control the disease worldwide, particularly in areas with seemingly different epidemiologic patterns.

2. Information and Education

National information and education campaigns on AIDS and HTLV-III/LAV infection should be targeted to individuals and groups whose behavior places them at high risk for AIDS, other sexually active adults, adolescents, preadolescents, and health care providers. A major target of mass information-education programs is the currently uninfected population, to assure that those persons know how to protect themselves. An additional purpose is to persuade infected persons to take appropriate steps to safeguard their own health and to avoid infecting others.

- o PHS should explore the advantages of using paid radio, TV and printed media advertising as well as public service announcements to inform the public on AIDS and HTLV-III/LAV infection.
- o PHS, State and local health departments, State and local boards of education, colleges, universities, and other organizations should support and encourage comprehensive education about AIDS and HTLV-III/LAV infection.
- o With the assistance of appropriate organizations, programs should be implemented to provide culturally sensitive, meaningful information and education to blacks, and Hispanics including homosexuals, IV drug abusers, blood donors, women both at risk themselves and also at risk for transmitting infection perinatally and other other segments of the public
- o Health care providers need current information and training on the diagnosis, psychosocial counseling and management of HTLV-III/LAV infected persons.

3. Prevention of IV Drug Abuse Transmission

IV drug abusers serve as the major reservoir for transmission of infection to heterosexual adults and their infants, as well as among themselves. As a group, they are not well organized, often poorly educated, and tend to have less interaction with the health care delivery system than other groups who participate in high risk behaviors. Efforts to change drug abuse behavior must proceed with the understanding that addictive behavior is not often changed without specific drug treatment.

- o A systematically increased capacity for treating IV drug abusers is needed. Until adequate capacity is available, persons in need of treatment should be prioritized. Decisions may vary by locality, but highest priority should be given to those presently on waiting lists for treatment.
- o All treatment and prevention approaches should include information and counseling on sexual and perinatal transmission of HTLV-III/LAV, availability of family planning services, and availability of voluntary serological testing for HTLV-III/LAV.

- o Until treatment capacity is adequate for persons who continue to abuse IV drugs, studies are needed to evaluate the efficacy and feasibility of promoting safer use of drug paraphernalia (for example, increased availability of sterile needles or "works") and education regarding use of sterile needles and sharing of needles.

4. Prevention of Sexual Transmission

Sexual contact will remain the primary mode of HTLV-III/LAV infection for the foreseeable future, with greater increase in the proportion of heterosexual transmission over the next 5 years.

A central goal of local disease control programs should be to reach the greatest number of HTLV-III/LAV infected persons with testing and counseling (provision of pretest and post-test information, including psychological support) about their infections and methods to reduce the likelihood of transmission to others, in order to change high risk sexual behaviors). At present, only a small proportion of the already infected population has been reached.

Several methods may help achieve this goal, although they may have differing efficacies in various settings and populations. These include encouragement of voluntary serological screening, self referral of sexual and/or drug abuse contacts, notification and counseling of contacts by health authorities, and targeted educational programs.

- o Serological testing of persons whose behavior places them at risk should be encouraged and made widely available. In all communities, appropriate medical care encompasses offering counseling and testing to all persons at risk, including persons with a sexually transmitted disease, IV drug abusers, and persons seen in private practice who engage in high risk behaviors. (Anonymous testing should be available as an option.)
- o Self-referral of an infected person's sexual and needle-sharing contacts should be encouraged. In some areas or populations, additional contact notification activities may be offered to infected persons by the health agency.
- o Research is needed on the efficacy of counseling and/or knowledge of personal serological status or both in modifying sexual and needle sharing behavior to reduce or eliminate the risk of transmission.

- o For persons who know that they are infected with HTLV-III/LAV yet continue to practice high risk sexual or needle-sharing activities, temporary involuntary isolation should be considered an option only in rare instances and after due process. Enforced isolation is not a practical way to minimize spread of the infection, since infected persons remain infectious for life. Education, counseling, and extension of social services--including drug treatment--are the main interventions for dealing with this problem and are appropriately applied to recalcitrant infected persons and their potential consenting partners. Uninfected persons must avoid behavior which would permit infection from persons who know or do not know they are infected.

5. Prevention of Transmissibility by Blood and Blood Products

The risk of transmission of HTLV-III/LAV by transfusion of blood and blood products is extremely low due to deferral of high risk donors, serological screening of donated blood and plasma, and the heat and chemical treatment of clotting factor concentrates. Nonetheless, some additional measures are appropriate to further reduce this low risk.

- o Increase the effectiveness of deferral by all persons at increased risk of HTLV-III/LAV infection by:
 - Collecting demographic and other data from donors found to have confirmed HTLV-III antibody. This will require some type of case reporting and subsequent interviews, but it is essential to the continued evolution of the high risk donor deferral strategy;
 - Improving communications to potential donors about self-deferral, taking into consideration their language skills and literacy;
 - Exploring the usefulness of providing means at the time of donation for blood donors, who do not self exclude but who have remaining doubts about their suitability, to designate that their donated unit not be used for transfusion.
 - Implementing the use of a signed donor consent form in all blood banks that clearly indicates the absence of specific risk factors for transmission of infections.

- o Continuing to require that blood and plasma establishments maintain deferral lists of donors who have repeatedly reactive ELISA tests.
- o Continuing to encourage development and use of more sensitive serologic tests for HTLV-III/LAV infection.
- o Recommending that current recommendations for HTLV-III antibody testing for donors of organs, tissues, cells and semen be made mandatory.
- o Encouraging increased activities to eliminate unnecessary transfusions.

V. PATIENT CARE AND HEALTH CARE NEEDS

Over the period of 1986 to 1991, AIDS and associated conditions will place an increasing burden on the health care delivery system through an increased number of patients and increased costs of care. The burden will be shared by a larger number of communities, including some which will have a less complete capacity for response. There will be increasing fragmentation and less health care control of services provided if more non-medical, less traditional and some unethical providers become involved.

PHS estimates that the direct health care costs of persons with AIDS will be between \$8 to \$16 billion* in 1991. These sums represents 1.2 to 2.4 percent of the expected total U.S. personal health care expenditures in 1991 of about \$650 billion. Because people with AIDS are concentrated in certain urban centers, however, these costs will be disproportionately borne.

These estimates may be conservative by 10 to 50 percent because of the increase need for care for the large population of patients with the other conditions associated with HTLV-III/LAV infection and the significant non-medical care costs necessary for management of these illnesses. Development of community-based health and social services support systems can reduce costs and enhance care during this five year period.

*The \$8 billion figure is based the projection of 71,000 AIDS patients alive in 1991 and 74,000 new cases by then. An additional 29,000 cases was added to account for the 20 percent underreporting or underascertainment of cases. The cost for treating a patient with AIDS used in the calculation was \$46,000. For the higher range, the \$8 billion figure was doubled.

Conclusions:

- o Develop a coordinated Federal, State, and local response to manage the health services and health financing crisis posed by the escalating AIDS epidemic. This response must reflect the pluralistic character of the American health care system, and must involve the coordinated participation of the public, private and voluntary sectors, as well as ambulatory, in-hospital and long term care providers;
- o Explore the feasibility and need for convening a national, blue-ribbon Commission representing the necessary constituencies to canvass needs and resources available and to make recommendations regarding how each sector of our society can help to fill financing and resource needs;
- o Emphasize the needs of institutional and community-based providers for training, continuing education, and psychosocial support;
- o Upon request, assist State, local governments, and community-based organizations to assess, develop and implement comprehensive service delivery systems of care for AIDS patients in a cost-effective manner;
- o Develop organized consortia of service delivery systems responsive to the care of AIDS patients; such consortia should include all the necessary components of care (that is ambulatory hospital, mental health, and dental health services, counseling, home health care, and hospice care.)
- o Explore efforts to set up regionalized consortia of services for AIDS patients;
- o Utilize studies of the special health services needs and barriers to prevention of HLTV-III/LAV infection in blacks and Hispanics, and best methods of information dissemination to foster inclusion of culturally sensitive service delivery for children with AIDS, IV drugs abusers, hemophiliacs, and minorities in all appropriate metropolitan areas;
- o Initiate demonstrations of the appropriate care needed at different stages of the illness, costs of services, and more cost effective provisions of needed services, including Model Medical Waiver programs;

- o Support health services research on AIDS that emphasizes cost of services for different risk groups, stages of illness, and treatment modalities and assesses potential improvement of methods and increased cost-effectiveness of care.

HHS NEWS

1982 Statement by the
Surgeon General -
Data on Health Consequences
of Marijuana Still Valid

Thursday, August 12, 1982

Statement by
C. Everett Koop, M.D.
Surgeon General of the U.S. Public Health Service

As surgeon general, I urge other physicians and professionals to advise parents and patients about the harmful effects of using marijuana and to urge discontinuation of its use.

The health consequences of marijuana use have been the subject of scientific and public debate for almost 20 years. Based on scientific evidence published to date, the Public Health Service has concluded that marijuana has a broad range of psychological and biological effects, many of which are dangerous and harmful to health.

Marijuana use is a major public health problem in the United States. In the past 20 years, there has been a 30-fold increase in the drug's use among youth. More than a quarter of the American population has used the drug. The age at which people first use marijuana has been getting consistently lower and is now most often in the junior high school years. In 1978, nearly 11 percent of high school seniors used the drug daily; and although this figure declined to 7 percent in 1981, daily use of marijuana is still greater than that of alcohol among this age group. More high school seniors smoke marijuana than smoke cigarettes. The current use (during previous 30 days) of marijuana is 32 percent; 29 percent smoke tobacco.

(More)

On March 24, Secretary Schweiker transmitted to the U.S. Congress a report reviewing the health consequences of marijuana use. Marijuana and Health: 1982, the ninth in a series, is primarily based on two recently-conducted comprehensive scientific reviews on the subject: one by the Institute of Medicine of the National Academy of Sciences and the other by the Canadian Addiction Research Foundation for the World Health Organization. Both independent reviews corroborate the Public Health Service prior findings of health hazards associated with marijuana use: Acute intoxication with marijuana interferes with many aspects of mental functioning and has serious acute effects on perception and skilled performance, such as driving and other complex tasks involving judgement or fine motor skills.

Among the known or suspected chronic effects of marijuana use are:

- o Marijuana impairs short term memory and slows learning;
- o Impaired lung function similar to that found in cigarette smokers. Indications are that more serious effects may ensue following extended use;
- o decreased sperm count and sperm motility;
- o interference with ovulation and prenatal development;
- o possible adverse effects on heart function; and
- o by-products of marijuana remaining in body fat for several weeks with unknown consequences. The storage of these by-products increases the possibilities for chronic effects as well as residual effects on performance even after the acute reaction to the drug has worn off.

I am especially concerned about the long-term developmental effects of marijuana use on children and adolescents, who are particularly vulnerable to the drug's behavioral and physiological

(More)

effects. The "amotivational syndrome" has been attributed by some to prolonged use of marijuana by youth. The syndrome is characterized by a pattern of loss of energy, diminished school performance, harmed parental relationships and other behavioral disruptions. Though more research is required to clarify the course and extent, in recent national surveys up to 40 percent of heavy users report that they observe some or all of these symptoms in themselves.

The Public Health Service review of the health consequences of marijuana supports the major conclusion of the National Academy of Sciences' Institute of Medicine:

What little we know for certain about the effects of marijuana on human health--and all that we have reason to suspect--justifies serious national concern.

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

COCAINE FREEBASE

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

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

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

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

CRACK

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

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

(more)

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

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

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NIDA Capsules

Issued by the Press Office of the National Institute on Drug Abuse
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COCAINE ABUSE

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

DANGERS OF COCAINE ABUSE

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

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

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

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

METHODS OF USE

Cocaine is usually sniffed or "snorted" at doses of 10-40 mg and absorbed through the mucous membranes in the nose. It can also be injected, or after chemical conversion to a purified form known as "freebase," it can be smoked. Of particular concern are recent reports that smoking of cocaine paste is becoming more common among users. Originally noted in a somewhat different form by investigators in South America, this practice, as observed with the refined drug in the United States, increases the pharmacological effect of the drug. Unfortunately, it appears that compulsive cocaine use may develop even more rapidly if the substance is smoked rather than ingested intranasally. Cocaine use ranges from episodic or occasional use to repeated or compulsive use, with a variety of patterns between these extremes.

METHODS OF ACTION

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

(More)

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

EXTENT OF COCAINE USE

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

National Household Survey

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

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

High School Survey

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

Emergency Room and Medical Examiner Mentions

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

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

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adamha update

FACTS AND FIGURES FROM THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

ALCOHOL AND DRUG ABUSE AMONG ADOLESCENTS

- o Approximately 6.2 million young people age 12-17 have used marijuana at some time during their lives; 2.7 million have used marijuana in the last month; 4.8 million have used marijuana in the past year. (1)
- o Nearly two-thirds (61%) of all American high school seniors use an illicit drug at least once before they finish high school; 40% have used drugs in addition to marijuana. (2)
- o Cocaine has been tried by at least 17% of seniors in the Class of 1985--the highest rate observed so far in the National High School Senior Survey. (2)
- o Approximately 80% of 1985 seniors acknowledged the harmful effects of using cocaine regularly (an increase of 10% since 1979); but only about 34% saw much risk in experimenting with it. (2)
- o One out of every 20 high school seniors (4.9%) smokes marijuana on a daily basis. (2)
- o Approximately 30% of high school seniors have smoked cigarettes during the last month, a substantial proportion of whom are daily smokers. (2)
- o About one in 20 seniors (5.0%) drinks alcohol daily.
- o Approximately 92% of all high school seniors have used alcohol; 66% used alcohol in the last month, and 86% used it in the past year. (2)
- o Nearly half (45%) of boys and more than 1/4 (28%) of girls in the 1985 senior class report heavy party drinking (five or more drinks in a row) on at least one occasion in the two weeks prior to the 1985 survey. (2)
- o Motor vehicle accidents involving alcohol are the leading cause of death for young Americans aged 15 to 19, accounting for 45% of fatalities in this age group. (3)
- o Although 16-24 year-olds comprise only 20% of licensed drivers in the U.S. and account for less than 20% of total vehicle miles traveled, they are involved in 42% of all fatal alcohol-related crashes. Close to 8,000 people between 15 and 24 were killed in alcohol-related traffic accidents in 1984, and an additional 220,000 were injured. (4)

No. 1, April 1986

Sources:

(1) National Household Survey of Drug Abuse, 1982, Population Projections, for the National Institute on Drug Abuse

(2) National High School Senior Survey, 1985, for the National Institute on Drug Abuse

(3) Vital Statistics in the U.S., 1980, Vol. II, Mortality, Part A, U.S. Department of Health and Human Services, 1985.

(4) Fatal Accident Reporting System, Department of Transportation, 1984.

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adamha update

FACTS AND FIGURES FROM THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

COCAINE USE IN THE UNITED STATES

- o Approximately 21.6 million Americans have used cocaine at least once in their lives. Four million Americans are "current users," defined as using at least once in the month prior to survey. (1)
- o Among 18-25 year olds, 28% have at least tried the drug. (1)
- o An estimated 60,000 children as young as 12-13 have tried cocaine. (1)
- o Cocaine use by high school seniors reached its highest level ever in 1985 -- with 17% of the students having tried cocaine at some time in their lives, and 6.7% using it within the past 30 days. (2)
- o On the basis of previous high school classes, it is estimated that nearly 40% of 1985 seniors will use cocaine by the time they are 25-26. (2)
- o Cocaine use among high school seniors increased in virtually all subgroups from 1984 to 1985--males and females, college-bound and non-college bound, rural and urban areas, and in all regions of the country except the South. (2)
- o About 80 percent of 1985 seniors acknowledge the harmful effects of using cocaine regularly, but only about one-third see much risk in experimenting with it. (2)
- o 49% of high school seniors reported in the 1985 survey that it would be easy for them to get cocaine. (2)
- o Another study that has tracked 1,325 secondary school students in New York State since 1971, when they were 15-16, found that by age 28-29, 43% of men and 28% of women had used cocaine, making it the second most frequently used drug, after marijuana. (3)
- o Total emergency room cases involving cocaine more than tripled between FY 1981 (3,253) and FY 1985 (9,733) in the 26 major cities that report to the Drug Abuse warning Network. (4)
- o Total deaths involving cocaine almost tripled in 25 cities, from 190 in FY 1981 to 547 in FY 1985. (5)

No. 2, April 1986

FACTS FROM RESEARCH

- o Cocaine is one of the most powerfully addictive drugs known. It works directly on reward centers of the brain, producing an even more compelling need than heroin. (6)
- o Given free access, laboratory rats prefer cocaine to water and food and will continue to self-administer cocaine until it kills them. (6)
- o The most accurate predictor of cocaine use is previous use of other drugs. Among adults 18 or older who have used marijuana 100 or more times, 74 percent have used cocaine. Among those who have never used marijuana, or used only once or twice, only 2.1 percent have used cocaine. (7)
- o A sharp increase has occurred recently in persons seeking treatment for cocaine dependence. More than half of all patients seen in an inner-city Chicago drug abuse treatment program in 1983 had a primary diagnosis of cocaine dependence, compared with 3 percent in 1980 and 36 percent in 1982. "Freebasing," which delivers high concentrations of cocaine into the central nervous system more rapidly than any other method of use, was the most frequently used route of administration in 44 percent of patients. (8)

Sources:

1. National Household Survey of Drug Abuse, 1982, for the National Institute on Drug Abuse (NIDA).
2. National High School Senior Survey, 1985, for NIDA.
3. "Cocaine Use in Young Adulthood: Patterns of Use and Psychosocial Correlates," Denise Kandel, Department of Psychiatry and School of Public Health, Columbia University, New York, N.Y. Presentation at ADAMHA Science Press Seminar, September 18, 1985.
4. Drug Abuse warning Network (DAWN), NIDA.
5. DAWN. (Total does not include New York City, which does not report drug-related deaths to DAWN.)
6. "Neural Mechanisms of the Reinforcing Action of Cocaine," Roy Wise. In: Cocaine: Pharmacology, Effects, and Treatment of Abuse, NIDA Research Monograph 40, 1984.
7. "Prevalence, Patterns, and Consequences of Cocaine Use," Edgar Adams, Joseph Gfroerer, and Ann Blanken. In: Cocaine: A Symposium. C.H. Brink, editor. Wisconsin Institute of Drug Abuse, 1985.
8. "Characteristics of Cocaine Abusers Presenting for Treatment," Sidney Schnoll, Judy Karrigan, Sarah Kitchen, Amin Daghestani, and Thomas Hansen. In: Cocaine Use in America: Epidemiologic and Clinical Perspectives, NIDA Research Monograph 61, 1985.

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adamba update

FACTS AND FIGURES FROM THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

ESTIMATED COSTS TO U.S. SOCIETY IN 1983
OF ALCOHOL ABUSE, DRUG ABUSE, AND MENTAL ILLNESS
(In millions)

<u>Core Costs</u>	<u>Alcohol Abuse</u>	<u>Drug Abuse</u>	<u>Mental Illness</u>	<u>Total</u>
Direct				
Treatment and Support	\$14,865	\$ 2,049	\$33,445	\$50,359
Indirect				
Mortality	18,151	2,486	9,036	29,673
Reduced Productivity	65,582	33,346	4,048	102,976
Lost Employment	5,323	405	24,044	29,772
Related Costs				
Direct				
Motor Vehicle Crashes	2,667	(1)	-	2,667
Crime	2,607	6,565	966	10,139
Social welfare	49	3	259	311
Other	3,673	677	831	5,181
Indirect				
Victims of Crime	192	945	-	1,137
Crime Careers	0	10,846	-	10,846
Incarceration	2,979	2,425	146	5,549
Motor Vehicle Crash (time loss)	583	(1)	-	583
Total(2)	\$116,674	\$59,747	\$72,775	\$249,196

Totals may not add due to rounding.

Source: "Economic Costs to Society of Alcohol and Drug Abuse, and Mental Illness," study for the Alcohol, Drug Abuse, and Mental Health Administration by Research Triangle Institute, Chapel Hill, North Carolina, 1984

For Further Information: Alcohol, Drug Abuse,
and Mental Health Administration, (301) 443-3783

Footnotes on reverse.

No. 3, April 1986

FOOTNOTES

(1) Costs are hypothesized to occur in this category, but sufficient data are not available to develop a reliable estimate.

(2) Total costs to society for the three ADM disorders are not comparable, since completeness of data available for each cost category varies significantly, e.g. the estimate of reduced productivity is relatively complete for alcohol abuse, only partially complete for drug abuse, and incomplete for mental illness.

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M

Department of Labor Initiative

- Met with Secretary William E. Brock 9/17/85
- Met with Assistant Secretary John A. Pendergrass of Occupational Safety and Health Administration
- Met with Ray Andrus and Frank Emig AFL/CIO 4/24/86
- Met with Dr. Ralph Yodiaken 5/28/86
- Met with Dr. James Weeks, United Mine Workers of America 2/10/86