A PROFILE OF DRUG ABUSE IN THE UNITED STATES

VOLUME II

Prepared by

Engineer Strategic Studies Group
Office, Chief of Engineers
Department of the Army

May 1972

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ANNEX A

DRUGS MOST COMMONLY ABUSED

I. NARCOTICS

1. General.

a. The term narcotic refers, generally, to opium and pain-killing drugs made from opium, such as heroin, morphine, paregoric, and codeine. These drugs are distilled from the juice of the base of the poppy flower and are among the most valuable drugs available to physicians. They are widely used for short-term acute pain resulting from such causes as surgery, fractures, and burns; they also are used to reduce suffering in the latter stages of terminal illness. In fact, morphine is the standard of pain relief by which all other drugs are evaluated. These drugs depress the central nervous system to produce

a marked reduction in sensitivity to pain, create drowsiness, induce sleep, and reduce physical activity.

b. The opium poppy grows in sections of Mexico and in the Near and Far East. Cultivators process poppy juices into crude opium. It can be prepared for smoking or further refined to a morphine base. Clandestine laboratory operators process the base drug to make morphine, codeine, or heroin for the United States market.

c. Manufacture and distribution of medicinal opiates are stringently controlled by the Federal Government through laws designed to keep these products available only for legitimate medical use. Those who distribute these drugs are registered with Federal authorities and must comply with specific recordkeeping and drug security requirements. Other drugs, pharmacologically entirely different from the opium derivatives, also have been included under the Federal law as narcotics. Most notable is cocaine, which is a derivative of the coca leaf and medically is not classified as a narcotic but as a stimulant to the central nervous system. Also, certain specially defined synthetic drugs, called "opiates," are classified as narcotic drugs under the Federal law.

2. Heroin. Heroin is the most popular narcotic drug of abuse because it causes intense, long-lasting euphoria. It is commonly known as "H," "junk," "skag," and "smack." It is synthesized from morphine and nearly 10 times as potent but has no legitimate use in the US.

Heroin in the form of a powder is usually melted into a liquid solution and injected into a vein; this is called "mainlining." Other methods of administration are oral, inhalation ("snorting"), and subcutaneous ("skin popping"), but "mainlining" gives the most pronounced and rapid effect. This is especially necessary in the United States because most heroin is of low quality, only about 5 percent pure. A new method of abuse has been the smoking of very high-grade heroin (practiced primarily by US troops in South Vietnam). The addiction potential is as great as mainlining because the drug is 90-95 percent pure, but euphoric effects occur less rapidly. Heroin depresses certain areas of the brain, and may reduce hunger, thirst, and the sex drive. The first emotional reaction is an easing of fears and relief from worry, followed, in cases of larger doses, by a state of inactivity bordering on stupor. Repeated use of heroin decreases the euphoric effect on the user, necessitating an ever-increasing dosage to achieve desired results. This is known as increased tolerance.

3. Morphine. Morphine (a substance obtained by refining crude opium) is used to relieve pain, and is second only to heroin as the narcotic of abuse. It is widely used by addicts, particularly when heroin is difficult to obtain. It is popularly known as "M," "white stuff," and "miss emma." Euphoria can be produced with small doses and tolerance builds rapidly. It is usually "mainlined" but can be taken orally. It takes large oral dosages to achieve a euphoria

equivalent to a mainlined dosage. Morphine is generally diverted from legitimate stocks and occurs in white powder, tablet, or liquid form, and (infrequently) in cubes.

4. Codeine. Codeine (a substance derived from pure opium) appears in white powder, tablet, or solution form. Codeine is often prescribed to relieve pain and is most commonly abused in the form of exempt narcotic cough preparations. It is commonly known as "schoolboy." Occasionally the pure drug is abused. It is less addictive than morphine or heroin and less potent in terms of inducing euphoria.

5. Cocaine. The coca bush grows in the Andes Mountains of South America. Farmers process its leaves into coca paste, then cocaine. Although classified by many laws as a narcotic, pharmacologically it stimulates the central nervous system rather than depresses as narcotics do. Cocaine is a white or colorless crystalline powder which is abused by inhalation or injection. It is commonly known as "snow," "C," or "happy dust." It can induce euphoria, excitation, anxiety, a sense of increased muscular strength, talkativeness, and a reduction in the feeling of fatigue. It is not physically addictive, but a psychological dependence can develop. In large doses, cocaine can produce hallucinations and paranoid delusions. Because of the intense stimulation received from this drug, most abusers voluntarily seek sedation, sometimes combining depressant drugs with cocaine. In cases of overdose as

a result of combining drugs, breathing and heart functions may become so depressed that death results.

6. Hydrocodone (Dihydrocodeinone). This drug was fairly popular when classed as an exempt preparation. However, since its classification as a narcotic, little effort has been expended in obtaining it in any great quantity. The drug is a codeine derivative and is used as an analgesic and cough sedative. It is abused primarily from narcotic cough preparations.

7. Pentazocine. Pentazocine is a recently developed analgesic originally thought to be as effective as morphine but without producing tolerance and being nonaddictive. Marketed under the trade name of Talwin, it has come under serious criticism because experiments at Federal research centers indicate that pentazocine produces a euphoric effect and a physical dependence. At the present time the drug is readily available and there are not sufficient controls regulating its distribution.

8. Hydromorphone (Dihydromorphinone). Hydromorphone, a semi-synthetic drug, is made from an opium extract through a chemical process. It is known as "Dilaudid" or "lords." Like morphine, it is an alternative to heroin and is usually injected but may be taken orally. Although almost as potent as heroin, it does not induce as intense a euphoria as that associated with mainlining heroin.

9. Meperidine. Meperidine was the first synthetic narcotic created and was claimed to be without addicting potential when first produced. Experience, however, has proved otherwise; however, it is slower to develop and less intense than morphine. The drug is used in Demerol and has a use as an analgesic and sedative. It may be taken orally or through injection and is commonly referred to as "Demorol" or "pethidine." Because of its easy accessibility, it is used excessively by many in the medical profession.

10. Oxycodone (Dihydrohydroxycodeinone). This substance, a morphine derivative, has recently been classified as a drug with high addiction potential. Although it is effective orally, most addicts dissolve tablets in water, filter out the insoluble binders, and "mainline" the active drug.

11. Exempt Narcotics. Under Federal law, some preparations containing small amounts of narcotic drugs may be sold in limited quantities without a prescription. Pharmacists selling exempt preparations must have a Federal narcotics stamp. The best known of these exempt narcotics are paregoric and certain cough mixtures. These are commonly known as "P.O.," "blue velvet," or "licorice." Paregoric is a liquid preparation which contains an opium extract and is used primarily to counteract diarrhea. Exempt cough mixtures containing codeine are useful in suppressing irritation or uncontrollable cough in certain upper respiratory infections. When used as directed, they are reasonably

safe and free from addiction potential. However, young people frequently abuse exempt narcotics and addicts may use them as substitutes when more potent drugs are not available. This latter abuse is done by boiling off the alcohol, filtering the impurities, and injecting the opium base.

12. Narcotic Substitutes.

a. Methadone. Methadone is a synthetic narcotic currently used as a clinical treatment for heroin addiction. Like heroin, it induces a tolerance and is highly addictive. It is known to abusers as "dollies" or "amidone" and can be injected intravenously or taken orally in liquid or tablet form. Methadone produces euphoria similar to heroin in nontolerant individuals; overdoses can cause death. When used in methadone maintenance programs, the methadone dosage starts low, is increased to the addict's level of tolerance, and is continued indefinitely. Once the tolerance is developed, the drug does not mask pain or cause drowsiness and permits the user to function in a relatively normal manner.

b. L-alpha-acetyl-methadol. This is an experimental substitute that appears as effective as methadone and is longer lasting. It can be used separately or in conjunction with methadone.

13. Narcotic Antagonists. Narcotic antagonists are drugs which are used in narcotic treatment programs to block the heroin "high." These drugs are not subject to abuse since they do not provide "mind-altering" effects. Cyclazocine, nalorphine, and naloxone are the most

notable drugs in this class. Cyclazocine and nalorphine are respiratory depressants and powerful analgesics. They are believed nonaddictive and can be administered orally or by injection. However, they do possess some undesirable side effects such as respiratory depression and hallucinations in some cases. The blockage effect lasts 20-26 hours per dosage. Naloxone is a pure antagonist without undesirable side effects; however, it is short acting (2,500 milligrams orally to equal 5 milligrams of cyclazocine for a 24-hour period). Some other experimental antagonists are EN-1639A (more potent than cyclazocine and longer lasting than naloxone) and M-5050 (it has been shown in animal studies to be 8-16 times more effective than naloxone). A fully safe and effective antagonist, however, has not yet been developed.

II. MARIJUANA

14. Marijuana. (Marijuana technically is classified as a hallucinogen but is sufficiently different from most hallucinogens to be listed separately.) All marijuana comes from the Cannabis sativa L. plant which is more frequently called Cannabis indica, hemp, or Indian hemp. The plant grows in mild climates throughout the world, especially Mexico, Africa, India, and the Middle East. It is commonly known as "grass," "pot," "tea," "hemp," "dope," or "mary jane." The drug is made by crushing or chopping the dried leaves and flowers into small pieces. Bulk quantities are in brick form, with large pieces of marijuana twigs,

stocks, leaves, and seeds compressed into blocks (called "kilos") measuring about 5 x 2½ x 12 inches and weighing 1 kilogram. Sometimes a finely processed veneer covers a coarse brick core. Processed marijuana is known as "manicured marijuana," and is a finely ground green product that looks much like coarsely ground oregano or, when less finely processed, thyme. It is generally packaged in match boxes, plastic bags, tins, and other small containers for retail sale. Cigarettes, generally shorter and smaller in diameter than the commercial type, usually contain manicured marijuana.

15. Hashish. Hashish is a more potent form of marijuana which is made from the cannabis plant resin (called "charas") or made from the dried flowering tops of the female cannabis plant (called "ganja"). In bulk quantities, hashish usually is packaged in the form of a light green-brown, dark brown, or black oblong, flat cake from 1/4 to 3/4 inches thick. These loaves or "soles" are broken into small irregular "cubes" or "chunks" and sold by the gram. This retail form of hashish appears as a pliable, gummy material which is usually mixed with tobacco before it is smoked because of its potency.

16. Potency. The potency of the cannabis plant ranges from the limited effects of poorly harvested marijuana to the more potent hashish. Its strength differs from place to place, depending on where it is grown, how it is grown, how it is prepared for use, and how it is stored. Marijuana grown in the United States is much weaker and far less popular

than that grown in Mexico. In 1966, the active ingredient of marijuana, tetrahydrocannabinol (THC) was synthesized. The amount of this chemical in the drug determines its strength. Although various substances called THC have been sold illegally, the high cost and difficulty of producing the material make it very unlikely that it is actually available illictly. Based on chemical analysis, no samples of THC purchased on the black market to date have proved to be THC.

17. Effects. When smoked, marijuana quickly enters the bloodstream and acts on the brain and nervous system. It affects the user's mood and thinking, but medical science still has not discovered just how the drug works in the body, what pathway it takes to the brain, and how it produces its effects. Some scientists report that the drug accumulates in the liver. Its effects on the emotions and senses vary widely, depending on the user's expectations, the circumstances of use, and the strength and quantity of the drug used. Time typically is distorted and seems much extended--5 minutes may seem like an hour; space may seem enlarged or otherwise distorted; sounds and colors sometimes seem intensified; thought frequently becomes dreamlike and the notion that one is thinking better is not unusual. Illusions (misinterpretation of sensations) are often reported, while hallucinations (experiencing nonexisting sensations) and delusions (false beliefs) are rare. Frequently, the user undergoes a kind of passive withdrawal accompanied by some degree of "high." Occasionally, uncontrollable laughter or crying may occur.

Despite several thousand years of use, less is presently known about the mode of action of this drug than is known about most other drugs in widespread use. It is only in the last few years that the synthesis of THC and the development of methods to assay THC in marijuana have made precise experiments possible.

III. STIMULANTS

18. General.

a. Stimulants are a group of drugs which directly stimulate the central nervous system. The most widely known stimulant in this country is caffeine--an ingredient of coffee, tea, and other beverages. Since its effects are mild, it is socially acceptable and is not an abuse problem. Synthetic stimulants, such as amphetamines, methamphetamine, and other closely related drugs are more potent and can be abused. These stimulants produce excitation, increased activity, an ability to go without sleep for extended periods of time, and reduced appetite. Amphetamines in moderate dosage (5-10 milligrams) are capable of rendering most individuals more alert, more wakeful (often to the point of insomnia), and less aware of fatigue and hunger. The greatest use in the US today appears to be by truck drivers, students, and housewives. However, the use of amphetamines in athletics is probably more widespread than is generally admitted, and studies have concluded that amphetamines are capable of driving trained athletes to increased performance in individual athletic events.

b. Abusers tend to become accident prone. They are especially dangerous on the highway because the drug effects mask fatigue and abusers exceed their physical endurance without realizing it. A principal hazard of general use of these drugs by self-administration lies in the fact that the user is rarely capable of evaluating his performance and is likely to overmedicate, leading to abuse by unstable individuals.

19. Cocaine. Cocaine is a stimulant federally classified as a narcotic. (See section of Narcotics.)

20. Amphetamines.

a. Ampetamines are the most widely known and frequently abused stimulants. They are commonly known as "bennies," "roses," "hearts," "greenies," and "cartwheels." Scientists have found that in the body, these drugs stimulate the release of norepinephrine (a substance stored in nerve endings) and concentrate it in the higher centers of the brain. This speeds up the action of the heart and the metabolic process through which the body converts food into the chemicals it needs. Thus, the body is in a general state of stress. Amphetamines artificially intensify and prolong such stimulation, keeping the body in a state of tension for prolonged periods of time. When properly prescribed by a physician, moderate doses can check fatigue and produce feelings of alertness, self-confidence, and well-being. In some people, this is followed by a letdown feeling or depression hangover. The drugs are normally prescribed for overweight patients to reduce their appetites,

for narcolepsy (a disorder characterized by an overwhelming need for sleep), for Parkinson's disease, and for minor mental depression.

b. Because tolerance increases rapidly, amphetamines require higher and higher doses to obtain the desired effect. Heavily increased dosages wildly exaggerate normal effects and result in excitability, talkativeness, tremor of the hands, enlarged pupils, and heavy perspiration. In serious cases, a drug psychosis resembling schizophrenia develops with delusions and hallucinations, both auditory and visual. These effects are particularly dangerous for long-distance drivers, since many take amphetamines to avoid the need for sleep and become unaware of their fatigue. Criminals often use amphetamines to increase their courage and alertness. If use continues for a few weeks, a person can become psychologically dependent on the drug though physical dependence usually does not occur. The sense of power, self-confidence, and exhilaration artificially created by amphetamine use is so pleasant, and the fatigue and depression that follow discontinuance are so severe, that the user is tempted to remain on the drug.

c. Illicit amphetamines appear most frequently in tablet and capsule form, but occasionally as powder or liquid. Amphetamine capsules may be a solid color, but are most often clear, filled with powder or multicolored time-disintegration beads.

21. Methamphetamine. Methamphetamine is chemically related to amphetamines, but it has more central nervous system activity and

correspondingly less effect on blood pressure and heart rate than amphetamines. The abuse of methamphetamine, which is often called "speed," "crystals," or "meth," is becoming more widespread. Many abusers mainline methamphetamine and eventually build up their intake to more than 100 times the normal medical dose. Frequently, abusers at this intake level are in an acute toxic state. The acute toxic effects of methamphetamine are manifested by increased physical activity, but without the necessary judgment and consideration that should accompany this increase. Loss of weight and social deterioration occur with heavy users. They tend to become impulsive, irritable, unreliable, and unstable. Behavior may become assaultive and unpredictable. "Speed-freaks" invariably become suspicious of those around them; in extreme cases they suffer from paranoid delusions. Schizophrenia-like disturbances resulting from prolonged, heavy use may last for several months after the drugs are discontinued. The depression into which methamphetamine abusers fall when they come down from their high ("crash") is extremely severe. Suicide during such moods is known. Lethargy, fatigue, muscle pains, ravenous hunger, and mental depression are the chief symptoms when the drugs are discontinued. Some scientists regard these as stimulant withdrawal symptoms indicating a true physical dependence. Methamphetamine appears in powder, tablets, or solution form for injection.

22. Phenmetrazine.

a. Phenmetrazine is similar in many aspects to amphetamines. Although it belongs to the same drug group, there are some important differences in its pharmacology. The toxicity of phenmetrazine is one-fourth that of amphetamines, and the central nervous system effect is seven to 10 times weaker. However, those who use both drugs prefer phenmetrazine because of the belief that it is more euphoric and has fewer side effects. The ordinary dosage recommended, when phenmetrazine is taken as an appetite-reducing drug, is one 25-milligram tablet, twice a day. Addicts often take 20-30 tablets at one time and repeat the dose in a few hours. Daily doses of 300-400 tablets have been reported. In mild intoxication, wide pupils, a quick, well-filled pulse, and lively motor activity are present; but, users are seldom aggressive. In greater intoxication, movements of the face are exaggerated and somewhat uncoordinated.

b. The main symptoms consist of strong paranoid ideas, auditory hallucinations, and intense anxiety often mounting to fear of being murdered. Visual hallucinations do not occur or are rare, but paranoid illusions are very frequent. Criminals that are psychotic from phenmetrazine commonly see policemen and detectives everywhere (called "police-paranoia" among addicts). Sometimes these psychotic episodes lead to dangerous situations because of the defensive actions of the patients. Another symptom is loss of orientation even in familiar

surroundings. Also, many addicts develop a "neatness mania." They take things out of drawers and wardrobes and may work for hours or days without really getting anything in order.

IV. DEPRESSANTS (SEDATIVES-HYPNOTICS)

23. General.

a. Depressants belong to a large family of drugs manufactured for medical purposes to relax the central nervous system. They are found in capsules, tablets, and solutions. They are not readily identifiable in tablet form since they come in a variety of shapes, tastes, and sizes. The best known depressants are the barbiturates which are made from barbituric acid. Barbiturates depress the central nervous system and are prescribed in small doses to induce sleep. They are also valuable in cases of acute anxiety, hyperthyroidism, and high blood pressure. Due to their sedative but nonanalgesic effects, barbiturates are used to treat both physical and mental illnesses. In higher doses, the effects resemble drunkenness: confusion, slurred speech, and staggering. The ability to think, to concentrate, and to work is impaired; and, emotional control is weakened. Users may become irritable, angry, combative, and finally may fall into deep sleep. Barbiturates slow down reactions and responses and are an important cause of automobile accidents, especially in concert with alcohol since they tend to heighten the alcoholic effects.

b. Although physical dependence does not develop with the dosages normally used in medical practice, it does occur with the excessive doses used by drug abusers. A tolerance is also developed. Withdrawal from heavy use can be exceedingly dangerous and can cause death.

24. Barbiturates. Barbiturates are known to drug abusers as "barbs," "candy," "goofballs," "sleeping pills," or "downers." Specific types are often named after their color or shape. Barbiturate capsules range widely in size and are usually filled with powder and occasionally time disintegration beads.

a. Pentobarbital Sodium in solid yellow capsule form is known by abusers as "yellow jackets" or "nimbies" (after a trade name of this drug). It is a moderately fast-starting, short-acting barbiturate found in Nembutal, and is chiefly used in its granular sodium or calcium salt form as a sedative, hypnotic, and antispasmodic drug.

b. Secobarbital Sodium in red capsule form is called "reds," "pinks," "red birds," "red devils," and "seggy" (after a trade name). It is a moderately fast-starting, short-acting barbiturate found in Seconal, and is chiefly used in the form of a bitter hygroscopic powdery sodium salt as a hypnotic or sedative.

c. Amobarbital Sodium (trade name Amytal) in solid blue capsule form is known by abusers as "blues," "blue birds," "blue devils," or "blue heavens." It is an intermediate-acting barbiturate, and its crystalline compound and sodium salt are used as hypnotics and sedatives.

d. Phenobarbital (Luminal) is usually found in pink or white circular tablet form. It is a crystalline barbiturate used as a hypnotic and sedative especially for "grand mal" epilepsy. It is found in Luminal, a slow-starting, long-acting drug, which therefore is less apt to be abused than the others cited. It is commonly known as "phennies."

e. Amobarbital Sodium combined with Secobarbital Sodium in red and blue capsule form is known as "rainbows," "red and blues," or "double trouble." The combination (trade name Tuinal) results in a short- to intermediate-acting barbiturate and is widely abused.

25. Other Sedatives.

a. Chloral hydrate--bitter colorless crystalline compound formed by treating chloral with water and used usually by oral administration for producing sleep.

b. Paraldehyde--colorless liquid of pleasant odor but disagreeable taste formed by adding a drop or two of sulfuric acid to acetaldehyde. It regenerates acetaldehyde on heating with dilute acids; thus, it is used chiefly as a source of acetaldehyde and as a hypnotic.

c. Meprobamate--bitter powder that is an ester of carbamic acid and a derivative of propane-diol and is used as a tranquilizer.

V. HALLUCINOGENS

26. General. Hallucinogens are so named because they may produce hallucinations or illusions during which a person's ability to perceive is not based on objective reality. Some users say they see sounds, taste colors, and hear motion; others panic and have psychotic or anti-social reactions with impulses toward violence and self-destruction. Under the influence of hallucinogens, the abuser's ability to separate fact from fantasy diminishes. He sees himself and his environment in a distorted frame of reference.

27. LSD-25. Known popularly as "acid," "cubes," and "25." LSD-25 is a powerful manmade chemical, D-lysergic acid diethylamide, generally called LSD. It was first developed in 1939 from one of the ergot alkaloids. Ergot is a fungus that grows as a rust on rye and other cereals. LSD can be found as a liquid or powder. The most powerful drug known to man, a dose of 50 to 200 micrograms (no larger than the point of a pin) will take the user on a "trip" for approximately 8 to 16 hours. During the first hour after ingestion, the user may experience visual changes followed by extreme changes in mood. In the hallucinatory state, the user may suffer loss of depth and time perception accompanied by distortions with respect to size of objects, movement, color, spatial arrangement, sound, touch, and his own "body image." During this period, the user's ability to perceive objects through the senses, to make

sensible judgments, and to see common dangers is lessened and distorted making him susceptible to personal injury. After the "trip," the user may suffer acute anxiety or depression for a variable period of time. Recurrences of hallucinations have been reported days or months after the last dose.. This phenomenon is known as "flashback," with the average occurring within several months after the last dose. The longest on record occurred 18 months after the last dose, an exceptional case since the individual was a prolonged and very heavy user of the drug. Psychoses, both short- and long-range, have sometimes followed the use of LSD. It is not yet known whether the drug causes the illness or merely precipitates it. LSD is considered an investigational drug, and its action on the body and nervous system is not yet understood. It has become the subject of considerable scientific study. Recently, independent experiments with animals show that LSD may cause central nervous system malfunctions. Research is currently being conducted into possible chromosomal effects from use of LSD. Approved investigators are experimenting on alcoholics and the mentally disturbed to determine if the drug holds any therapeutic benefits.

28. Marijuana. See section on marijuana.

29. Mescaline (Peyote). Mescaline, which is derived from the buttons of the peyote cactus plant, has been used for centuries by various Indian tribes of Central America and the southwestern United States. The Native American Church, which uses peyote in religious

ceremonies, has been exempted from certain provisions of the Federal law. Generally ground into a powder, peyote is taken orally. Commonly known as "big chief," and "the button," a dose of 350 to 500 milligrams of mescaline produces illusions and hallucinations for 5 to 12 hours. The vast majority of the drugs sold on the street as mescaline has been analyzed as being LSD. American youth are being influenced by the ecology movement, believing that if a drug is organic it cannot hurt you.

30. Psilocybin and Psilocyn. Also derived from plants, psilocybin and psilocyn are obtained from psilocybe mushrooms generally grown in Mexico. Like mescaline, they have been used in Indian rites for centuries. Popularly known as "mushrooms," their effects are similar to those of mescaline, except that a smaller dose of from 4 to 8 milligrams is ample. The experience lasts for approximately 6 hours.

31. DMT (Dimethyltryptamine). Known popularly as the "businessman's special," DMT is a short-acting hallucinogen that can be made chemically or from extracts of a shrub grown in the West Indies and South America (Piptadenia peregrina). The powdered seeds have been used for centuries as a snuff--called "cohoba"--in religious ceremonies to produce a state of mind which the Haitian natives claim enable them to communicate with their gods. DMT is not taken orally, but its vapor is inhaled from the smoke given off by burning the ground seeds or powder mixed with tobacco, parsley leaves, or even marijuana. It can

also be injected. The effects of a single dose--60 to 150 milligrams--last only from 45 to 60 minutes and will produce hallucinations.

32. Bufotenine. Commonly known as "buf," this drug, which is related chemically to DMT, is derived from the dried glandular secretions of certain toads as well as from the amanita fungus. It can be prepared in the laboratory. Generally injected rather than taken orally, a dose of 15 milligrams will produce visual disturbances and alterations of time and distance perceptions. The experience may last from 6 to 10 hours. Bufotenine also is used as a snuff. Its symptoms appear almost immediately. As a side effect it can cause high blood pressure.

33. Ibogaine. Commonly known as "ibo," this drug is derived from the roots, bark, stem, and leaves of an African shrub. It also was used in primitive society. Natives were known to use the compound while stalking game to enable them to remain motionless for a long period of time while maintaining normal alertness. High doses reportedly cause excitement, intoxification, mental confusion, and hallucinations. Ibogaine can be made in the laboratory with considerable difficulty. In its raw state, it may be chewed; the laboratory preparation of alkaloid crystals is taken orally. The average dose is 3 milligrams with the effects lasting from 1 to 3 hours.

34. DET (Diethyltryptamine). DET is chemically related to DMT but has not yet been found in plant life. However, it can be produced in a laboratory. Injecting a dose of 50 to 60 milligrams causes visual

distortions, dizziness, and timelessness. The experience may last from 2 to 3 hours. DET is usually taken by smoking it in a mixture of tobacco, tea, parsley, or marijuana.

35. DOM (4-methyl-2, 5-dimethoxyamphetamine). Known popularly as "STP," DOM appeared on the psychedelic scene in the early spring of 1967. Articles in underground newspapers promoted its use, claiming it to be stronger than LSD. Little is known about its therapeutic, pharmacological, or psychological effects. However, doses of 1 to 3 milligrams produce euphoria, and doses of more than 3 milligrams can cause pronounced hallucinogenic effects lasting from 8 to 10 hours. One of the approved investigators of the drug states that DOM is almost 200 times more powerful than mescaline, but only one-tenth as potent as LSD. DOM is not found in nature, but is synthesized in the laboratory and has appeared in illegal channels in tablet form.

36. PCP (Phencyclidine). PCP appears in tablet, capsule, and powder form from clandestine labs and is often sold under the guise of synthetic marijuana. Little is known about the therapeutic, pharmacological, or psychological effects; but, PCP is presently being used to some extent as a veterinary anesthetic. Commonly known as the "peace pill," it has much the same effect as marijuana and is classified as a mild hallucinogen. It produces drowsiness, anxiety, confusion, laughter, and impairment of coordination. Unlike marijuana, in large doses it will cause unconsciousness. It may be taken orally or by injection.

VI. VOLATILE SUBSTANCES

37. General. The abuse of volatile substances is predominantly a phenomenon of youth. It is regarded as child's play by older abusers and as such is limited almost entirely to elementary and junior high school students, especially boys. The immediate effect is one of pleasant exhilaration or intoxication. This state lasts for minutes or an hour or so depending on the substance and dosage. The intoxication may also be accompanied by nausea, dizziness, muscle spasms, and other features of a general drunken state. The primary method of abuse is saturating a cloth known as a "glad rag" or "wad" with the substance and inhaling. The abuser or "gluey" also may place the substance in a bag or sack and cover his nose and mouth in that manner. The abuser, in an intoxicated state, with impaired judgment and motor functions, can be very susceptible to accidents. Death is not unknown and is caused by suffocation when the individual falls into a stupor with the "glad rag" covering his breathing passages or by vomiting uncontrollably. Continued use may seriously damage the liver and kidney and create psychological dependence.

38. Commercial Solvents. Model airplane glue, plastic cements, paint thinner, gasoline, cleaning fluids, nail polish remover, and cigarette lighter fluid contain combinations of highly volatile solvents which are toxic. These solvents include hexane, benzene, toluene, xylene, halogenated hydrocarbons, ketone, esters, alcohols, and glycol. These

solvents are the most frequently abused volatile substances, with airplane glue being the most popular.

39. Aerosols. Spray cans used for deodorants, hair sprays, and insecticides also may be abused. These aerosols contain gases of hydrocarbons and may be sprayed on a cloth or breathed directly.

40. Anesthetics. Anesthetics are the least abused volatile substances. They include chloroform, ether, and nitrous oxide (laughing gas). Nitrous oxide is available commercially as a tracer gas to detect pipe leaks, as a creamwhip propellant, and to reduce preignition in racing cars.

ANNEX B

GLOSSARY OF SLANG TERMS ASSOCIATED WITH DRUG ABUSE

This glossary of slang drug terms was compiled from numerous sources including personal interviews with narcotic addicts and contains, for the most part, those terms in common usage. It should be noted, however, that no glossary can contain all drug terms since usage changes frequently and varies widely between the different parts of the nation.

A--LSD

Acapulco Gold--a high-grade form of marijuana

ACE--marijuana cigarettes

Acid--LSD, lysergic acid diethylamide

Acid Funk--LSD-induced depression

Acid Head--LSD user

Acid Rock--music with a psychedelic orientation

Acid Test--party at which LSD has been added to the punch

All Lit Up--under influence of drugs

AMP--ampule

Amping; Over Amping--overdose of drugs, usually heroin

Angel Dust--phencyclidine on parsley leaf

Around the Turn--gone through withdrawal period

Artillery--equipment for injecting drugs

A's--amphetamines

B--marijuana

Babo--Nalline: this is a morphine-related substance and is used to treat narcotic poisoning from heroin, methadone, or morphine. It is called "babo" since it "takes the user to the cleaners."

Babysit--to guide a person through his drug experience

Backtrack--to withdraw the plunger of a syringe before injecting drugs to make sure needle is in proper position

Backwards--term applied to tranquilizers

Bad Trip--bad experience with drugs, especially LSD or STP

Bag--a container of drugs

Bagman--a drug supplier

Bale--a pound of marijuana

Ball--blast, gas, a party; a good time; absorption of stimulants and cocaine via the genitalia; sexual experience

Balloon--rubber balloon used for storing or delivering narcotics; usually capped heroin in bulk form, but occasionally papered

Bammies--poor quality marijuana

Bang--to inject drugs

Barbs--barbiturates

Barf Tea--peyote

Bash--marijuana

Batted Out--arrested

Beaming--under the influence of marijuana

Beast--LSD; heroin

Beautiful--term of approval

Bedbugs--fellow addicts

Been Had--arrested or cheated out of something

Belly Habit--drug causing withdrawal symptoms

Belongs--on the habit

Bennies; Beans--amphetamines (Benzedrine)

Bent--under the influence of drugs

Bernice--cocaine

Big Chief--mescaline

Big "D"--LSD

Big John--the police

Big O--opium

Bindle--a small paper packet of heroin, morphine, cocaine, or Methedrine

Bird's Eye--very small amount of narcotics

Biz--equipment for injecting drugs

Black--opium

Black and White--a patrol car

Black Columbus--marijuana

Black Mote--marijuana aired in sugar and honey

Black Russian--dark-colored, very potent hashish

Blanks--poor quality narcotics

Blast; Blow--to smoke a marijuana cigarette

Blasted--under the influence of drugs

Blow a Stick--to smoke a marijuana cigarette

Blow a Vein--unsuccessful attempt to puncture a vein

Blow Your Cool--to lose self-control

Blow Your Mind--to get high on drugs

BLTC--better living through chemistry

Blue Bands--Pentobarbital Sodium

Blue Birds--Sodium Amytal

Blue Caps--LSD

Blue Cheer--type of LSD

Blue Devils; Blue Birds; Blue Heaven; Blues--amobarbital capsules; amytal; amobarbital sodium

Blue Velvet--paregoric and an antihistamine

Boast; Boost--to obtain, steal

Bobo Bush--marijuana

Bogart--to "Bogart a joint" is to either salivate on or to retain (and not pass around) a marijuana cigarette (from Humphrey Bogart)

Bombed--intoxicated on drugs

Bombido; bombita--injectable amphetamine

Boo--marijuana

Booster--consumption or injection of additional dosage to continue or prolong a "trip"

Bottle--injected amphetamine

Bottle Dealer--a person who sells drugs in 1,000-tablet or capsule bottles

Box--a metal container for marijuana

Boxed--in jail

Boy--heroin

Bread--money

Brick--kilo of marijuana in compressed brick form

Bridge--usually refers to an alligator clamp or a similar device used to hold marijuana cigarette while smoking it

Brown Dots--LSD

Brown Shoes--name for squares

Bull--a Federal narcotic agent; a police officer

Bull Horror--illusioned fear cocaine abusers have of being observed by the police

Bummer; Bum Trip--a "bad trip"; see "freak trip," "freak out"

Bundle--small quantity of narcotics

Burn--to accept money and give no drug in return, or to give a substance in lieu of the drug; also, to burn the skin when injecting

Burned--used to describe the acquisition of bad drugs, diluted drugs, or no drugs at all

Burned Out--the sclerotic condition of the vein; present in most conditioned addicts

Bush--marijuana

Businessman's Trip--DMT experience

Busted--arrested

Button--peyote buttons (containing the psychedelic, mescaline)

Buy--to purchase drugs

Buzz--try to buy drugs; drug-induced "high"

Buzz on--to feel good

C--cocaine

Caballo--heroin

Ca-Ca--heroin; inferior quality heroin; hashish; LSD; counterfeit heroin

Cactus--mescaline

Cadet--new addict

Can--one ounce of marijuana. The term is derived from the tobacco cans in which marijuana was commonly sold in the past. Now it is more frequently sold in small plastic or paper bags.

Candy--barbiturates

Candy Man--seller of drugs

Cap--capsule containing a drug; commonly a number 5 capsule

Carga--Spanish for heroin

Cargo--load or supply of narcotics or drugs

Carrying--in possession of a drug

Carry Nation--cocaine

Cartwheel--amphetamine tablet (round, white, double scored)

Cecil--cocaine

Cents--C.C.'s (cubic centimeter)

Chalk--methamphetamine

Champ--drug abuser who won't reveal his supplier, even under pressure

Charas--marijuana

Charge--marijuana

Charged Up--under the influence of drugs

Charlie--cocaine

Chicago Green--marijuana

Chicken Powder--amphetamine powder for injection

Chief--LSD

Chip; Chipper; Chipping--to play around with a drug; to use drugs sporadically

Chippy--abuser taking small irregular amount; prostitute

Chiva--stuff or heroin

Cholly--cocaine

Christmas Tree--Tuinal

Churus--marijuana

Clean--to remove stems and seeds from marijuana; also refers to an addict who is free from needle injection marks; also not holding or possessing any narcotics

Clear up--to withdraw from drugs

Clocked--doing time in jail

Coasting--under the influence of drugs

Cocktail--a regular cigarette into one end of which a partially smoked marijuana cigarette is inserted so as to waste none of the drug

Cod Cock--codeine cocktail

Coke--cocaine

Coked Up--under the influence of cocaine

Cokie--a cocaine addict

Cold--tough deal, as "cold heart"

Cold Turkey--trying to break the habit. "Kicking it cold turkey" is breaking the habit of addictive drug use without the aid of any medication or medical care.

Come Down--to come off drugs

Connect--to buy drugs

Connection--refers to the peddler or source of supply for the user

Contact High--a feeling of being on drugs or "high" from merely being in contact with someone or something reminding one of drugs

Contact Lens--LSD on a round gelatin flake

Cook--underground pharmacist who sells drugs without a prescription

Cooker--bottle cap for heating drug powder with water

Cook Up a Pill--to prepare opium for smoking

Cool--good; "out of sight"

Cop; To Cop--to get drugs

Cope--to handle oneself effectively while under the influence of drugs

Co-pilots--amphetamines, usually Dexedrine

Cop-out--to alibi; confess

Corine--cocaine

Cotics--narcotics

Cottons; Cotton Top--bits of cotton saturated with narcotic solution used to strain foreign matter when drawing solution up into hyperdermic syringe or eyedropper. These cottons are often saved by addicts for an emergency, as they contain a residual amount of the drug--also "satch cotton."

Count--amount of purity of a drug

Cowboy--independent dealer

Crackers--LSD

Crash--to end a drug experience, particularly from an amphetamine like Methedrine

Crash Pad--temporary residence, usually for a night or two, usually communal, often used to end a drug experience

Crazy--exciting; in the know; enjoyable

Croaker; Crooker--physician who sells drugs illegally

Crossroads--amphetamine tablets

Crutch--device used to hold marijuana cigarette when it has burned to the point where it will burn the fingers--usually a half of a paper match book. Also, a container for a hypodermic needle.

Crystal--Methedrine (methamphetamine), "speed," or other amphetamine

Crystals--amphetamine powder for injection

Cube--sugar cube impregnated with LSD

Cubehead--frequent user of LSD

Cut--to dilute a powder with milk, sugar, baking powder, etc.

"D"--LSD

Dabble--to take small amounts of drugs on an irregular basis

D.D.--fatal dose

Dead on Arrival--phencyclidine

Dealer--a drug peddler

Deal in Weight--sell large amounts of drugs

Deck--a small packet of narcotics

Deeda--LSD

Deuce Bag--a $2 container of a drug

Dexies--dextroamphetamine sulfate or amphetamine tablets, a mixture of barbiturate and amphetamine (Dexedrine)

Dice--Methedrine

Dime or Dime Bag--$10 worth of drugs

Dirty--possessing drugs, liable to arrest if searched

DMT--dimethyltryptamine, a psychedelic nicknamed "the businessman's LSD"

Doing--may be any "happening," but specifically the taking of a drug

Doing Your Thing--doing what seems best to you; finding your "bag"

Dollies--Dolophine (brand of methadone hydrochloride) tablets

Domino--to purchase drugs

Dope--any drug

Doper--drug user

Dotting--placing LSD on a sugar cube

Double Cross--ampethamine tablets (double scored)

Double Trouble--Tuinal (brand of amobarbital sodium and secobarbital sodium) capsules

Doup--smoke a joint; or take an injection of heroin

Downs; Downer--a depressant drug such as a barbiturate or tranquilizer; also, a "bum trip"; also, to come off drugs

Dreamer--one who takes opiates or morphine

Dried Up--off drugs, particularly heroin

Dripper--eyedropper used for an injection

Drop--swallow drug

Drop a Dime--to call police to cause a raid or arrest

Dropped--arrested

Dubbe--slang for marijuana roach

Dummy--purchase which did not contain narcotics

Dust--cocaine

Dynamite--highly potent narcotic

Ego Games--a deprecating term applied to social conformity and to normal activities, occupations, and responsibilities of the majority of the people

Electric Koolade--koolade spiked with LSD

Explorers Club--a group of acid heads

Eye Openers--amphetamines

Factory--equipment for injecting drugs

Fat--describing someone who has a good supply of drugs

Finding Your Bag--doing what seems best to you

Fine Stuff--drugs of unusually good quality; only slightly adulterated

Finger--to betray; marijuana cigarette

Fink--informer, phony

Fit; Outfit--equipment for injecting drugs

Fix--to inject drugs or one dose of a particular drug; also "outfit"

Flake--cocaine

Flash--the intense feeling the user has just after "fixing"; to throw up after "fixing"

Flashback--reoccurrence of the drug reaction from LSD, weeks to months later, without taking the drug again

Flea Powder--poor quality narcotics

Flip--become psychotic

Floating--under the influence of drugs

Flush--the initial feeling the user gets when injecting a drug like methamphetamine

Fool Pills--barbiturates

Footballs--amphetamines (oval shaped)

Forwards--pep pills, especially amphetamines

Fours--aspirin with codeine tablets

Frantic--nervous, jittery drug user

Freak--one who has flipped; i.e., one who uses drugs to the point of loss of reality; especially used as "speed freak," referring to a heavy Methedrine user

Freak Out--to lose all contact with reality; to have a drug party

Freak Trip--adverse drug reaction, especially with LSD

Fresh and Sweet--out of jail

Frisky Powder--cocaine

Full Moon--peyote

Fuzz-the law

Gage--marijuana

Garbage--poor quality drugs

Gasket--device attached to the dropper tip to prevent air from entering the vein

Gassing--sniffing gasoline fumes

Gate-keeper--one who initiates another into the use of LSD

Gee; Geeze--injection of drugs

Gee-head--paregoric abuser

Geetis--money

Geronimo--barbiturates dissolved in an alcoholic beverage

Ghost--LSD

Gig--a job

Giggle-smoke--marijuana smoke

Gimmicks--the equipment for injecting drugs

Gin--cocaine

Girl--cocaine

Give Wings--to inject somebody with heroin by vein or to teach a person how to

Glad Rag--a piece of cloth saturated with glue or gasoline, usually a sock; also, "wad"

Gluey--glue sniffer

Go--to participate freely in the drug scene

Going Up--taking drugs for their effects; said of smoking marijuana or injecting "speed," etc.

Gold--marijuana

Gold Dust--cocaine

Gong--an opium pipe

Gong-beater--smoker of opium

Good Go--a good or reliable dealer in drugs

Good H--good quality heroin, approximately 50 percent pure

Goods--narcotics

Good Trip--happy experience with psychedelics

Goof Balls; Goofers--barbiturates; any barbiturate tablet or capsule; may be combined with an amphetamine

Goofed Up--under the influence of barbiturates

Goofer--one who drops pills

Gow-head--an opium addict

Gram--gram of heroin, approximately 10 capsules

Grape Parfait--LSD

Grapes--wine

Grass--marijuana in the raw states such as leaves, stems, seeds

Grass Brownies--cookies containing marijuana

Grasshopper--marijuana user

Greenies--green, heart-shaped tablets of dextroamphetamine sulfate and amobarbital

Griefo--marijuana

Griffo--marijuana

Groovy--good; "out of sight"

Ground Control--caretaker in LSD session

Guide--one who "babysits" with a novice when he goes up on a psychedelic substance

Gun--a hypodermic needle; syringe

Guru--companion on a trip who has tripped before

"H"--heroin

Habit--physically or psychologically dependent on drugs; addiction to drugs

Hag--an addict using large doses

Hand-to-hand--delivery of narcotics person-to-person

Hang-up--a personal problem

Happy Dust--cocaine

Hard Stuff--morphine, cocaine, or heroin

Harness Bulls--uniformed police officers

Harry; Hairy--heroin

Hash; Hashish--resin from the Cannabis Indica plant which has a very high tetrahydrocannabinol content

Hashbury--Haight-Ashbury, a district in San Francisco

Hawaiian Sunshine--LSD

Hawk--LSD

Hay--marijuana

Head--chronic user of a drug or drugs

Hearts--amphetamines, specifically dextroamphetamine and Benzedrine sulfate; also Dexedrine (orange-colored, heart-shaped tablets)

Heat--a police officer; the law

Heavy--significant, weighty; highly emotional

Heeled--well-supplied with money and/or drugs

Heifel--marijuana

Hemp--marijuana

High--under the influence of a drug; a drug user who is "up"

Hip; Hep--to understand; opposite of square

Hippies--beatniks

Hit--one dose of a particular drug; to purchase drugs; an arrest

Hocus--a narcotic solution ready to inject

Hog--a drug user who takes all of a drug he can get his hands on; phencyclidine mixed with vegetable material

Holding--possessing narcotics

Hooked--addicted; a confirmed addict

Hophead--narcotic addict

Hopped Up--under the influence of drugs

Horning (Snorting; Sniffing)--sniffing narcotics through nasal passages

Horse--heroin

Hot--wanted by police

Hot Shot--a fatal dosage

Hustle--activities involved in obtaining money to buy heroin

Hype--one who uses intravenous drugs, specifically heroin or "speed"

Hype Outfit--equipment for injecting drugs

Ice--cocaine

Ice Cream Habit--sporadic use of drugs

Ice Cream Man--seller of opium

Indian Hay--marijuana

J; Jay--"joint" or marijuana cigarette

Jack--prolong injection by advancing plunger slowly

Jacked Up--to be interrogated or arrested

Jacking Off the Spike--prolonging injection by allowing blood to flow into the syringe

Jag--under influence of amphetamine sulfate

Jar Dealer--a person who sells drugs in 1,000-tablet or capsule bottles

Jive--marijuana; to lie; cheat

Jive Stick--marijuana cigarette

Job; Jab--to inject drugs

Joint--a marijuana cigarette; also state prison

JoJee; JeeGee--heroin

Jolly Beans--pep pills

Jolt--an injection of narcotics

Joy Pop--intermittent (rather than continuous) injection of one dose of a drug; also one who is "joy popping" only takes an injection now and then

Joy Powder--heroin

Jug--1,000-tablet or capsule bottle

Juice--wine, whiskey; liquid for intravenous injection; stamina; power; influence

Junk--heroin

Junkie--a narcotic addict

Juvies--juvenile officers

Kee--kilo (2.2 pounds)

Keg--25,000 amphetamine capsules or tablets, or more; kilogram of marijuana

Kick; Kicking--to stop using drugs (see "cold turkey")

Kicks--a drug experience

Kief--Arabic for marijuana in dried resin form

Kilo--2.2 pounds

Kit--narcotic paraphernalia (see "outfit")

Kite--1 ounce of marijuana

L--LSD

L.A.--long-acting marijuana

Lab--equipment used to manufacture drugs illegally

Lace--to cut or add drugs

Lady--cocaine

Laid Out--being informed on

Lame--not very smart; dumb or green; not street-wise

Laydown--place where opium is smoked

Layout--the equipment for injecting drugs

Lean--a nondrug user

Leaves--marijuana

Lemonade--poor quality heroin

Lid--1 ounce of marijuana

Lid Poppers--amphetamines

Lipton Tea--poor quality narcotics

Lit Up--under the influence of drugs

Llesca--marijuana

Loaded--high on drugs; under the influence of drugs

Locoweed--marijuana

Lucy in the Sky with Diamonds--LSD

M--morphine

Machinery--equipment for injecting drugs

Magic Mushroom--the Mexican species of mushroom, containing psilocybin, a psychedelic

Mainline--veins of body, usually arms; also intravenous injection

Mainliner--one who injects narcotics directly into the veins intravenously

Maintaining--keeping a certain level of drug effect

Majoun--marijuana

Make a Meet; Buy--to purchase drugs

Make It--to buy narcotics; to leave the scene, area

Man--the law; a connection (drug supplier); heroin

Manicure--prepare marijuana for use in cigarettes, removing seeds and stems

Marathons--amphetamines

Mary Jane--marijuana

Master Key--sledge hammer used by police to break down a door

Matchbox--a small amount of cannabis sufficient to make between five to eight cigarettes; about a fifth of a lid

MDA--a hallucinogen, methyl-3, 4-methylenedioxyphenethylamine

Meet--to buy drugs

Mellow Yellow--smoking banana skins

Mesc--mescaline; alkaloid in peyote

Meth--methamphetamine, usually injected for rapid result

Mezz--marijuana

Micro Dots--LSD

Mickey; Mickey Finn--chloral hydrate

Mikes--micrograms

Mind blower--pure, unadulterated drugs

Miss Emma--morphine

MJ--marijuana

Mohasky; Mu; Muggles--marijuana

Mojo--narcotics

Monkey--a drug habit where physical dependence is present

Mor a Grifa--marijuana

Mota--marijuana (Spanish)

Mud--opium for smoking

Muggles--marijuana cigarettes

Mule--a person who delivers or carries drugs for a dealer

Muscle--inject intramuscularly

Mushrooms--psilocybin and psilocyn; derived from the psilocybe mushroom

Mutah--marijuana

Nabs--police

Nark; Narco--narcotics agent

Needle--hypodermic needle

Nickle buy, bag--a $5 purchase

Nimby--"Nembutal" (brand of pentobarbital) capsules

Nod--to experience relaxation after taking a drug

Number--a joint

O--opium

O.D.--overdose of drugs, usually heroin

Off--withdrawn from drugs

OJ--opium joint

On a Trip--under the influence of LSD or other hallucinogens

On the Nod--under the influence of drugs

On the Street--out of jail

Ope--opium

Oranges--"Dexedrine" (brand of dextroamphetamine sulfate) tablets

Outfit; Fit--equipment for injection by hypodermic method; a "hype" outfit--eyedropper and needle, spoon, pacifier, etc.

Out of It--not in contact; not part of the drug scene

Out of Myself--feelings experienced under the influence of LSD

Out of Sight--good; groovy; a positive descriptive term

Overjoit--overdose of drugs

Owsley's Acid--LSD purportedly illegally manufactured by Augustus Owsley Stanley III; also infers that it is good quality LSD

Oz; Ounce--refers to ounce of drugs, usually heroin or Methedrine

Pack--heroin

Paddy--caucasian

Panama Red--a potent type of South American marijuana

panic--refers to condition when the drug supply has been cut off (usually caused by the arrest of a big peddler); a scarcity of drugs

paper--a container of drugs

Peace Pill; PCP--refers to the drug phencyclidine, originally an anesthetic for dogs

Peaches--"Benzedrine" (brand of amphetamine sulfate) tablets

Peanuts--barbiturates

Pearly Gates--a type of morning glory seed

Pearls--amyl nitrate capsules

Peddler--one who sells narcotics

Per--a prescription

Peter--chloral hydrate

Pez--PEZ candles impregnated with LSD

P.G.; P.O.--paregoric

Phennies--phenobarbital (Luminal)

Piece--a pistol, revolver; 1 ounce of marijuana or heroin

Pig--a drug user who takes all of a drug he can get his hands on; policeman

Pill Head; Pill Freak; Pilly--amphetamine or barbiturate user

Ping the Pill--to knock off some of the powder from a heroin capsule to spare some for an extra dose

Pinks--"Seconal" (brand of secobarbital) capsules

Plant--a cache of narcotics

Playing the Girls--using prostitutes for one's income

Point--hypodermic needle

Poke--a puff on a "joint"

Pony--heroin

Pop--a subcutaneous injection, usually referred to as "skin popping"

Popper--amyl nitrate in ampule form, inhaled

Pot--marijuana

Pothead--marijuana user

Pot Likker--marijuana tea, usually made with cannabis leaves

Powder--amphetamine powder

Prickly Feeling--sensation of air entering a vein

Pure--pure heroin, prior to adulteration. "This is the pure; you can cut it five or six times at least."

Purple Haze; Purple Barrels--LSD

Purple Hearts--combination of Dexedrine and amobarbital

Pusher--drug peddler to users; one who seeks more business from regular customers

Put Down--stop taking drugs

Put On--to tease; mock

Quarter--quarter of an ounce of either heroin or Methedrine, usually 4 to 8 grams

Quill--a folded matchbox cover from which narcotics are sniffed through the nose

Rainbows--Tuinal (amobarbital sodium and secobarbital sodium)

Rainy Day Woman--marijuana cigarette

R and R--drinking ripple wine and taking secobarbital capsules

Rap--discuss at length; talk

Rare--to inhale cocaine or heroin through the nose

Rat Fink--informer for police

Reader--a prescription

Red; Reds; Red Birds; Red Devils--Seconal (secobarbital sodium)

Red and Blues--Tuinal (amobarbital sodium and secobarbital sodium)

Reefer--marijuana cigarette

Reentry--return from a trip

Register--to wait until blood comes into the "hypodermic" before injecting a drug intravenously

Righteous--good quality drugs

Rip Off--to rob a peddler of his drugs or money

Roach--small butt of marijuana cigarette

Roach Holder--device for holding the butt of a marijuana cigarette

Roll; Roll Deck--a tin foil wrapped roll of tablets

Roll Dealer--a person who sells tablets in rolls

Root--marijuana

Rope--marijuana

Roses--Benzedrine tablets

Roust--an interrogation or arrest

Ruler--a judge

Run--to take drugs continuously for at least 3 days, particularly amphetamines

Rush--the intense feeling the user has just after "fixing"; to throw up after "fixing"

Sam--Federal narcotic agent

Sandos--LSD

Satch Cotton--cotton used to strain narcotics before injection

Scag--heroin

Scat--heroin

Schoolboy--codeine

Score; Scoring--make a drug purchase

Script--drug prescription

Seeds--marijuana seeds; morning glory seeds

Seggy--"Seconal" (brand of secobarbital) capsules

Sex Juice--drug to stimulate sexual desire

Shooting Gallery--place where users can purchase drugs and inject them; place where an injection of a drug can be used and/or bought

Shoot Up--to inject drugs

Short--automobile

Short Sled--vehicle

Shot--an injection of a drug

Sick Dizzy's--peyote

Sitter--LSD veteran who guides new users during trips

Siva--Hindu god who gave man marijuana

Skin Popping--intradermal or subcutaneous injection

Slammed--in jail

Sleepers--a depressant-type drug such as barbiturates

Sleigh Ride--using "snow"; cocaine

Smack--heroin

Smashed--intoxicated, "stoned," "high"

Smoke--wood alcohol

Snatch and Grab Junkie--unrealiable, not too honest seller of small quantities of heroin

Sniffing; Snorting; Horning--using narcotics by sniffing through nasal passages, usually heroin or cocaine

Snitch--informer; stoolie

Snort--inhale a drug through the nose

Snow--cocaine

Snowbird--cocaine user

Softballs--barbiturates

Source--where narcotics are obtained; supplier, such as pusher, dealer, connection

Space Out; Spaced--in a daze, particularly a daze resulting from a trip due to use of drugs

Spaghetti Sauce--Robitussin AC cough syrup

Spatz--capsules

Speed--Methedrine (methamphetamine) or crystal; now broadened use in some areas to mean any amphetamine or any stimulant

Speedball--a powerful shot of a drug, usually heroin and cocaine combined

Speed Freaks--a heavy Methedrine user; one who uses drugs to the point of loss of reality

Spike--hypodermic needle

Splash--speed; orgasmic sensation; Benzedrine

Splints--marijuana cigarettes

Split--to leave; flee; break up with

Spoon--a quantity of heroin, theoretically measured on a teaspoon (usually between 1 and 2 grams), 16 spoons per ounce

Sport of Gods--to inhale cocaine through the nose

Square--a person who does not know what's happening--a nonuser

Stanley's Stuff--LSD purportedly manufactured by Augustus Owsley Stanley III; see Owsley's Acid

Star Dust--cocaine

Stash--place where narcotic or "outfit" is hidden; also refers to one's own supply of drugs

Stick--a marijuana cigarette

Stoned--under the influence of drugs

Stoolie--informer

STP--serenity, tranquility, peace--a drug mixture of Methedrine and pschedelic compounds (4-methyl 2, 5 dimethoxy alpha methly phenethylamine), DOM-hallucinogenic drug

Straight--under the influence of narcotics; applied to a peddler--gives a good deal; not using drugs

Strawberry Fields--LSD

Street Market--black market

Strung Out--heavily addicted or hooked

Stuff--general term for drugs and narcotics

Sugar--powdered narcotics; LSD

Swingman--a drug supplier

Swiss Purple--high-grade LSD

Syndicate Acid--STP

T--marijuana

Taste--a small sample of a narcotic

TD Caps--time-disintegrating capsules

Tea--marijuana

Tea Party--marijuana party

Texas Tea--marijuana

Thoroughbred--a high-type hustler who sells pure narcotics

Toke Up--to light a marijuana cigarette

Tooies--"Tuinal" (brand of amobarbital sodium and secobarbital sodium) capsules

Torn Up--intoxicated; stoned

Toxy; Toy--the smallest container of prepared opium

Tracked Up--numerous injection marks along vein

Tracks--a series of puncture wounds in the veins caused by continuous narcotic injections

Travel Agent--a pusher of hallucinogenic drugs

Trey--a $3 purchase

Trick--easy mark; sucker; fool

Trigger--to smoke a marijuana cigarette immediately after taking LSD

Trip; Tripping Out--the hallucinations and/or feelings experienced by a person after taking a drug, particularly LSD

Truck Drivers--amphetamines

Tuned In--sympathetic to LSD use or using it

Turkey--a capsule purported to be narcotic but filled with a nonnarcotic substance

Turned Off--withdrawn from drugs

Turning People On--to give others drugs; or to excite and interest them

Turn On--to use drugs or to introduce another person to the use of drugs

Turn On, Tune In, Drop Out--take LSD, learn about the "real" world, and drop out of the nondrugged world

Turps--elixir of terpin hydrate with codeine

Twenty-five; 25--LSD

Uncle--Federal narcotic agent

Upper--amphetamine

Up Tight--angry; anxious; (may rarely also be used to mean good as in the words to a song "Everything up tight, out of sight)

User--one who uses drugs

Vibes; Vibrations--feelings coming from another; may be "good" or "bad" vibes

Vipers Weed--marijuana

Virgin State--period when one is taking drugs but is not yet dependent

Wad--a piece of cloth saturated with glue or gasoline (see "glad rag")

Wake-ups--amphetamines

Washed Up--withdrawn from drugs

Wasted--high or drunk

Weak Acid--morning glory seeds

Wedges--small tablets of wedge (almost triangular) shape

Weed--marijuana

Weed Head--marijuana smoker

Weekend Habit--irregular drug habit

Weird--on drugs

West Coast Turn-arounds--amphetamine tablets or capsules

Wheels--car; automobile

Where It's At--where (drug) action is taking place

Whiskers--Federal narcotic agents

Whites--amphetamine tablets

White Stuff--morphine

Wig Out; Wigging--get high on drugs (see "blow your mind")

Wired--to be addicted or habituated

Works--equipment for injecting drugs

Yellow Jackets; Yellows--Nembutal (phenobarbital sodium)

Yen--craving for narcotics; a "burning yen" is a marked craving

Yen-hok--a long steel needle upon which an opium pill is cooked

Yen-pock--a ration of opium prepared for smoking

Yen-pop--marijuana

Yen-shee--the residue left in the opium pipe's bowl and stem after the opium has been smoked

Yen-shee Doy--a Chinese drug addict

Yen-shee Gow--a scraper for removing yen-shee from the opium pipe

Yen-shee Suey--opium wine; yen-shee mixed with water or whiskey

Yen Sleep--a drowsy, restless state during the withdrawal period

Yesca--marijuana

Youngblood--a young person using marijuana for the first time

Zig-Zag--roll-your-own cigarette paper

Zounk; Zonk--under the influence of narcotics

ANNEX C

STATISTICAL ANALYSIS OF DRUG USE

1. Sources of Data.

a. Surveys and polls were used to estimate patterns of drug use across the United States. To insure a high level of confidence, the methodology of each available survey and poll was evaluated to determine relevance and to eliminate those based on improper sampling techniques. Seventy-two surveys of all types were considered, with several being compendiums of individual local surveys. Of the 72 surveys considered, 63 (88 percent) were found usable; of those, 58 surveys of college and high school students were selected for a detailed statistical analysis. The remaining surveys were not selected because they were limited in

scope and of very unique population types. Annex G contains a bibliography of all usable surveys and polls.

b. The 58 surveys of college and high school students can be grouped into three categories. The number of surveys and the sample population for each category are shown in Figure C-1.

SURVEYS OF COLLEGE AND HIGH SCHOOL STUDENTS

Category	Number of Surveys	Sample Population
National College Surveys	6	21,831
Individual College Surveys	29	77,309
Individual High School Surveys	23	155,034

Figure C-1

c. The 58 surveys were conducted between 1964 and 1971. Figure C-2 shows the number of surveys in each category by year.

2. Categorization of Data.

a. Not every survey collected data on every drug or drug category. The various surveys collected a wide range of information. Figure C-3 shows how many surveys in each category collected information on each type of drug.

SURVEYS BY YEAR OF COLLEGE AND HIGH SCHOOL STUDENTS

Year	National College Surveys		Individual College Surveys		Individual High School Surveys	
	Number of Surveys	Sample Population	Number of Surveys	Sample Population	Number of Surveys	Sample Population
1971	2	4,063	3	2,593	1	8,257
1970	3	17,248	3	5,600	4	31,942
1969	--	--	8	41,401	4	74,389
1968	--	--	2	3,080	3	22,257
1967	1	520	10	23,061	11	18,189
1966	--	--	--	--	--	--
1965	--	--	2	1,366	--	--
1964	--	--	1	208	--	--

Figure C-2

CATEGORIES OF DRUG INFORMATION COLLECTED

	National College Surveys	Individual College Surveys	Individual High School Surveys
Hallucinogens	0	0	2
LSD	4	25	18
Marijuana	6	27	23
Other	1	8	6
Stimulants	1[a/]	1[a/]	0
Amphetamines	2	9	15
Other	0	3	6
Depressants	1[a/]	1[a/]	0
Barbiturates	2	8	11
Tranquilizers	0	4	3
Narcotics	0	0	0
Heroin	3	4	7
Other	1	6	3
Glue and Other	0	4	14

a/ Stimulants and depressants combined into one category.

Figure C-3

b. All the surveys sought information on the frequency of illicit drug use. The questions and allowable answers, however, were not identical among the surveys. Depending on the survey, respondents could choose from the following answers: "never used," "ever used," "used in the last year," "used once," "used two to five times," "occasionally used," "currently used," "frequently used," "infrequently used," "used six to 10 times," "used more than 10 times," "used every

week or so," "used regularly," and "will not stop." These answers have been grouped into three categories for simplicity and convenience of use. The first category is limited to those individuals who responded that they had never used drugs illegally, the second includes all those who have ever used drugs at any time in the past, and the third is limited to those who reported a repeated and continuing drug abuse. The third category is thus a subclass of the second category which excludes one-time experimenters and infrequent users. The third category includes anyone who chose one of the following responses: "10 or more times," "will not stop," "frequently," "every week or two," "regularly," or "current."

3. Statistics of Samples.

a. By definition, a sample is a small part of a larger aggregate or population (in this case high school or college students) about which information is desired. After the sample is selected, it is surveyed and the desired data are collected. Since the data collected in the survey are subject to variation, estimates made from the data are also subject to variation. As a result, the estimate is to some degree uncertain. However, if the survey could be repeated many times and all the results combined, the estimate would ultimately settle into an unchanging value which can be thought of as the true or definitive answer. The purpose of a statistical analysis of survey results is to determine what the data from the samples can indicate about the true

answers. Tests of significance and confidence limits are tools used to determine the validity of the sample. This validity is subject to two basic conditions:

(1) The sample must be a statistically significant proportion of the total population.

(2) The sample must be a random sample of the total population. By definition, simple random sampling is a method of selecting units out of the total population such that each element in the population has an equal chance of being selected as a part of the sample. If the first condition is not satisfied, the stated precision (level of confidence) of the sample will be low. If the second condition is not met, the inferences drawn from the sample may contain bias. To the degree that a total population has been identified, properly applied sampling methodology will yield a random sample and an unbiased result.

b. Each of the 58 surveys analyzed was based on a statistically significant sample of its corresponding total population and meets the requirements for a 90 percent or higher level of confidence. The national college surveys were based on random samples of the total college population. The individual college and individual high school surveys provided random or near-random samples of their separate total populations. Although the combined individual college and combined individual high school surveys do not comprise a national random sample for statistical purposes, their relevance to the total national student

populations is still high as evidenced by the graphic plots in Figures 2-13 in the basic report.

4. Theory of Sampling.

a. Since surveys based on samples are used to indicate drug usage of the whole population, this paragraph mathematically describes the theoretical relationship between a sample and the population which the sample represents. For the serious student of mathematics who desires more detailed information on sampling theory, Harold Freeman's Introduction to Statistical Inference published by Addison-Wesley Publishing Company, 1963, is recommended.

b. For purposes of this study, the population is described by a general discrete random variable x, and of concern is the behavior of random samples drawn without replacement from such a generally described population. The population is composed of N different elements, each characterized by a distinct number. A sample $x_1, x_2, \ldots x_n$ is taken with the proviso that not more than one element of the sample can fall on any one element of the population; thus, if $x_1 = X_3$, $x_2 \neq X_3$. In the present case this means that no student is polled more than once about drug abuse.

c. Let all points in the event space have the same probability p; that is, let the sampling process be random.

Then

$$p = \frac{(N-n)!}{N!}$$

By definition, the population mean λ and variance σ^2 are

$$\lambda = \sum_{i=1}^{N} \frac{X_i}{N}$$

$$\sigma^2 = \sum_{i=1}^{N} \frac{[X_i - E(X)]^2}{N}$$

Next, consider the probability behavior of the mean $\bar{X}$ of a random sample of size n taken without replacement from this population. This equates to

$$E(\bar{X}) = \frac{1}{n} E\left[x_1 + x_2 + \ldots + x_n\right] \quad (1)$$

$$= \frac{1}{n}\left[E(x_1) + E(x_2) + \ldots + E(x_n)\right], \quad (2)$$

where (2) follows from (1) by the relationship

$$E\ (x_1 + x_2 + \ldots x_n) = E(x_1) + E(x_2) + \ldots + E\ (x_n)$$

which holds for all random variables, independent or not (as in (1) and (2) above). To evaluate (2), consider one of the expectations in the equation. $E(x_2)$ is a good example. By definition, this expectation is obtained by multiplying each possible value taken on by x_2 by the probability of its occurrence and summing this product over all possible values of x_2:

$$E(x_2) = X_1 \cdot \text{prob}\ (x_2 = X_1) + X_2 \cdot \text{prob}\ (x_2 = X_2)$$
$$+ \ldots + X_n \cdot \text{prob}\ (x_2 = X_n). \quad (3)$$

Consider the first term to the right of the equality sign. There are $\frac{N!}{(N-n)!}$ points in the event space. Only one of these points has $x_2 = X_1$, for if x_2 is to be X_1, x_2 can assume only one population value (X_1 itself). The x_1 can be only one of the remaining N-1 population values; x_3 one of the remaining N-2 population values; etc.

Therefore,

$$\text{prob } (x_2 = X_1) = \frac{\frac{(N-1)!}{(N-n)!}}{\frac{N!}{(N-n)!}} = \frac{1}{N}$$

d. From the evident symmetry under permutation, note that all x_i have the same marginal distribution. For the same reason (x_i, x_j) have the same joint distribution for an i, j, etc. Similarly, all probabilities in (3) are $\frac{1}{N}$; therefore, $E(x_2) = \lambda$ and finally from (2)

$$E(\bar{x}) = \lambda$$

e. On the average, the mean of a sample taken without replacement is equal to the mean of the finite population. Therefore, given a random sample from the population of high school or college students, on average, the mean of the sample drug usage is equal to the mean of the population usage.

ANNEX D

MAJOR FEDERAL DRUG ABUSE LAWS AND EVENTS

1909--First Federal act prohibiting importation of opium, its preparations, and derivatives except for medical use.

1909--First Conference of International Commission on Opium in Shanghai which was followed by conventions in 1912, 1913, and 1914.

1914--Harrison Act providing for the registration with collectors of Internal Revenue in order to impose a special tax, all persons who produce, import, manufacture, compound, deal in, disperse, sell, distribute, or give away opium, coca leaves, their salts, derivatives, or preparations.

1919--Amendment to Harrison Act to prevent evasion of certain of its provisions.

1919--"US Versus Doremus" Supreme Court decision upholding Harrison Act.

1919--Experimental outpatient clinics for treatment of addicts. Closed in 1923 by Federal authorities.

1922--Narcotic Drugs Import and Export Act limits the importation of crude opium and coca leaves to amounts deemed necessary for medical and scientific needs and specifically prohibits the importation of opium for smoking or the manufacture of heroin. A revision of the Harrison Act.

1924--Federal act prohibiting the importation of crude opium for the purpose of manufacturing heroin.

1929--Federal act establishing two United States narcotic farms for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs who have been convicted of offenses against the United States.

1930--Amendment to Harrison Act establishing the Federal Bureau of Narcotics for the specific purpose of enforcing the Harrison Act.

1932--Congress proposed a model state uniform narcotic law which was passed by all but two or three states. These states passed their own laws.

1937--Marijuana Tax Act imposed an occupational tax on certain dealers in marijuana and a transfer tax on certain dealings in marijuana.

1937--Federal act increasing the punishment of second, third, and subsequent offenders against the narcotic laws.

1938--Federal Food, Drug, and Cosmetic Act divided drugs into two main classes: prescription drugs and over-the-counter drugs. Enforcement of this law was under the Federal Food and Drug Administration.

1939--Federal act providing for the seizure and forfeiture of vessels, vehicles, and aircraft used to transport narcotic drugs, firearms, and counterfeit coins, securities, and paraphernalia.

1942--The Opium Poppy Control Act prohibiting the cultivation, purchase, sale, transfer, or giving away of the opium poppy, without proper license.

1944--Amendments to the Internal Revenue Code, the Narcotic Drugs Import and Export Act, and the Tariff Act of 1930 to classify any new synthetic drugs.

1946--Federal act providing for the coverage of certain drugs (opiates) under the Federal narcotic laws. "Opiate" shall mean any drug having an addiction-forming or addiction-sustaining liability similar to that of morphine or cocaine.

1948--Criminal Justice Act providing for the informal treatment in or at a hospital of a person on probation who consents to such treatment being made as a condition of his parole.

1951--The Bogg Amendment providing the penalty provisions applicable to persons convicted of violating certain narcotic laws, by providing more severe penalties for the illegal possession or sale of narcotic drugs and limits the suspension of sentences or the granting of probation or parole.

1951--Amendment to the Federal Food, Drug and Cosmetic Act to include barbiturates and amphetamines.

1953--Amendment to the Internal Revenue Code and the Narcotic Drugs Import and Export Act so as to provide that certain drugs which are or may be chemically synthesized shall be included within the classification of narcotic drugs.

1954--Federal act providing for the revocation or denial of merchant marine documents to persons involved in certain narcotic violations.

1954--Amendment to the Internal Revenue Code to permit the filling of oral prescriptions for certain drugs.

1955--Federal act authorizing subpoenas in connection with the enforcement of the narcotic laws.

1956--The Narcotic Control Act providing as a penalty for the unlawful sale of narcotics or marijuana between adults (first offense), a sentence of not less than 5 or more than 20 years, with an optional fine up to $20,000. No probation, suspension, or parole is allowed. For the adult who in any manner furnishes heroin to a minor, the act provides for imprisonment from 10 years to life, for an optional fine up to $20,000, or for the death penalty if the jury so directs.

1960--The Narcotic Manufacturing Act covering the manufacture of a narcotic drug, either directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction or chemical synthesis.

1962--White House Conference on Narcotics and Drug Abuse.

1964--The Supreme Court of California ruled that Indians have the right to use peyote as a sacremental symbol.

1965--The Drug Abuse Control Amendment amends the Federal Food, Drug and Cosmetic Act applying to depressant and stimulant drugs which are determined to have potential for abuse because of their depressant, stimulant, or hallucinogenic effect on man. Barbiturates, amphetamines, LSD, and other comparable drugs are included under these provisions; other drugs may be added as the need arises. These amendments place strict controls over the illegal manufacture, distribution, possession, or prescription of these drugs and increase the enforcement powers of the Food and Drug Administration inspectors in dealing with infringements of the law.

1966--The Narcotic Rehabilitation Act covering the civil commitment and rehabilitation of narcotic addicts respecting institutional custody and aftercare using Federal, State, and private facilities.

1967--Designation of Federal hospitals at Lexington, Kentucky and Fort Worth, Texas as drug abuse research institutions under programs administered by the National Institute of Mental Health.

1968--Amendment to the Federal Food, Drug and Cosmetic Act to increase the penalties for unlawful acts involving LSD and other depressant and stimulant drugs.

1968--Governmental reorganization combining the activities of the Bureau of Drug Abuse Control (established by Drug Abuse Control Amendment of 1965) and the Federal Bureau of Narcotics under one office, the Bureau of Narcotics and Dangerous Drugs within the Justice Department.

1969--Supreme Court decision holding the Marijuana Tax Act is unenforceable when the accused claims Fifth Amendment privilege against self-incrimination. It declares as unreasonable the law's presumption that a man with marijuana in his possession knows that it was imported illegally, thus violating due process of law.

1970--Comprehensive Drug Abuse Prevention and Control Act of 1970 for the first time consolidated all Federal drug laws into one comprehensive act designed to control the legitimate drug industry and to curtail illicit importation and distribution of drugs throughout the United States.

1970--The Uniform Controlled Substances Act designed to achieve uniformity between Federal and State laws was adopted by the National Conference of Commissioners on Uniform State Laws under sponsorship of the Justice Department. Twenty-five states have enacted the act or modified versions.

1971--Special Action Office for Drug Abuse Prevention established by Executive Order to coordinate policies and programs against drug abuse.

1972--Drug Abuse Law Enforcement Office in the Justice Department established by Executive Order to utilize the enforcement personnel of the Justice and Treasury Departments in stamping out the illicit narcotic traffic, at home and abroad.

ANNEX E

DRUG ABUSE REHABILITATION AND TREATMENT CENTERS--QUESTIONNAIRE AND LISTING

1. A questionnaire was prepared and sent to 84 major drug abuse rehabilitation and treatment centers across the nation. Its purpose was to obtain current information on their activities for use both in the rehabilitation portion of the basic study and also to assist the Army Staff in planning its own program. The centers were selected from a list provided by the National Institute of Mental Health. Selection was based on: experience; locations in areas of high addiction; a range of addict population types; varieties of staffing patterns and treatment modalities; and representative organizational types (i.e., Federal, state, private).

2. Appendix E-1 of this annex is a copy of the questionnaire, and Appendix E-2 is a listing by states of the organizations contacted. The response rate was approximately 40 percent; organizations which replied are indicated by an asterisk.

APPENDIX E-1

QUESTIONNAIRE

1. What rehabilitation modes do you employ?

2. What do you consider success, what is the average length of time to achieve it, and what is your success rate (in percent)?

3. Do you have a follow-up program? If so, what is your long-term success rate?

4. After your patients have completed your program, what after-care services are available to them and do you feel they are adequate?

5. Do you insure confidentiality for your patients; and if so, how is this done?

6. Are different or special rehabilitation techniques used for people who are voluntarily rather than non-voluntarily admitted to your program?

7. What research do you consider necessary in the rehabilitation field?

8. What is your operating philosophy and what aspects of your program do you consider unique?

9. Have any US Army representatives visited your program? If so, who were they and when did they visit?

10. Please return your completed survey to:

Engineer Strategic Studies Group
Office, Chief of Engineers
6500 Brooks Lane
Washington, D. C. 20315

NAME: _____

TITLE: _____

ORGANIZATION: _____

ADDRESS: _____

PHONE: _____

APPENDIX E-2

LISTING OF DRUG ABUSE REHABILITATION AND TREATMENT CENTERS

Arizona

*Maricopa County General Hospital
Department of Psychiatry
3435 West Durango Street
Phoenix, Arizona 85009

California

California Correctional Institution at Tehachapi
P.O. Box 1031
Tehachapi, California 93561

*California Rehabilitation Center
P.O. Box 841
Corona, California 91720

Drug Abuse Treatment Program
County of Santa Clara Health Department
2220 Moorpark Avenue
San Jose, California 95128

*The Foothill Free Clinic
547 East Union Street
Pasadena, California 91101

*Haight-Ashbury Free Clinic
558 Clayton Street
San Francisco, California 94117

*Mendocino State Hospital
Box X
Talmage, California 95481

*Narcotic Addict Outpatient Program
Parkway Center, Vinewood Center
107 South Broadway, Room 3014
Los Angeles, California 90012

Narcotics Prevention Project
Boyle Heights Center
507 Echandia Street
Los Angeles, California 90033

Northeast Mental Health Center
Drug Abuse Screening Unit
2450 22nd Street
San Francisco, California 94110

The Salvation Army Manhattan Project
916 Francisco Street
Los Angeles, California 90015

Colorado

*Colorado State Hospital
Alcoholic Treatment Center and Day Care Center
1600 West 24th Street
Pueblo, Colorado 81003

Division of Psychiatric Services
Denver General Hospital
West Sixth Avenue and Cherokee Street
Denver, Colorado 80204

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*Indicates organization responded to questionnaire.

Connecticut

*Alcohol and Drug Dependence Division
State of Connecticut, Department of Mental Health
51 Coventry Street
Hartford, Connecticut 06112

*Connecticut Valley Hospital
Alcoholism and Drug Dependence Unit and New Haven Unit
Middletown, Connecticut 06457

*Drug Dependence Unit
Connecticut Mental Health Center
34 Park Street
New Haven, Connecticut 06520

Daytop, Inc.
312 Roosevelt Drive
Seymour, Connecticut 06483

*Narcotic Addict Rehabilitation Unit
Federal Correctional Institution--Danbury
Danbury, Connecticut 06810

District of Columbia

Bonabond, Inc.
412 5th Street, NW
Suite 105
Washington, D. C. 20015

Blackman's Development Center
6406 Georgia Avenue, NW
Washington, D. C. 20015

Drug Addiction Treatment and Rehabilitation Center
District of Columbia Department of Public Health
1825 13th Street, NW
Washington, D. C. 20009

Guide, D. C. Program
Psychology Department
Catholic University
Washington, D. C. 20017

Last Renaissance
Holly House
Saint Elizabeths Hospital
Washington, D. C. 20032

Narcotics Treatment Administration (NTA)
122 "C" Street, NW, Room 200
Washington, D. C. 20001

Narcotics Treatment Administration
Community Addiction Treatment Center (CATC)
1400 Que Street, NW
Washington, D. C. 20009

Narcotics Treatment Administration
Drug Addiction Medical Services (DAMS)
D. C. General Hospital
1905 E Street, SE
Washington, D. C. 20011

Narcotics Treatment Administration
NARC Center Satellite
919 12th Street, NW
Washington, D. C. 20015

Neighborhood Treatment Center
519 C Street, NE
Washington, D. C. 200002

New School of Psychotherapy
4600 Connecticut Avenue, NW
Washington, D. C. 20008

Northwest Settlement House
448 Ridge Street, NW
Washington, D. C. 20015

Project Reach
(Pride, Inc.)
1536 "U" Street, NW
Washington, D. C. 20009

Regional Addiction Prevention,
Inc. (RAP)
1904 "T" Street, NW
Washington, D. C. 20009

Residential Treatment Center
519 C Street, NE
Washington, D. C. 20002

Veterans' Administration
Hospital Drug Treatment and
Research Unit
50 Irving Street, NW
Washington, D. C. 20422

The Washington Free Clinic
Georgetown Lutheran Church
1532 Wisconsin Avenue, NW
Washington, D. C. 20017

Illinois

Illinois Drug Abuse Program
Illinois Narcotic Advisory
Council
5801 South Ellis Avenue
Chicago, Illinois 60637

Maryland

Montgomery County Drug Abuse Program
8500 Colesville Road
Silver Spring, Maryland 20910

*Narcotic Outpatient Clinic of
Baltimore
2100 North Eutaw Place
Baltimore, Maryland 21217

Potomac Foundation for Mental Health
5413 West Cedar Lane
Bethesda, Maryland 20014

*Prince George's County Health
Department
Cheverly, Maryland 20785

Project ADAPT
Provident Hospital
1514 Division Street
Baltimore, Maryland 21217

*SAND
Echo House Foundation
1705 West Fayette Street
Baltimore, Maryland 21223

Massachusetts

*Drug Addiction Rehabilitation
Center
Boston State Hospital
591 Morton Street
Boston, Massachusetts 02124

*Drug Addiction Treatment Center
Massachusetts Correctional
Institution
Bridgewater, Massachusetts 02324

Drug Addiction Treatment Unit
Boston City Hospital,
Psychiatric Service Unit
249 River Street
Mattapan, Massachusetts 02126

Missouri

*Narcotic Addiction Treatment Program
Department of Psychiatry,
Missouri Institute of Psychiatry, University of Missouri
5400 Arsenal Street
St. Louis, Missouri 63139

*Western Missouri Mental Health Center
600 East 22nd Street
Kansas City, Missouri 64108

New Jersey

*Drug Addiction Rehabilitation Enterprise
209-211 Littleton Avenue
Newark, New Jersey 07103

*The Mount Carmel Guild Narcotics Rehabilitation Clinic
9 South Street
Newark, New Jersey 07102

*New Jersey Neuro-Psychiatric Institute
Drug Addiction Treatment Unit
P.O. Box 1000
Princeton, New Jersey 08540

The New Well Narcotic Rehabilitation Center
173 Belmont Avenue
Newark, New Jersey 07103

Passaic County Narcotic Aftercare Clinic
323 Main Street
Paterson, New Jersey 07505

St. Dismas Rehabilitation Center for Drug Addiction
396 Straight Street
Paterson, New Jersey 07501

*Union County Narcotics Clinic
43 Rahway Avenue
Elizabeth, New Jersey 07202

New Mexico

Bernalillo County-University of New Mexico School of Medicine
Comprehensive Community Mental Health Center
1007 Stanford, NE
Albuquerque, New Mexico 87106

New York

*Addicts Rehabilitation Center of the Manhattan Christian Reformed Church
253 West 123rd Street
New York, New York 10027

Bronx Narcotics Aftercare Clinic
Ward's Island
New York, New York 10035

Corps Outreach Program
1991 Lexington Avenue
New York, New York 10031

*County of Nassau Drug Abuse and Addiction Commission
320 Old Country Road
Garden City, New York 11530

Daytop Village
184 Fifth Avenue
New York, New York 10010

Drug Abuse Section
Lincoln Hospital, Department of Psychiatry
333 Southern Boulevard
Bronx, New York 10467

*Encounter
150 Spring Street
New York, New York 10012

Exodus House
304 East 103rd Street
New York, New York 10029

Greenwich House Counseling Center
27 Barrow Street
New York, New York 10011

Horizon Project
Lower East Side Demonstration Project
71 Worth Street
New York, New York 10013

*Inward House
45 West 177th Street
Bronx, New York 10453

Kinsman Hall
Box K, Route 22
Hillsdale, New York 12529

Lower Eastside Service Center
165 East Broadway
New York, New York 10002

**Manhattan Narcotic Aftercare Clinic
39 East 17th Street
New York, New York 10003

**Manhattan State Hospital
Drug Addiction Unit, Ward's Island
New York, New York 10035

Middletown State Hospital
Drug Addiction Unit
Middletown, New York 10940

*Motivational Guidance Association
443 West 47th Street
New York, New York 10036

**Narcotic Addiction Unit
Kings Park State Hospital
Kings Park, New York 11754

*National Family Council on Drug Addiction
401 West End Avenue
New York, New York 10024

*Odyssey House
309-311 East Sixth Street
New York, New York 10003

The Peoples Program
204 West 136th Street
New York, New York 10030

Phoenix House Foundation
205 West 85th Street
New York, New York 10024

Quaker Committee on Social Rehabilitation
135 Christopher Street
New York, New York 10014

Reality House
2065 Amsterdam Avenue
New York, New York 10032

**Indicates organization no longer in existence.

*The Renaissance Project
515 North Avenue
New Rochelle, New York 10801

Samaritan Halfway Society
130-15 89th Road
Jamaica, New York 11418

Virginia

Alexandria Community Mental
Health Center, Drug Abuse
Program & Second Genesis
720 North St. Asaph Street
Alexandria, Virginia 22314

Arlington County Drug Abuse
Program
1800 North Edison Street
Arlington, Virginia 22207

*Fairfax County Drug Abuse Clinic
4100 Chainbridge Road
Fairfax, Virginia 22030

ANNEX F

SUGGESTED BRIEFING SCRIPT AND VISUAL AIDS OF STUDY

1. General.

a. This annex consists of a suggested briefing script (Appendix F-1) and major supporting visual aids (Appendix F-2).

b. It takes approximately 35 minutes to present the briefing in its printed format, but it was originally designed as a multimedia presentation. This can be accomplished by adding appropriate film clips, voice tapes, and 35-mm slides illustrating points made in the script. Although this particular briefing has been designed for presentation to military audiences, and especially to Army audiences, the only portion of the script that applies particularly to the military is the closing statement. The closing statement should be altered to meet the needs of the particular audience receiving the presentation.

2. Background.

a. This briefing was originally prepared for and presented to the Army World-Wide Drug Abuse Conference held in Washington, D. C. in

APPENDIX F-1

BRIEFING SCRIPT
FOR
A PROFILE OF DRUG ABUSE IN THE UNITED STATES

I. OPENING STATEMENT

Shooting heroin, popping pills, and smoking marijuana occur throughout every corner of the US--the big city, the small town, the ghetto, suburbia, the West Coast, the Great Plains, the poor, the rich...anyone, anywhere.

We've been hearing about it for decades; it has been with us for centuries, but only today is it threatening the fabric of our nation.

The problem began to surface in the mid-1960's, and the nation, slow to respond at first, is just beginning to act decisively.

(Slide 1 On) There are five key questions that we must answer if we are going to solve this problem.

What is the magnitude of the problem?

What motivates drug use?

How are we, as a nation, responding to it?

What can our past experience teach us?

And what are our prospects? (Slide 1 Off)

II. PATTERNS OF DRUG USE

Just what is the magnitude of the problem?

Just how many people are abusing drugs?

Contrary to popular belief, much data are available. (Slide 2 On) Since the mid-1960's many surveys have been made, and we have analyzed almost 75 of them. The best data date from 1967.

These surveys are nationwide, although some areas are better surveyed than others. They include a wide range of ages, education, and ethnic groups; but most of those surveyed were in college and high school because it is easy to survey students. (Slide 2 Off)

The data are not uniform across the nation. Each individual school and neighborhood have their unique problems in terms of which drugs are being abused and who is abusing them. However, there are threads running through all the surveys which form patterns common to the nation as a whole.

The use of marijuana is the most widespread national pattern. Although the exact number of users is unknown, estimates range from 15 to 24 million persons.

(Slide 3 On) Two years ago, most colleges reported that about one-fourth of their students had experimented with marijuana at some point in their lives. The latest national poll of college students,

which was released in January 1972, indicates that marijuana use has doubled in just 2 years to 51 percent among students, and other survey information indicates even higher percentages.

It's important to note that not all of those who experiment with drugs continue their use. (Slide 3 Flip) In 1969, less than half of those who had experimented continued using marijuana. The latest data indicate that more than half of those who have experimented are continuing its use. (Slide 3 Off) There is less marijuana used in high school than in college, although it is difficult to find consistent nationwide patterns. (Slide 4 On) The best data available come from San Mateo, California where surveys have been conducted for 4 years. Their trend shows a leveling at below 50 percent. This may not apply to the rest of the nation, but it is the first leveling of drug use that we have seen anywhere. (Slide 4 Off)

On the other hand, survey data indicate that first usage throughout the nation is beginning at earlier ages...often before junior high school.

Traditionally more men than women have experimented with marijuana because male roles have emphasized excitement, adventure, and risk taking. This is still true for younger students; but, in college, females are almost equally represented. This reflects, in part, the changing roles of women in our society.

Marijuana use was identified one generation ago with the big city ghetto, but now it pervades every segment of our society. It is common knowledge that anyone who wants marijuana can get it almost as easily as a quart of milk.

The same pattern is becoming true for heroin. Heroin is almost as available to our young people as marijuana. The remark made by a student that "I get offered heroin every damned time I buy grass," is typical for almost every campus and every community in the nation. It is little wonder that the abuse of heroin is increasing. (Slide 5 On) There have been many surveys of heroin abuse, but (because of the fear of legal penalties and the social stigma attached to it) these results are considered understated by most authorities. (Slide 5 Off)

Until this year, heroin use among students across the nation seemed fairly consistent at between 1 and 2 percent in most survey locations. This appeared true for young people of both college and high school ages. (Slide 6 On) The latest survey information shows usage increasing to between 3 and 4 percent although the data are by no means uniform across the nation. It appears that a little more than one million young people have tried heroin in the United States. Survey data do not tell us how many have become addicted, but official estimates of more than 300,000 seem reasonable. If the trends of the past 3 years continue for the next 3 or 4 years, these numbers will at least double, and the increase could be larger. (Slide 6 Off)

Other drugs commonly abused are hallucinogens (other than marijuana), stimulants, and depressants. Their use patterns fall between that of marijuana and heroin. The number of users fluctuates widely depending upon location and popularity of the moment; overall, abuse of these drugs is increasing.

Until the last few years, it was easy to describe the typical drug abuser. Marijuana and heroin were used by the black, the poor, the deprived--those who had given up on life and who sought release in much the same way as the "skid-row" alcoholic. Stimulants and depressants were abused mainly by middle class adults who cloaked their abuse as a medical need.

Today's drug abuser no longer fits this pattern. True--drug abuse remains high in the ghetto, but the big increase is among the young, white, middle class, who are above average in intelligence and education. He may or may not have long hair. He might wear a business suit or levis. His father may be a politician, a construction worker, or a corporate manager. About the only thing we know for sure is that he is young.

In a sentence, he is any man and any man's son from any place, and his use of drugs--all drugs--is increasing.

III. WHY ARE DRUGS ABUSED?

Why is drug abuse so popular and why is it increasing?

Whay are so many young people willing to ignore the risks--both criminal and medical?

The true reasons are not easily found. Most young people give ore of three answers.

(1) Because of pressure from friends.

(2) It offers escape from problems, or

(3) It's fun.

But these answers are symptoms or reasons, not the reasons themselves.

The real questions remain unanswered.

(1) Why do they succumb to pressure?

(2) Why do they turn to escape rather than solutions?

(3) Why is this their idea of fun?

In our study we tried to find a consensus among experts and drug users that would show relationships between the many factors that box in the young person and convince him that his only escape is through drug abuse.

America is often called "a drug-oriented society." (Slide 7 On) Drugs of all kinds are readily available and in many cases greatly over-produced. Earlier this summer President Nixon criticized last year's production of 5 billion doses of tranquilizers, 5 billion doses of

barbiturates, and 3 billion doses of amphetamines, when our actual needs are much less. One estimate for amphetamines is in the hundreds of thousands--not in the billions.

A recent survey among doctors and pharmacists showed that two-thirds of the doctors believe they prescribe too many of these drugs and the pharmacists think the public buys too many of them. The American public acts as though the solution to all problems can be found in medicine. "A pill for every problem" is the message of advertising, and $300 million each year is spent selling it on television alone.

With this national tendency to overuse drugs, (Slide 7 Flip) it is not surprising that the young person who has never used drugs may not act wisely when he finds himself in a group where drugs are available and the group is urging him to try them and "turn on."

This is when the first hard decision about drugs is made--and under these conditions he is likely to act irrationally. (Slide 7 Flip) At this point, much depends upon his personality and how he thinks of himself as a person. All young people are curious--especially about drugs. They look for new experiences. Adolescence is the one time in everyone's life to experiment, to discover sex, and to test oneself. For many, drug abuse is the route they choose in their search.

To them, drug taking is great adventure. The dangers of physical harm, the risk of getting caught, and the disapproval of parents and

the law make drug abuse exciting. This appeals to those young people who are bored because they spend so much of their time in schools they don't enjoy or in jobs that are meaningless.

How a young person thinks of himself as a person is also important. Most feel inadequate among their peers. Drug use can boost confidence and provide acceptance in a group. For many, drug abuse is a cry for help--a search for someone who sincerely cares about him as an individual--a search for someone who is concerned about him as a person. The heroin abuser is especially eager to find friends to share his misery and life style.

(Slide 7 Flip) His relationship with his family and his position in the community will influence his decision to use drugs. Drug abuse can be a reaction to parents who are intolerant or overly protective--a rebellion against restrictions on his freedom. On the other hand, he may react to the lack of guidance or the disinterest of his parents. Young people seek and desire limits, but the limits must not be changed casually. The young recognize hypocrisy just as you and I do. The old "do as I say--not as I do" does not work. The young person sees his parents using alcohol, stimulants, and tranquilizers for their problems. His attitude toward his drugs appears just as reasonable as their attitude toward their drugs.

If he is close to his family and they share a home of mutual trust and respect, their feelings will matter to him and will influence his

decision not to use drugs. If he has no close ties with his family and little responsibility, he is more apt to turn to drugs.

For young people drugs have special meanings. (Slide 7 Flip) In the youth culture, drug use stands for "openmindedness" and "intellectual depth." Some are supposed to make you more creative, to "unlock the secrets of the universe," to help find true religious and mystical understanding of life. Other drugs are said to increase sexual desire and sexual potency. The use of drugs is also a symbol of defiance. They are waved in protest against an establishment that screws up everything it trys to correct. Whether or not these meanings are true or false is beside the point. They are believed by young people and are a part of the drug culture.

(Slide 7 Flip) The stress and frustration caused from living in today's complex society are increasing. Institutions are unresponsive; our cities are overcrowded and falling apart; our highways are jammed; our environment is becoming polluted; and national issues of racism, war, and poverty are not being resolved fast enough. For many, a sense of resignation and hopelessness for our nation and for life results. The "Tune In, Turn On, and Drop Out" philosophy is one way of expressing these feelings. (Slide 7 Off)

Three conclusions can readily be drawn from all this. (Slide 8 On)

First and most important--the decision to use drugs is based on attitudes and emotions of the moment and is not rational.

Second--there is no single reason for drug abuse; there are many interrelated reasons.

Third--deciding to use drugs is not a one-time decision but occurs many times on many occasions throughout life. However, if the first use of drugs is a good experience, this becomes a major influence the next time. (Slide 8 Off)

IV. THE NATIONAL RESPONSE TO THE PROBLEM

We have said that drug abuse is increasing rapidly and the reasons are complex and difficult to understand. In this environment, how is the nation responding to the problem?

Most of our national energy has been in two areas--prevention and rehabilitation. By prevention, we mean law enforcement and education.

First, we'll look at law enforcement.

The Harrison Act of 1914 was the first national law passed to control the production, distribution, and use of narcotics. Since then, numerous laws have been passed regarding drug abuse. However, as our drug problem has grown, we found in our survey that many of our laws do not reflect our changing attitudes and our growing understanding of the problem. Laws have not been aimed at prevention but have been based on a reaction to a specific problem of another era.

Each state and many localities have their own laws, and there is no coordination between states. Many laws are outdated and inadequate. Many states and localities recognize this and are changing their laws; many are not.

(Slide 9 On) The Ohio law is typical of those based on earlier attitudes. For simple possession of marijuana, the first offense is punishable by 2 to 15 years in jail and a fine up to $10,000. For selling or providing marijuana, the penalty is 20 to 40 years in jail.

If the full extent of this law were applied to the 16,000 students at one major university in Ohio who claimed they have used marijuana, the state would have to provide jail space for 252,000 man-years and students or parents would have to pay $168 million in fines. This is only one university of 64 in the state. Obviously, if the law were fully enforced, the system could not support it. (Slide 9 Off)

Thus, we found that police at the local level can only enforce the law on a selective and unequal basis. Officials, in expressing their concern to us over this, pointed out that respect for the law is quickly undermined when laws fail to gain universal acceptance and universal enforcement. The officials did not mean that drugs should be legalized, although there are some who urge legalization, but that the law should be realistic.

The Controlled Substances Act of 1970, the most recent Federal law, is more realistic. (Slide 10 On) It reflects some of our changing attitudes toward drugs. In this law, narcotics, marijuana, and dangerous drugs are classified into five categories. Penalties vary for each category. Penalties are heaviest against major distributors and manufacturers, whereas simple possession of any controlled substance is now a misdemeanor for the first offense. Drug experimenters without previous convictions may be placed on parole or probation. This law also treats the distribution of small amounts of marijuana as a misdemeanor. States are being encouraged to update and revise their laws to complement this new Federal act. (Slide 10 Off)

We recognized in conducting our study that it's easy to be critical of the laws that seem outdated and unrealistic. The difficult job is to find the correct balance. But certainly respect for all laws and all authority begins to break down when laws become unjust because of erratic enforcement and ineffectual because millions of citizens will not accept them. Eventually, the stability of the nation is threatened. We found that this is recognized at the Federal level, and laws are being changed.

We also found that this is not as well understood at the state and local levels, and many laws remain unchanged.

V. EDUCATION

The other half of prevention is education. As long as drugs were limited to a few persons in the ghetto, there was no interest in drug abuse education in this nation. All this has changed abruptly in just the last 2 or 3 years. However, the drug problem has grown much faster than our understanding of it; and, of course, we cannot educate if we do not understand.

Traditionally, the family, the church, and the schools shared responsibility for developing the minds and attitudes of our young. The emphasis has changed over the years, and today we depend almost entirely on the schools. In our pursuit of money and possessions, little time is left for education at home. Many parents and their children don't communicate well about most things (much less about something as serious as drug abuse), especially when the young people are better informed about drugs than their parents. The church by and large has not had the expertise to become effectively involved in drug abuse. So, when we speak of education, we are referring primarily to formal education in the shcools with full knowledge that some of the responsibility belongs at home and at church.

In our survey of drug abuse education we found no lack of interest, no lack of desire, and certainly no lack of effort at all levels of education, but, we found a lack of understanding of the complexities of

the problem. Much of this lack of understanding can be traced to our past information about drugs. (Slide 11 On) During the 1930's, the movies and information media portrayed drug abuse as an "evil." The drug abuser was a fiend, and his drugs would corrupt and kill the young. Drug abuse was morally wrong, and only evil people and criminals were involved. There were almost no facts available about the physical effects of drugs and no understanding of the motivations behind their use.

All these attitudes have continued up until the last several years. Many Americans still have some of these views. It is not surprising that education based on fear has been ineffective with today's youth. (Slide 11 Off)

All this is changing. The subject of drug abuse fills more and more space in the newspapers, time on television, and attention in our conversations. We are continually adding to our understanding of the problem, although much remains to be done. But, it is not easy. In our survey we were almost overwhelmed by the many sources of information, (Slide 12 On) and it is difficult to know who is right when everyone is saying something different. When even the experts cannot agree, how can we expect the average teacher to understand--much less our young people. Some of the best examples of this problem are the many drug films that are available for school use. About half of them have been

rated "scientifically unacceptable" because of inaccurate facts. It was no surprise, therefore, when we found a consensus among professionals that most drug abuse programs in schools are ineffective and often counterproductive. Teachers simply have not had the facts nor the understanding to make their efforts effective. Also, young people know far more about drugs than adults realize. They do not accept information when it appears phoney and exaggerated beyond what they themselves have observed. (Slide 12 Off)

(Slide 13 On) The National Institute of Mental Health and the Bureau of Narcotics and Dangerous Drugs have taken the lead in trying to bring together all the facts and to present them to educators and the public. This is a large task. (Slide 13 Off)

(Slide 14 On) We found that the education problem is far more basic than inaccuracies in information. The problem is twofold.

First, formal drug abuse education is based on the assumption that decisions to use drugs are rational, whereas actual decisions are casual and irrational.

Many teachers still assume that if a student knows that drugs may hurt him or put him in jail, he will not abuse them. This may work in a few cases but most educators agree that it does not go far enough. Some are beginning to introduce programs in their schools aimed at changing values and lifestyles as well as providing drug facts.

In this broader concept, education is charged with: providing young people with tools for solving problems rather than escaping from them; teaching them how to avoid boredom through personal initiative and imagination; helping them cope with problems of self-identity and expressing themselves; and helping them face the problems of living in a modern society without using drugs as a crutch.

We have been able to find only a few systems where this larger concept is operating. Our reports indicate that these systems have less drug abuse than neighboring systems.

(Slide 14 Flip) The second concern that educators face is that drug abuse decisions are not made only once but over a lifetime.

Several drug abuse surveys of white, middle class suburbia indicate that a growing number of 10-, 11-, and 12-year olds are starting to use drugs--including heroin. Many school systems are beginning to face this problem by starting drug abuse programs in the elementary grades. Educators also agree, even more strongly, that adults need drug education--especially parents and prospective parents--but it is more difficult to include them. In any event, drug abuse education is a continuing process, starting early and aiming at developing healthy attitudes. (Slide 14 Off)

VI. REHABILITATION

When drug abuse prevention fails because of poor or inadequate education or ineffective and unrealistic laws--or for whatever reason--and there must be reasons we have not found yet--then we turn to rehabilitation.

At the outset, let me say that historically and up until the present time, rehabilitation has been considered ineffective. (Slide 15 On)

Our Federal Research Center at Lexington, Kentucky which has had the most experience with drug rehabilitation, tells us that only about 13 percent of their males have remained drug free after completing their program which can take several years. The Lexington program uses many different methods of treatment--almost anything that works. In many of our local community rehabilitation centers, especially half-way houses, success (if measured in terms of "totally drug free") is very low--around 5 percent or less--and it is often necessary to have the graduate live and work under sheltered conditions.

(Slide 15 Flip) The reasons for this apparent ineffectiveness, like so many in the drug abuse business, are complex and difficult to understand.

We all know that most physical problems, such as detoxification, can be handled in several days or weeks at the longest; and, we realize

the psychological and social problems are not so easily solved and require long-term attention. Experts agree that people respond to different treatments according to their own unique needs. (Slide 15 Off)

Since the mechanics of the intensive treatment required are highly varied and extremely complex, we do not have time to go into the details here. However, we do want to make two observations based on our survey of the rehabilitation process. After his intensive treatment, the individual must rejoin the community. His rehabilitation does not stop at this point. He must be followed and provided with additional services as he begins to find his place in the community which often is hostile to him.

We found a growing awareness among professionals that after-care services may be as important as intensive treatment. At the present time, after-care is the most poorly developed and least understood phase of the rehabilitation process. During our survey, we often heard experts say "drug abuse is a total community problem requiring total community support." This statement seems to apply especially well to after-care services.

There is also a growing consensus among professionals (Slide 16 On) that our standards for measuring rehabilitation success are not realistic. They ask if it is absolutely necessary to be totally cured or to remain permanently drug free.

Can something less be accepted? They argue that it should be enough to ask a man (after treatment) to reenter society, hold a job, support and live with his family, and in general lead a productive life. (Slide 16 Off) (Slide 17 On)

At Lexington, with only 13 percent judged totally cured, 85 percent are employed and off drugs 80 percent of the time.

Other institutions report 70 percent and higher rates of productive activity.

The methadone maintenance programs which have success rates of more than 75 percent might be included in this category. (Slide 17 Off)

We are not entirely sure what these figures mean since all programs screen out those abusers that appear to be bad risks. (Slide 16 On Again Plus Flip) We also must be aware that for many, remaining totally drug free is the only choice, just as remaining totally alcohol free is the only choice for many alcoholics.

But if the nation is willing to accept something less than a total cure, then we see a glimmer of hope; and, certainly, if ever we needed hope with a problem, this is the time. (Slide 16 Off)

VII. THE PROSPECTS AHEAD

As we conducted our study and analyzed the many surveys, papers, and books, and as we talked with professionals, officials, and workers at all levels, we were constantly aware of an urgency (almost a desperation) that we must beat the drug problem and beat it now. We also were constantly aware of the many failures and the overwhelming frustrations of those working closely with the drug abuser. We found no lack of desire to beat the problem, but we also found no sure way of beating it. The one hope that we see results from reevaluating the traditional problem and redefining it to reflect today's society and scientific awareness.

Basically it's a grim, nasty business and the prospects ahead are not encouraging. What has developed is an instant religion promising instant ecstacy at the point of a needle. America is faced with losing a significant percentage of our most precious national resource--our young people. (Slide 18 On)

The overriding trend is that drug abuse will continue to increase. We see no leveling off or topping out for any drug--at least not over the next few years.

This is our conclusion, and it is the almost unanimous belief of everyone working in this field. (Slide 18 Off)

(Slide 19 On) It appears, therefore, that attempts to eliminate drug abuse from the national scene will continue to be unattainable. What does appear attainable is control of drug abuse within some limits. Although this will require changing the attitudes of many Americans, this may not be an unreasonable goal. We tolerate 6 million alcoholics (some say 20 million) and 37,000 deaths each year from the effects of alcohol. We tolerate almost 300,000 deaths each year from tobacco-related problems. (Slide 19 Off) (Slide 20 On)

As drug abuse continues to increase, the nation's laws and law enforcement, especially in the local community, will become more ineffective and counterproductive unless major changes are made. (Slide 20 Off)

(Slide 21 On) Because of outdated laws, law enforcement of drug abuse in many parts of the nation today adds to our problems by destroying respect for authority and the law.

Although these problems are recognized by many, especially at the national level, changes at the state and local levels are difficult to obtain. Unless reforms can be made, we will not be able to preserve the respect for law and authority--by all Americans--that is essential for national stability. (Slide 21 Off)

(Slide 22 On) As drug abuse continues to increase, drug abuse education programs will become even more ineffective unless basic concepts are changed. (Slide 22 Off)

(Slide 23 On) Formal drug education programs are directed toward a rational decision-making process, whereas the decision for drug use is never a rational process.

Education also is directed toward a one-time decision, whereas decisions on drug usage are made many times on many occasions.

Unless educators enlarge their programs to include irrational influences and develop continuing programs as well as provide facts for all age groups, education will not be able to do the job that is required. (Slide 23 Off)

(Slide 24 On) As drug abuse continues to increase, requirements for rehabilitation will expand rapidly and appear less successful than necessary--if we insist upon totally cured, drug-free individuals. (Slide 24 Off) (Slide 25 On) Rehabilitation should be directed toward returning an individual to productive life in society--whether or not he remains drug free. (Slide 25 Off)

VIII. CLOSING STATEMENT

Let me step back and put all this into perspective.

We Americans have a gift for not being honest about our problems. We can look directly at them and deny they exist, or deny they are serious or that resources need to be spent to solve them. With drug abuse these are deceptions the nation cannot afford.

The people and agencies who deal with the drug problem told us that the average citizen and many officials do not understand the magnitude of the problem or what it's going to take to solve it.

These involved people feel that the nation has yet to commit the resources necessary to control drug abuse and believe that the nation's hopes should not be raised if we are not willing to devote the required resources.

It's obvious that the nation has a serious societal problem that affects, most of all, the youth upon whom the Army's life blood and continued existence are directly dependent.

If we minimize our responsibility by claiming that the Army has inherited society's problem, we will be turning our backs on a vital challenge.

The Army has pioneered new causes many times in our nation's history. The opening of the West and integration of the Armed Forces are well known examples.

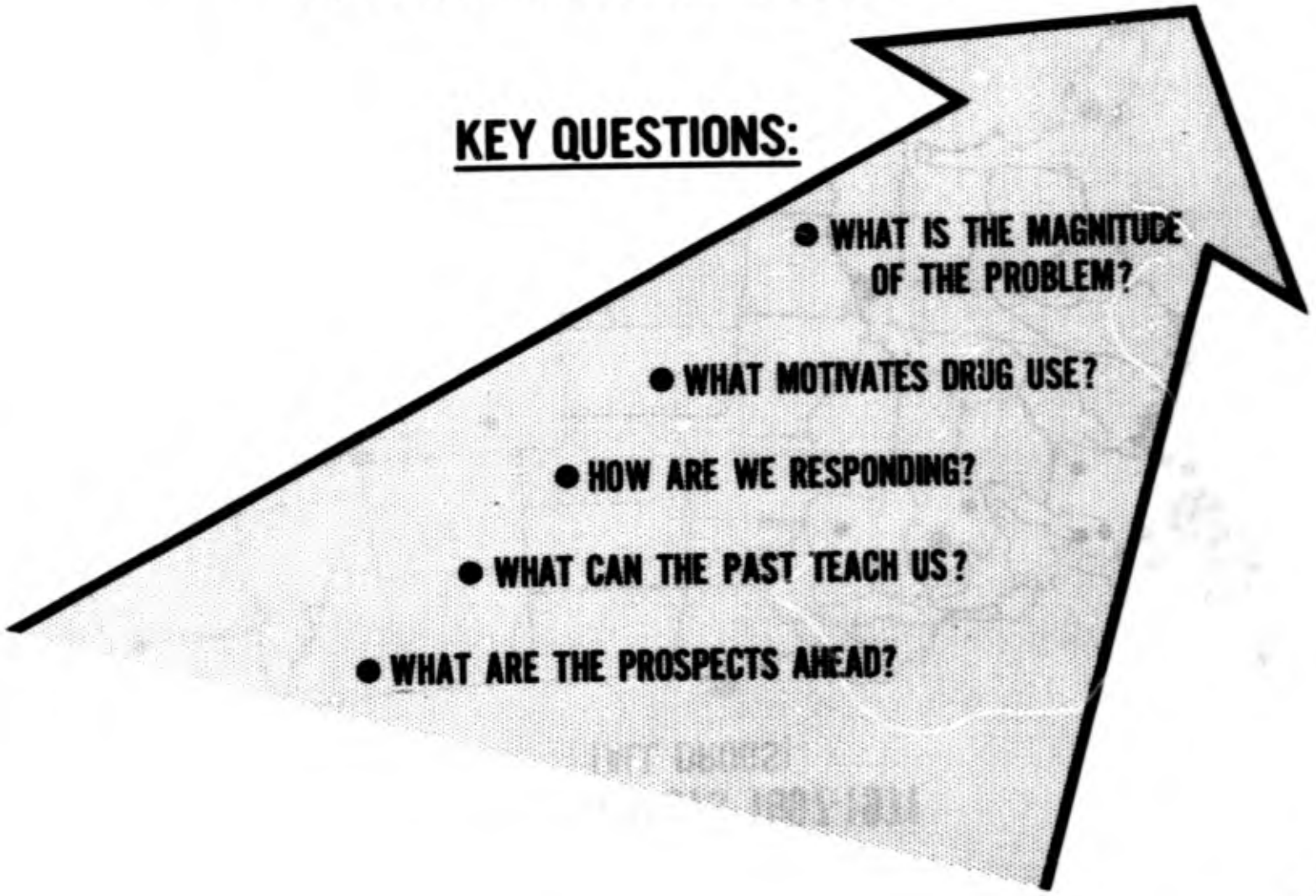
The Army has much to contribute in the way of resources, management know-how, sheer willingness to grapple with difficult problems, and--most of all--leadership.

If the Army leads in getting hold of the drug problem, its reputation will be enhanced and a troubled nation will be grateful.

APPENDIX F-2

SUGGESTED GRAPHICS FOR A PROFILE OF DRUG ABUSE IN THE UNITED STATES

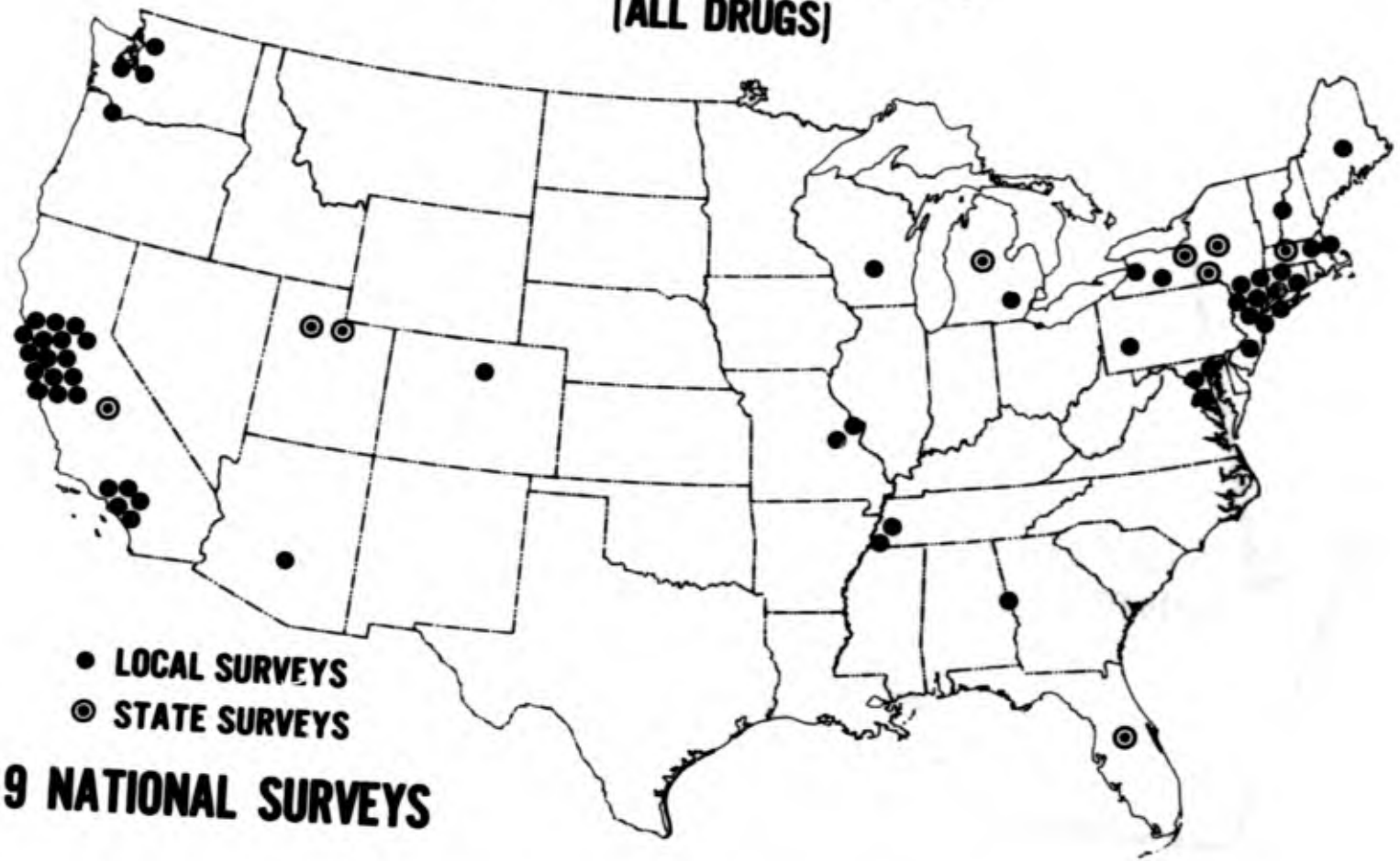
A PROFILE OF DRUG ABUSE IN THE UNITED STATES



F-2-1

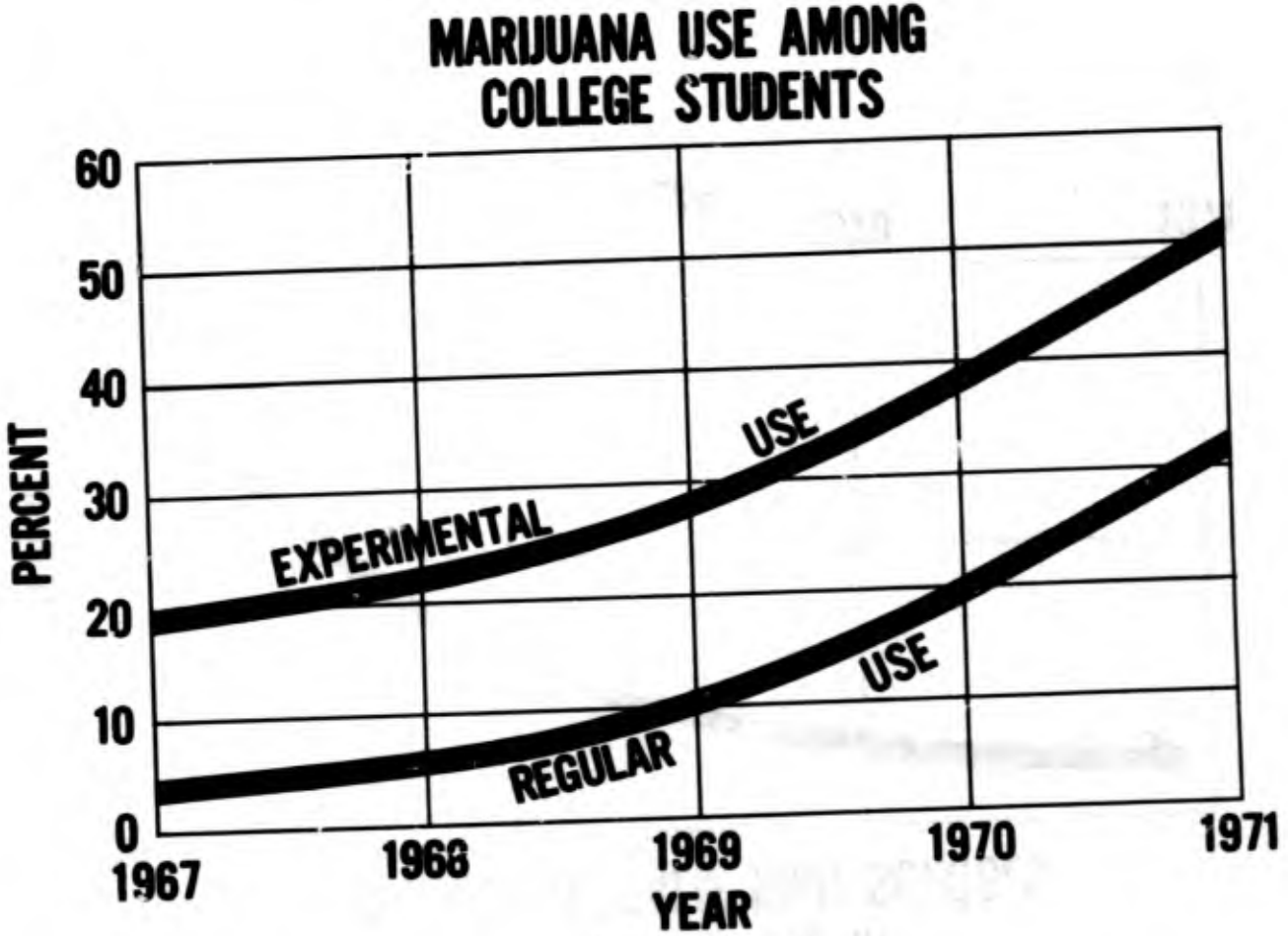
SLIDE-1

DRUG SURVEYS 1967-1971
(ALL DRUGS)



F-2-2

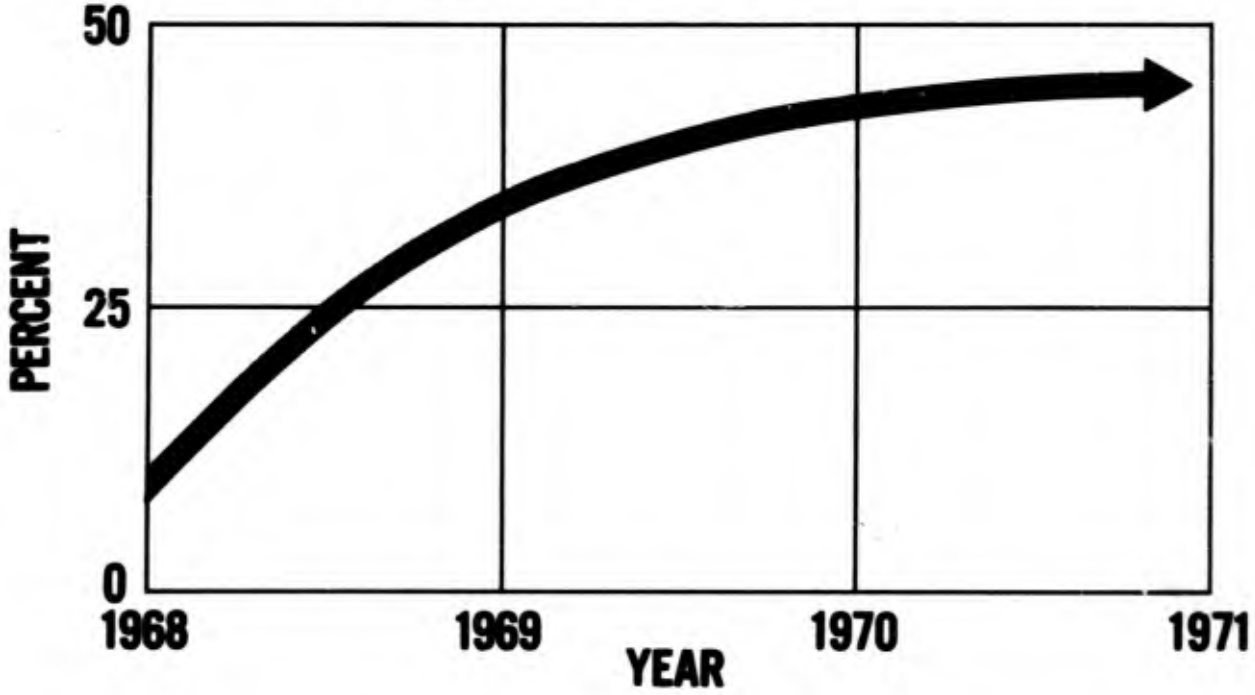
SLIDE-2


MARIJUANA USE AMONG
COLLEGE STUDENTS
PERCENT
60
50
40
30
20
10
0
EXPERIMENTAL USE
REGULAR USE
1967
1968
1969
1970
1971
YEAR

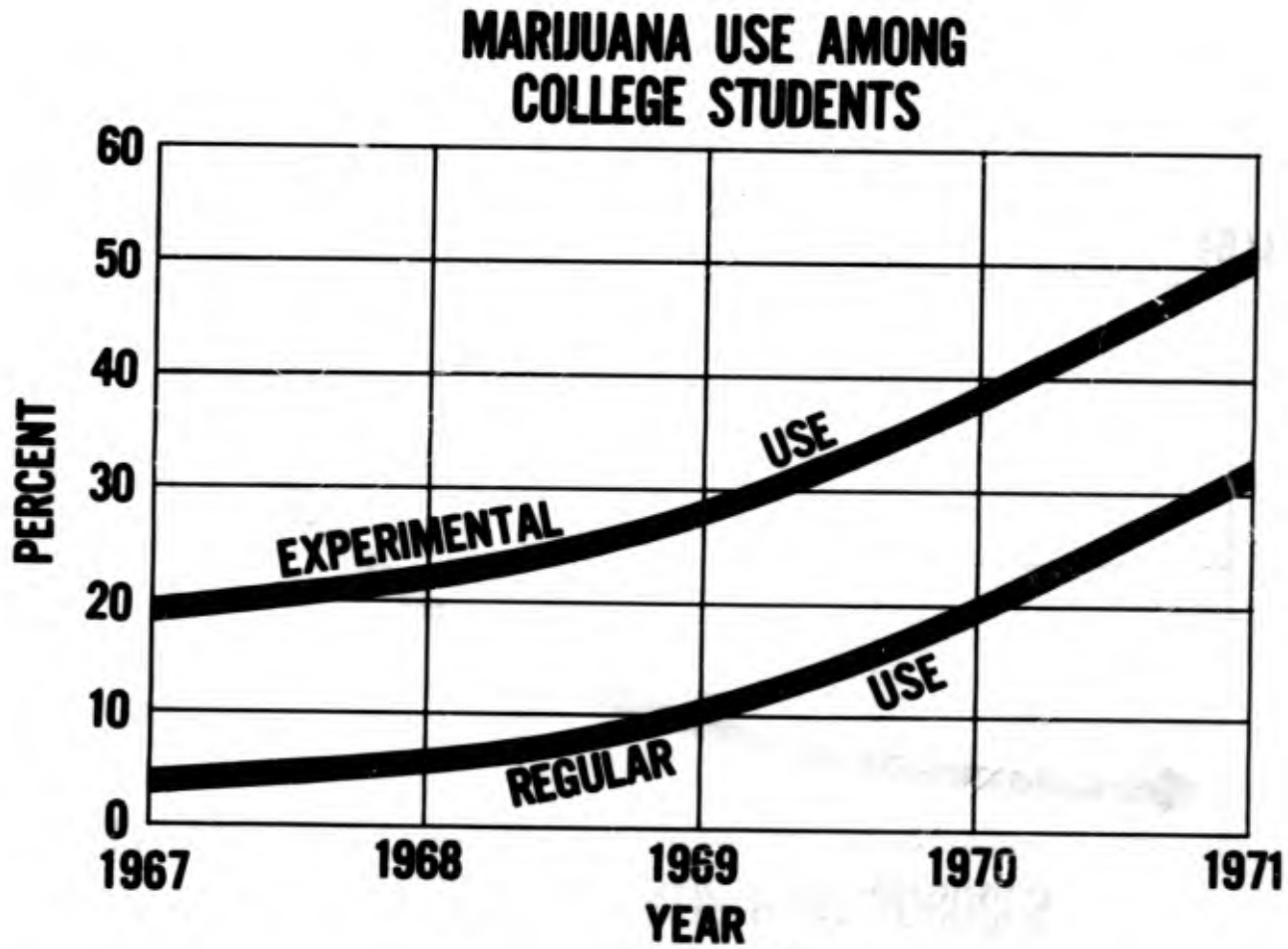
F-2-3

SLIDE-3

MARIJUANA USE IN SAN MATEO, CALIF HIGH SCHOOLS



SLIDE-4


MARIJUANA USE AMONG
COLLEGE STUDENTS
PERCENT
60
50
40
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20
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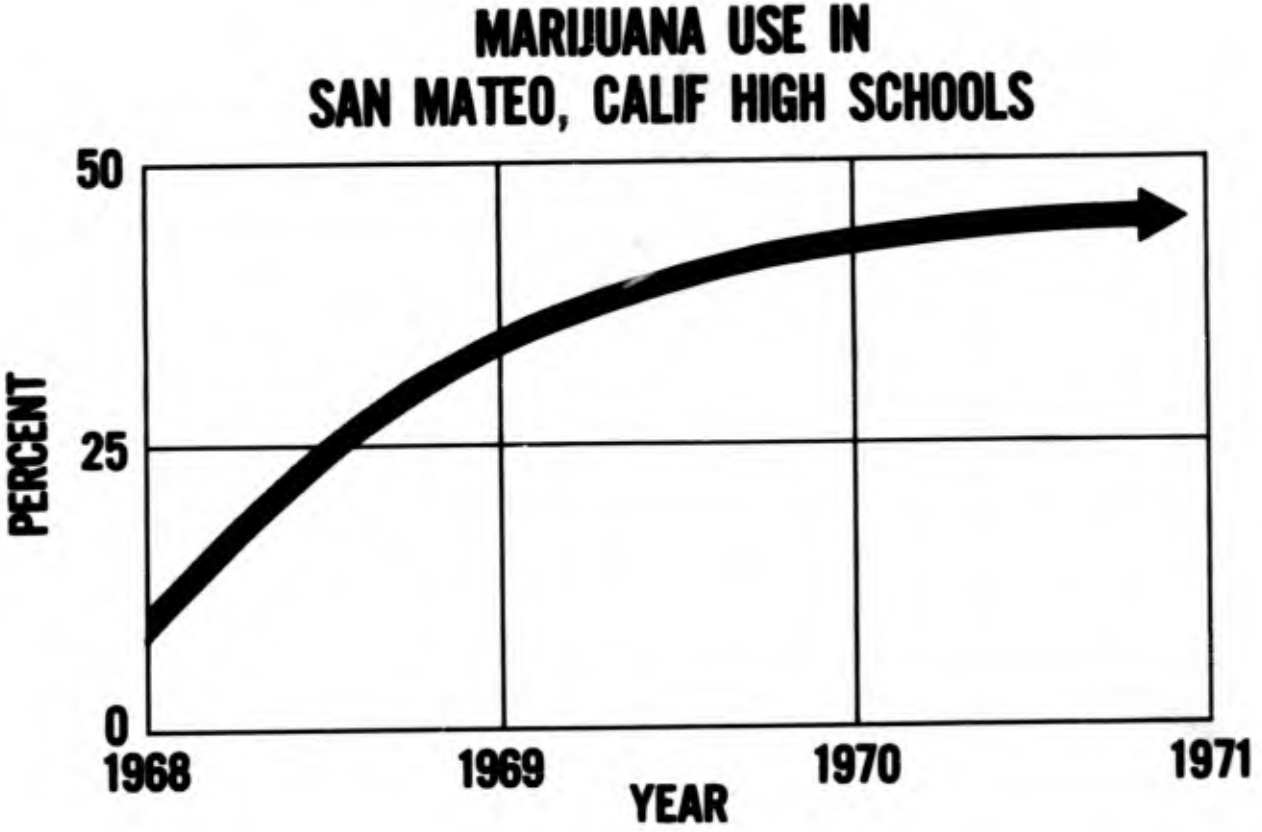
EXPERIMENTAL USE
REGULAR USE
1967
1968
1969
1970
1971
YEAR

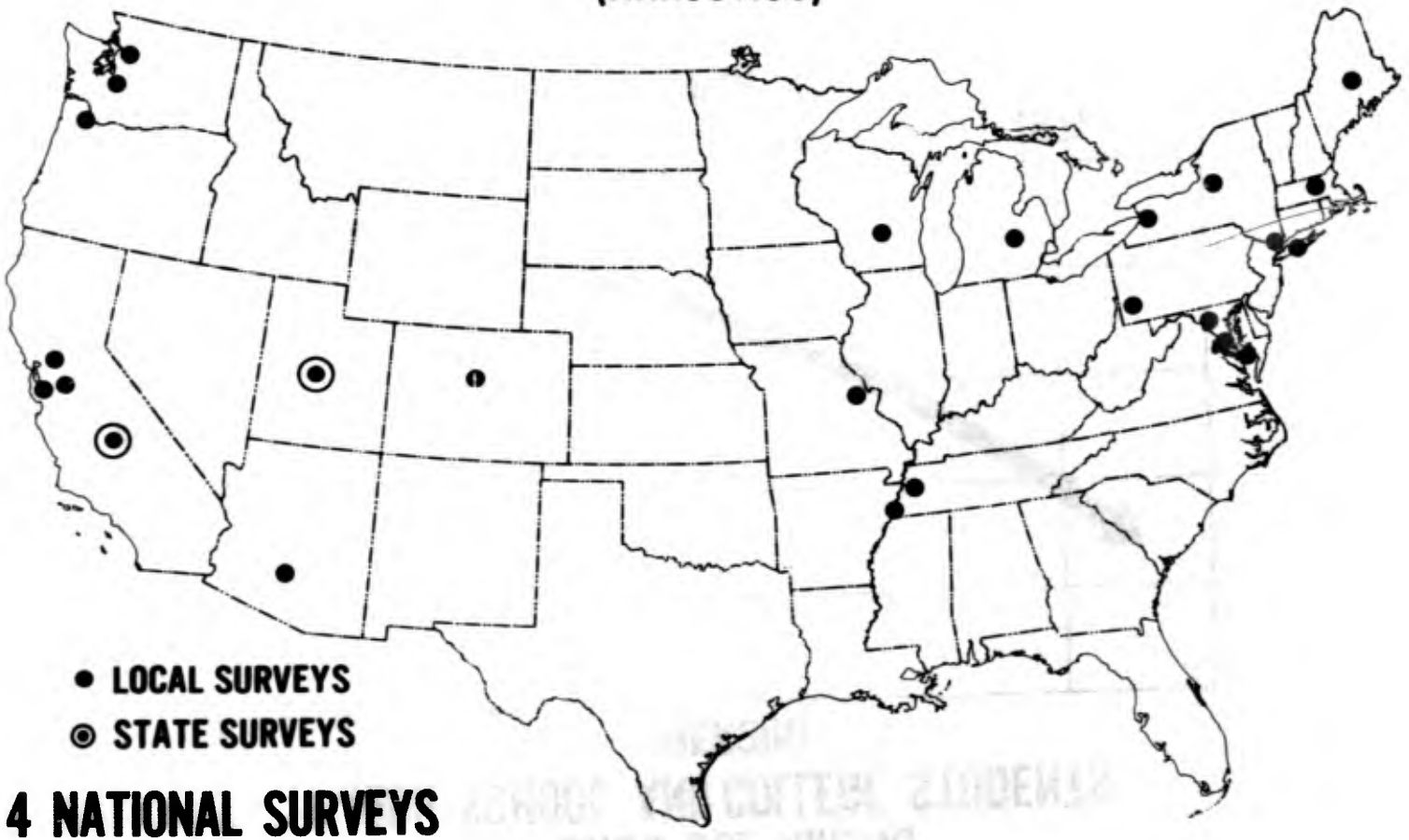
F-2-3

SLIDE-3


MARIJUANA USE IN
SAN MATEO, CALIF HIGH SCHOOLS
50
25
0
PERCENT
1968
1969
1970
1971
YEAR

SLIDE-4

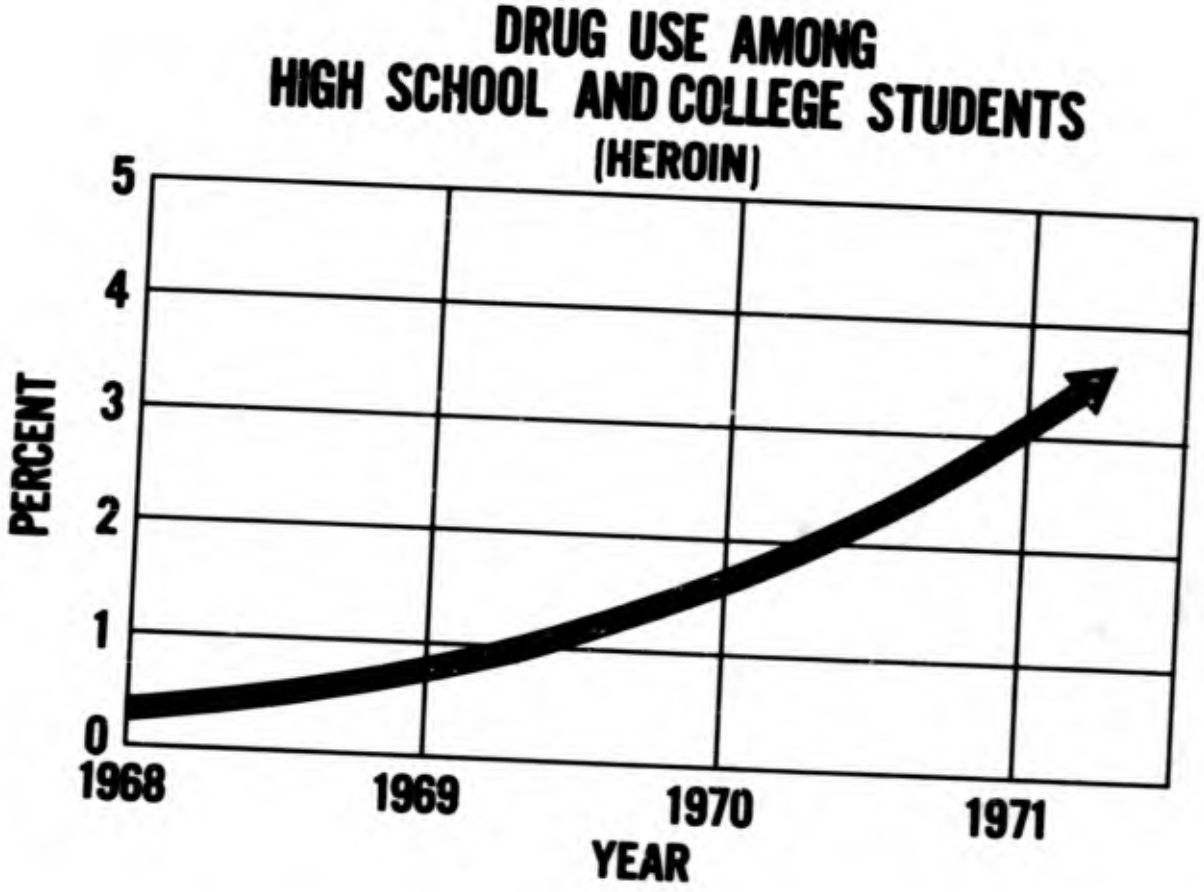
DRUG SURVEYS 1967-1971
(NARCOTICS)



4 NATIONAL SURVEYS

F-2-5

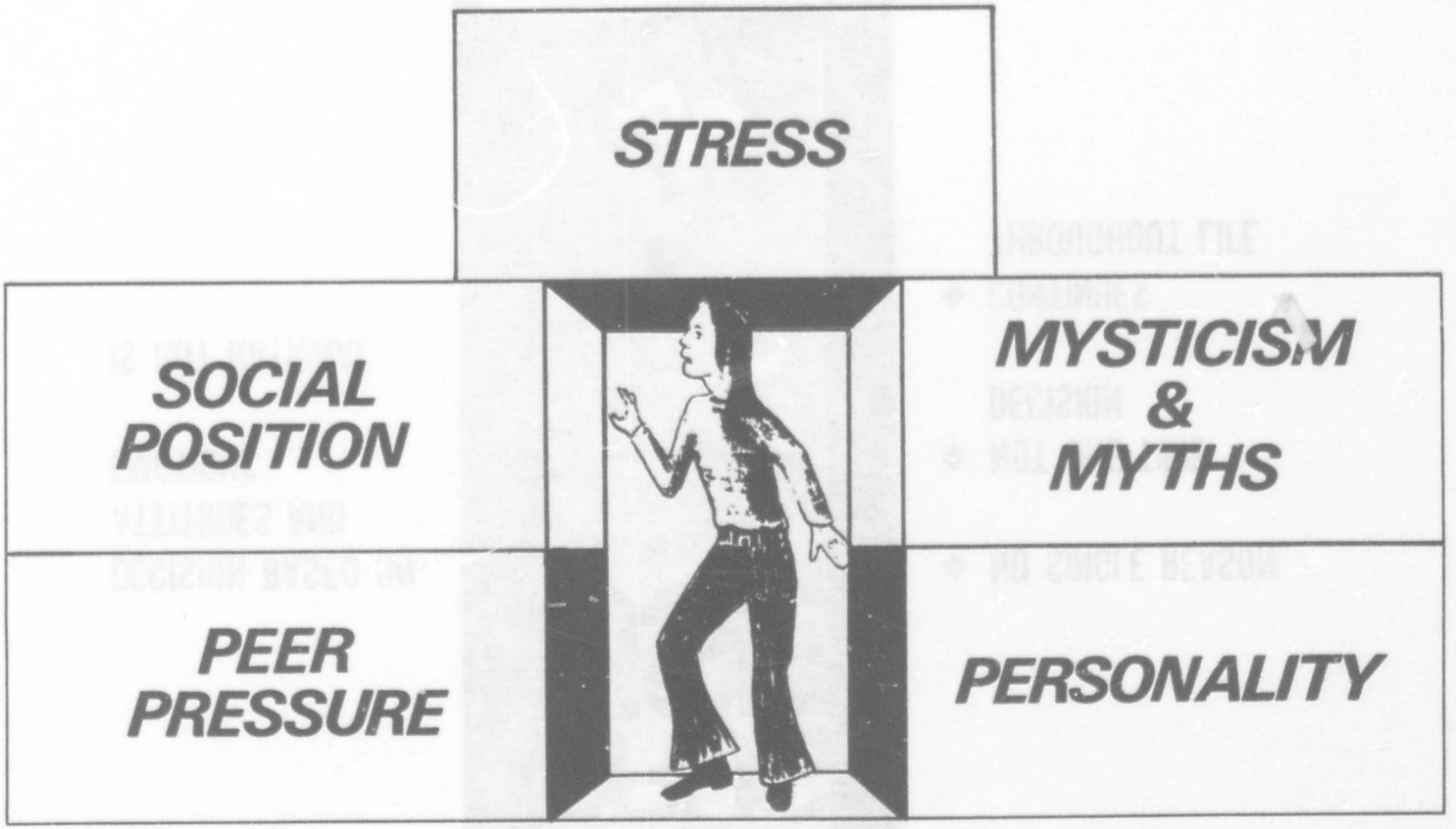
SLIDE-5


DRUG USE AMONG
HIGH SCHOOL AND COLLEGE STUDENTS
(HEROIN)
PERCENT
5
4
3
2
1
0
1968
1969
1970
1971
YEAR

SLIDE-6

MOTIVATION FOR DRUG USE

DRUG-ORIENTED SOCIETY

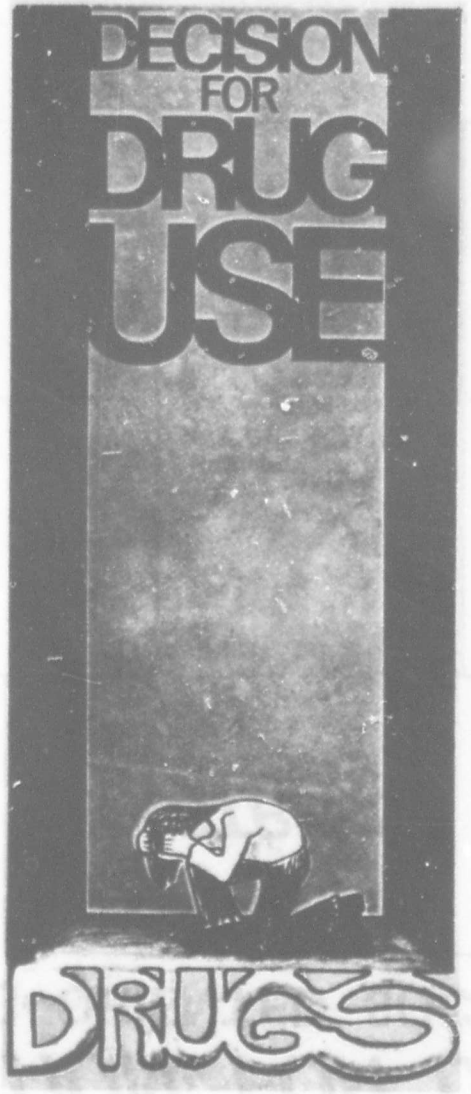


F-2-7

SLIDE-7

DECISION BASED ON ATTITUDES AND EMOTIONS ...

IS NOT RATIONAL

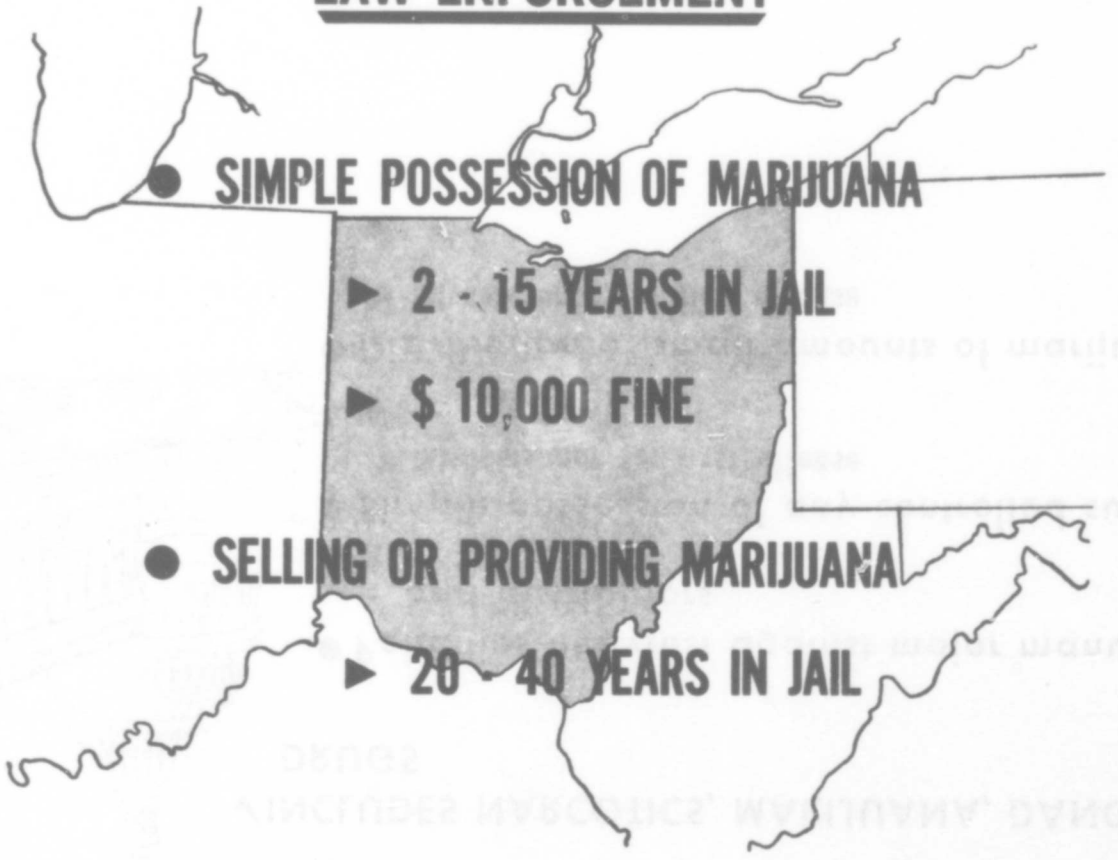


- NO SINGLE REASON
- NOT ONE-TIME DECISION
- CONTINUES THROUGHOUT LIFE

F-2-8

SLIDE-8

LAW ENFORCEMENT



F-2-9

SLIDE-9

CONTROLLED SUBSTANCES ACT OF 1970

✓INCLUDES NARCOTICS, MARIJUANA, DANGEROUS DRUGS

- Penalties heaviest against major manufacturers and distributors
- Simple possession of any controlled substance
  Misdemeanor for first offense
- Distribution of small amounts of marijuana
  Misdemeanor for first offense

F-2-10

Beware! Young and Old—People in All Walks of Life!

Marihuana Cigarette

This may be handed you

by the friendly stranger. It contains the Killer Drug "Marihuana"--a powerful narcotic in which lurks

Murder! Insanity! Death!

Compact flower, female Marihuana (weed)

WARNING!

Dope peddlers are shrewd! They may put some of this drug in the

or in the Cock-tail **or in the tobacco cigarette.**

WRITE FOR DETAILED INFORMATION, ENCLOSING 12 CENTS IN POSTAGE — MAILING COST

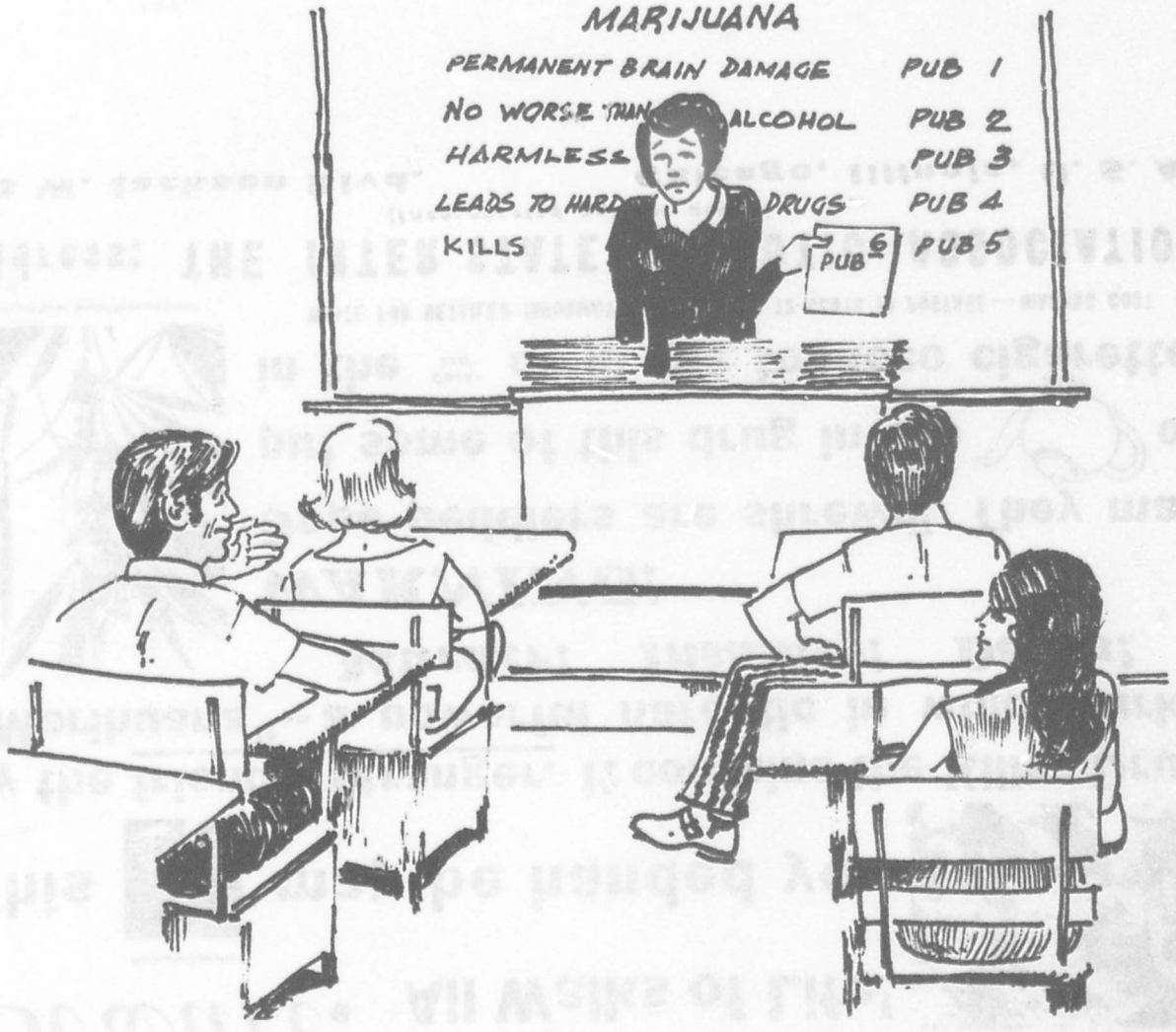
Address: THE INTER-STATE NARCOTIC ASSOCIATION

(Incorporated not for profit)

52 W. Jackson Blvd. Chicago, Illinois, U. S. A.

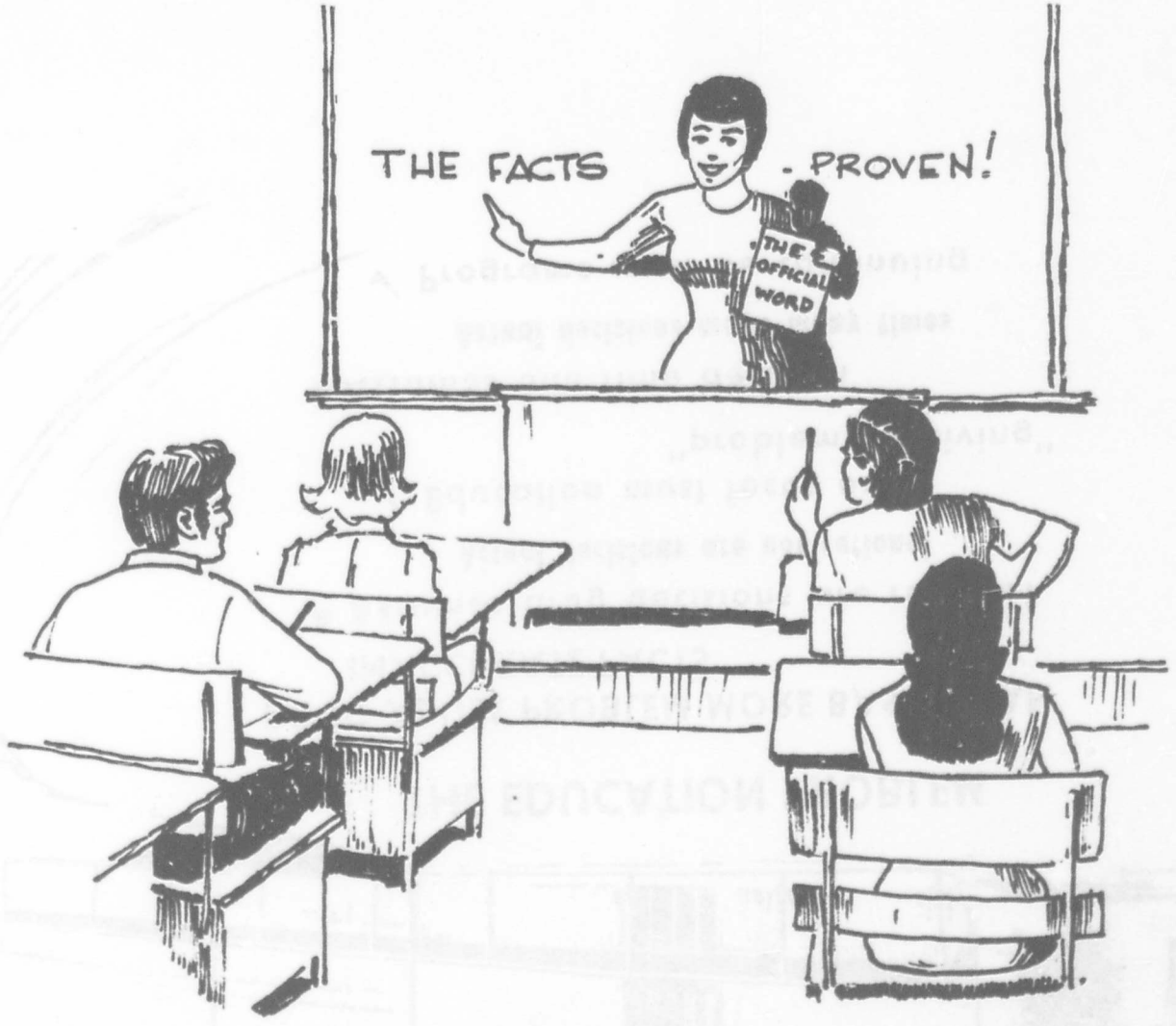
F-2-11

SLIDE-11



F-2-12

SLIDE-12



F-2-13

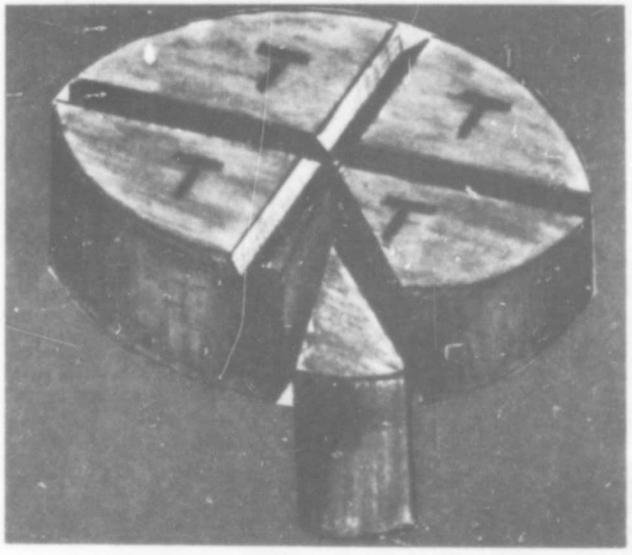
SLIDE-13

THE EDUCATION PROBLEM

DRUG ABUSE PROBLEM MORE BASIC THAN INACCURATE FACTS

- Assumes drug decisions are rational
  - Actual decisions are not rational
  - ✓ Education must focus on "problems of living"
- Assumes one time decision
  - Actual decisions made many times
  - ✓ Programs must be continuing

REHABILITATION PROGRAMS INEFFECTIVE USING CURRENT STANDARDS



5–13%
TOTALLY
DRUG FREE

- REASONS FOR APPARENT FAILURE ARE COMPLEX, DIFFICULT TO UNDERSTAND
  - MOST IMPORTANT... EACH INDIVIDUAL HAS PROBLEMS UNIQUE TO HIMSELF

F-2-15

SLIDE-15

F-2-16

SLIDE-16

REHABILITATION PROGRAMS EFFECTIVE USING PRODUCTIVITY STANDARDS

LEXINGTON FEDERAL CENTER	OTHER INSTITUTIONS	ON METHADONE
85% EMPLOYED	70% LEAD PRODUCTIVE LIVES	75% LEAD PRODUCTIVE LIVES

F-2-17

SLIDE-17

THE PROSPECTS AHEAD

OVERRIDING TREND

F-2-18

✓ DRUG ABUSE WILL CONTINUE

TO INCREASE

SLIDE-18

BASIC OBSERVATIONS:

- **TOTAL ELIMINATION OF DRUG ABUSE IS UNATTAINABLE**

- **DRUG ABUSE MUST BE CONTROLLED WITHIN ACCEPTABLE BOUNDS**

THE PROSPECTS AHEAD

LAW ENFORCEMENT

AS DRUG ABUSE CONTINUES TO INCREASE

F-2-20

✓ LEGAL CONTROLS WILL BECOME MORE INEFFECTIVE,
MORE COUNTER-PRODUCTIVE

..... UNLESS MAJOR CHANGES ARE MADE

SLIDE-20

OBSERVATIONS ON LAW ENFORCEMENT:

WITHOUT REFORMS

- ✓ RESPECT FOR AUTHORITY AND LAW WILL BE UNDERMINED

F-2-21

- ✓ NATIONAL STABILITY WILL BE THREATENED

SLIDE-21

THE PROSPECTS AHEAD

EDUCATION

AS DRUG ABUSE CONTINUES TO INCREASE

✓ EDUCATION WILL BECOME EVEN MORE INEFFECTIVE

F-2-22

..... UNLESS BASIC CHANGES IN CONCEPT ARE MADE

SLIDE-22

OBSERVATIONS ON EDUCATION:

TO BECOME EFFECTIVE, EDUCATION PROGRAMS MUST EMPHASIZE

F-2-23

- **IRRATIONAL INFLUENCES ON DRUG USE DECISIONS**
- **LIFETIME DEVELOPMENT OF ATTITUDES**

THE PROSPECTS AHEAD

REHABILITATION

AS DRUG ABUSE CONTINUES TO INCREASE

✓ REQUIREMENTS FOR REHABILITATION WILL EXPAND RAPIDLY AND CONTINUE TO APPEAR UNSUCCESSFUL

..... IF TOTAL CURE IS REQUIRED

F-2-24

SLIDE-24

OBSERVATIONS ON REHABILITATION :

- ✓ FOR MANY, TOTAL CURE MAY NOT BE NECESSARY

F-2-25

- ✓ REHABILITATION SHOULD BE DIRECTED TOWARD RETURNING INDIVIDUAL TO PRODUCTIVE LIFE

ANNEX G

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ASDIRS No.:
Study Category: Development Studies
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Study Sponsor: DCSPER
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Reference No.: None
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Study Subcategory: Personnel
Starting Date: June 1971
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Abstract: This two-volume study develops a profile of the national drug problem in the United States. Surveys of drug use have been statistically analyzed to determine patterns of drug usage for all major drugs of abuse. The profile includes reasons why drugs are abused; the national response to the drug problem in three areas--law enforcement, education, and rehabilitation; and a projection of national trends over the next several years. This profile specifically excludes consideration of alcohol abuse and drug abuse in the Armed Forces.

Time Frame: 1968-1973

Study Descriptors: Manpower; human resources; psychology; behavioral; civilian; human factors; morale; motivation; religious; stress.

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