Drug Use Among Racial/Ethnic Minorities

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ACKNOWLEDGMENTS

This publication was produced for the National Institutes of Health, National Institute on Drug Abuse (NIDA), Division of Epidemiology and Prevention Research, by CSR, Incorporated, Washington, D.C., under Contract No. N01DA-6-5053. The report was developed by the project officer, Andrea Kopstein, of NIDA, and the co-project officer, Leslie Cooper, Ph.D. Significant contributors to the report include Diane Deitz, Ph.D., Lisa Gibson, M.P.M., Thomas Nephew, M.P.P.S., Faith Samples, Ph.D., Lorna Sanchez, William Scarbrough, Ph.D., and Fred Stinson, Ph.D., of CSR, Incorporated, under contract to NIDA.

National Institute on Drug Abuse
NIH Publication No. 98-3888
Printed 1995
Revised September 1998

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Chapter 1. INTRODUCTION

The purpose of this report is to provide policymakers, researchers, and others with an understanding of the nature of drug use among minorities by summarizing the most current data on this issue. The data in this report came from several large- and small-scale epidemiological studies that collect and analyze data on the incidence, prevalence, morbidity, mortality, and other adverse health consequences of drug use among racial/ethnic populations. These surveys are sponsored by several Federal agencies including, but not necessarily limited to, the U.S. Bureau of the Census, the Centers for Disease Control and Prevention (CDC), the Department of Education, the Department of Justice, the National Center for Health Statistics, the National Institute on Drug Abuse (NIDA), National Institute of Justice, and the Substance Abuse and Mental Health Services Administration (SAMHSA). Information on youths' attitudes toward drugs also is included from the Partnership for a Drug-Free America's (PDFA's) Partnership Attitude Tracking Survey (PATS).

The United States has been undergoing major demographic changes and will continue this transformation in the coming years. By the year 2030, racial/ethnic minorities are expected to constitute one-half of the student population¾kindergarten through 12th grade (Education Research Service 1995). In contrast, the non-Hispanic white share of the U.S. population is expected to decrease from 74 percent in 1995 to 72 percent in 2000, 68 percent in 2010, 61 percent in 2030, and 53 percent in 2050 (U.S. Bureau of the Census 1996). Consequently, racial/ethnic minorities will require increased attention from policymakers so the Nation can understand, prevent, and address many of the social and economic problems that plague minority families and minority neighborhoods.

Beginning in 1963 the President's Advisory Commission on Narcotic and Drug Abuse, and in 1972 the National Commission on Marihuana and Drug Abuse, recognized the growing problem of drug abuse (National Commission on Marihuana and Drug Abuse 1973). Reports from both commissions cited the inadequacy of the data available at that time to assess the true prevalence of drug use in our society. Knowledge regarding the epidemiology of drug abuse in the general population expanded with the establishment of NIDA in 1974; the development of the National Household Survey on Drug Abuse (NHSDA), initiated in 1971; and the Monitoring the Future Study, initiated in 1975. The Anti-Drug Abuse Act of 1986 and the Anti-Drug Abuse Act of 1988 focused data collection efforts on special populations, including racial/ethnic groups and those in drug abuse treatment. Epidemiologic data about alcohol and other drug abuse among minorities has slowly been emerging for both youth and adults, but more attention is needed to adequately understand the extent of the problem for these populations.

Research has shown persons at high risk for drug abuse often are those whose lives are marked by poverty, illiteracy, malnutrition, and other unhealthy environmental conditions. It has been estimated from the NHSDA that the prevalence of drug use generally is higher in urban areas than in suburban or rural areas. Because minorities, particularly African Americans and Hispanics, often are concentrated in central city areas, they may be more at risk for drug abuse and, ultimately, more at risk for associated negative social and health consequences. Given these findings, this report aims to compile published data on the subject and to discuss some of the implications of these findings.

DEFINITION OF RACE AND ETHNICITY

Current definitions of race and ethnicity are under increasing scrutiny. Many scientists believe race is a mere "social construct," and the boundaries between different races depend on the classifier's own cultural norms (Begley 1995). Similarly, the definition of race varies from survey to survey; however, many national-level data collection systems follow Census Bureau standards. The Census Bureau collects and publishes racial statistics as outlined in *Statistical Policy Directive No. 15*, issued by the Office of Management and Budget (OMB) (U.S. Department of Commerce 1978). According to that directive, the primary racial categories are American Indian/Alaskan Native, Asian/Pacific Islander, black, and white. The directive identifies Hispanic origin as an ethnicity, which is defined as the nationality group or country of birth of a person or a person's parents or ancestors before arrival in the United States. Persons of Hispanic origin may be of any race. The definitions for race and for Hispanic ethnicity, as specified under *Directive No. 15*, are as follows:

- American Indian/Alaskan Native—a person having origins in any of the original peoples of North America who maintains cultural identification through tribal affiliations or community recognition;
- Asian/Pacific Islander—a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands;
- Black—a person having origins in any of the racial groups of Africa;
- Hispanic—a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race; and
- White—a person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Particularly since the 1990 Census, these classification standards have come under increasing criticism from those who believe the above categories fail to reflect the growing diversity of our Nation's population. During the 1980's, immigration to the United States from Mexico, Central and South America, the Caribbean, and Asia reached historic proportions. In addition, as a result of the increase in interracial marriages, the number of persons born of mixed race or ethnicity has grown. *Directive 15* also has been criticized as failing to be scientific, and has been the basis of a major lawsuit. In response to these and other criticisms, OMB announced in June 1993 that it would undertake a review of the current classifications for data on race and ethnicity.

OMB established the Interagency Committee for the Review of the Racial and Ethnic Standards in March 1994 to facilitate the participation of Federal agencies in the review process. The Interagency Committee's 30 members were employees of the agencies who represent the diverse Federal needs for data on race and ethnicity, including statutory requirements for such data. Two major elements of the process were (1) public comment on present definitions and (2) research and testing related to an assessment of the possible effects of recommended changes regarding the quality and usefulness of the resulting data. The goal of the Committee's work was to produce definitions resulting in consistent, publicly accepted data on race and ethnicity to meet the needs of the Federal Government and the public, while recognizing the diversity of the population and respecting the individual's dignity.

This section details the Interagency Committee's recommendations for changes in racial and ethnic categories for use by the U.S. Government. The Census Bureau is expected to incorporate these changes into the questions for the 2000 Census "practice run" in 1998.

The minimum categories for data on race and ethnicity for Federal statistics and program administrative reporting are defined as follows:

- American Indian or Alaskan Native—a person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community recognition.
- Asian or Pacific Islander—a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. These areas include, for example, China, India, Japan, Korea, the Philippine Islands, Hawaii, and Samoa.
- Black or African American—a person having origins in any of the black racial groups of Africa.
- Hispanic—a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- White—a person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

The recommended changes for data collection also include an emphasis on data quality. When race and ethnicity data are collected separately, ethnicity data should be collected first. In addition, the minimum designations for ethnicity and race are as follows:

- Ethnicity
  - ¾ Hispanic Origin, and
  - ¾ Not of Hispanic Origin; and

- Race
  - ¾ American Indian or Alaskan Native,
  - ¾ Asian or Pacific Islander,
  - ¾ Black or African American, and
  - ¾ White.

In addition, persons can, but are not required to, report more than one race. A minimum of one additional racial category, designated "more than one race" has been recommended to report the aggregate number of multiple race responses. Greater detail of multiple race responses also is encouraged. For example, terms such as "Haitian" or "Negro" can be used in addition to "Black" and "African American," while terms such as "Latino" or "Spanish origin" can be used in addition to "Hispanic." This classification system will allow for the collection of data on "Hispanic and one or more races" and "More than one race."

For the full text of the Committee's analysis and recommendations, readers should refer to Appendix 2 of the *Federal Register* for July 9, 1997. These recommendations, designed to provide minimum standards for Federal data on race and ethnicity, concern options for reporting by respondents, formats of questions, and several aspects of specific categories, including possible additions, revised terminology, and changes in definition.

The following population statistics and information pertaining to drug use among members of each race/ethnicity are summarized from existing reports and provide a context for the data discussed later in this report. A summary of Asian/Pacific Islander information is provided for completeness only; data available on drug use among this population are very limited.

American Indians/Alaskan Natives

At the turn of the century, 220,000 American Indians/Alaskan Natives lived in the United States; the 1990 census indicated this population had grown to approximately 2 million, which is two times the 1970 count (U.S. Bureau of the Census 1991). This exceptional increase is due to improved health care for all ages, an accelerated birth rate, and a greater willingness to report Native American ancestry. In 1994 the birth rate among American Indians/Alaskan Natives was 13 percent higher than that of the country at large (U.S. Bureau of the Census 1997).

In 1993 there were 341 federally recognized tribes (Hirschfelder and Montano 1993, in Moran 1995). By 1997 there were 558 federally recognized tribes (U.S. Bureau of Indian Affairs 1997). The median age of the American Indian/Alaskan Native population was 24.2 years in 1990, compared with 34.4 years for U.S. whites (Indian Health Service 1993). This could account for the significant differences in drug use prevalence rates that exist between the two groups. Sixty-two percent of American Indians now live away from traditional native communities or reservations. Most groups are small with not much land (Robbins 1994). Indian culture and physical characteristics, though thought to be homogeneous, are best described as diverse.

Alcohol and other drug use has been reported as a serious concern among American Indian populations (Beauvais et al. 1989). Research indicates there is more substance use among American Indians than most, if not all, ethnic minority groups in the United States (Office for Substance Abuse Prevention 1990). The high prevalence of American Indian substance abuse cuts across a wide range, affects both genders, and nourishes the cycle of poverty and disease (Robbins 1994). American Indian youth begin using cigarettes and alcohol at an earlier age than their white counterparts (Young 1988), and they are more likely to try marijuana at an earlier age than do white youth (Office for Substance Abuse Prevention 1990). Past-month prevalence data show that American Indian/Alaskan Native youth use marijuana, cocaine, cigarettes, and alcohol at two or more times the ratio of white, black, or Hispanic youth. By age 12, lifetime rates of use of alcohol, tobacco, marijuana, and other drugs among American Indians exceed the rates for other groups (Federman et al. 1997).

Asian/Pacific Islanders

Asian/Pacific Islanders comprise more than 60 separate racial/ethnic groups and subgroups, and these groups are heterogeneous (Sue 1987). Through the early 1990s, Asian/Pacific Islanders had the fastest growth rate of all racial/ethnic groups identified by the Census Bureau. In recent years Southeast Asian refugees, Filipinos, and Koreans have been the fastest growing Asian groups. By the year 2000, it is estimated Filipinos will be the largest group, followed by the Chinese, Vietnamese, Koreans, Asian Indians, and Japanese. These changes undoubtedly will bring about certain changes in alcohol and other drug use patterns of Asian communities in the United States (Kim et al. 1995).

Most information pertaining to drug use among Asian/Pacific Islanders comes from isolated surveys conducted by individual researchers. A common belief is that drug use among Asian/Pacific Islanders occurs less frequently than among non-Asian populations. However, some

studies suggest this may be due to underrepresentation of Asian/Pacific Islanders in studies of drug use. Asian/Pacific Islanders may be less likely to pursue treatment services because they are not culturally appropriate. Rates of alcohol use in native countries, where services are likely more actively utilized, are actually higher than rates of alcohol use among whites in the United States (Kuramoto 1994). In this report, Asian/Pacific Islanders are classified mainly within the "other" category, when a category is indicated, due to their underrepresentation in national surveys.

African Americans

African Americans comprise 12.1 percent of the total U.S. population (U.S. Bureau of the Census 1996). However, the African American population is projected to grow at an annual rate nearly two times that of the white population, with the percent change in the population projected to increase (U.S. Bureau of the Census 1996). The African American share of the total U.S. population is expected to slowly increase from 12.6 percent in 1995 to 12.9 percent in 2000, increase to 14.0 percent in 2020, and increase to 15.4 percent in 2050 (U.S. Bureau of the Census 1996). The 1990 Census showed the median age of the black population is 6 years younger than that of the white population.

African American high school seniors consistently have lower rates of licit and illicit substance use compared with whites. This finding also is true among African American youth in lower grades, where less dropping out has occurred. Despite these findings, illicit drugs are a major problem in the African American community (Johnston et al. 1995). One reason for this is African Americans who use alcohol and other drugs experience higher rates of drug-related health problems than do users from other ethnic groups (Herd 1989). Another reason is drug abuse is among a variety of long-standing factors believed to cause criminal behavior in African American communities.

It is important to note that data in surveys such as the Monitoring the Future Study (MTF), the Drug Abuse Warning Network (DAWN), and the Arrestee Drug Abuse Monitoring Program (ADAM) (formerly known as the Drug Use Forecasting System) are taken from samples in which African Americans typically are underrepresented. Consequently, the findings may not accurately reflect the true extent of the drug use problem in this population (Primm 1987).

Hispanics

Over the past 20 years, Hispanics have emerged as one of the fastest growing segments of the U.S. population. In 1995 Hispanics composed 10.2 percent of the total U.S. population. Since 1980 the Hispanic population has increased by approximately 71 percent, compared with the non-Hispanic white population, which grew by only 14 percent (U.S. Bureau of the Census 1996). Data from the Census Bureau suggest that every year from 1995 to 2050, more persons of Hispanic ethnicity will join the U.S. population than persons of any other ethnic group.

Hispanics comprise one of the youngest segments of the U.S. population. The median age of Hispanics is 26.5 years, compared with 34.9 years for the U.S. population overall (U.S. Bureau of the Census 1997a). Poverty rates for Hispanics are high compared with non-Hispanic whites. Twenty-five percent of Hispanic families fall below the poverty level, versus approximately 9 percent for non-Hispanic white families (Delgado 1995). In addition, only 50 percent of the Hispanic population has completed 4 years or more of high school, versus 80 percent of non-Hispanics. There also exist wide socioeconomic disparities among Hispanic subgroups, such as Puerto Ricans, Mexican Americans, and Cubans, which should be considered when analyzing

Hispanic data. Regrettably, very little national-level data are available for Hispanic subgroups, and all but one table in this report present data for the entire Hispanic population. It would be preferable to analyze the Hispanic data by country of origin, level of acculturation, and immigrant versus U.S.-born status but, to date, little information is available.

Studies on the prevalence of drug use among Hispanics indicate it is alarmingly high among adolescents and, because a large proportion of the Hispanic population is young, a larger proportion of Hispanics may be at increased risk for drug use (Johnston et al. 1991). Stresses associated with poor economic conditions, combined with low educational rates, a high degree of drug availability, and the impact of racism on self-esteem make Hispanics particularly vulnerable to alcohol and other drug use and abuse (Delgado 1995). Data on current drug use from the 1997 MTF Survey indicate Hispanic high school seniors have the highest rates of use for cocaine, crack, other cocaine, and heroin (Johnston et al. 1997).

OVERVIEW OF DRUG USE AND DRUG-RELATED PROBLEMS

Concern about illicit drug use among members of diverse racial/ethnic groups has intensified, partly as a result of specific drug use-related behaviors in various subcultures (Spiegler et al. 1989). Drug use threatens users with many negative health-related consequences, including fatal and nonfatal overdose, hepatitis B infection, bacterial endocarditis, AIDS (acquired immunodeficiency syndrome), and other sexually transmitted diseases. Drug use also may increase the risk of accidents and injury, complications in pregnancy and delivery, suicide, and other psychiatric problems. In addition, drug use may have negative effects on employment, school achievement, socioeconomic status, family stability, and crime and violence rates, although it is difficult to determine whether these factors are the causes or the effects of drug use. What is known, however, suggests that minority populations may be overrepresented among those who are at risk for and suffer from the adverse consequences of drug use.

There is a recognized need to generate information on the drug use behaviors among different age as well as racial/ethnic cohorts; on the phenomena associated with these behaviors, such as crime and poor educational achievement; and on the personal and societal consequences of drug use. This report presents data relevant to the current understanding of drug use among minorities as it relates to youth, adverse health consequences, and overall population studies.

METHODS

This report presents current available data on drug use and drug-related problems among racial/ethnic groups residing in the United States. The information was obtained from published and unpublished data from both governmental and nongovernmental agencies and organizations. In each case, the sponsoring agency or organization collected data using its own methods and procedures. Therefore, data vary with respect to source, method of collection, definitions, and reference period. Although a detailed description and comprehensive evaluation of each data source is beyond the scope of this report, summaries of data sources used and a general overview of their designs appear below. More complete and detailed descriptions can be obtained from the sponsoring agency or organization.

Overall estimates from most of the surveys used in this report have relatively small sampling errors; however, estimates for certain racial/ethnic subgroups may be based on small numbers and have relatively large sampling errors. It is not always possible to measure the

magnitude of these errors or their impact on the data. Where possible, the tables include footnotes containing descriptions of the sample and the method of data collection to enable the reader to evaluate the data effectively. The reader should note that columns of numbers may not add up to their totals because of rounding.

The data presented in the report consist primarily of prevalence statistics from national data sources. Some of the tables contain data tabulated specifically for this report, including data from the NHSDA, the Youth Risk Behavior Survey (YRBS), the National Longitudinal Survey of Youth (NLSY), the ADAM program, and DAWN. Other tables present information previously published. Standard error estimates are not presented in the tables; however, they have been calculated for a majority of the national data sets. For those tables produced specifically for this report, estimates with large relative standard errors have been suppressed. The discussions accompanying the tables highlight only data findings. Consequently, the discussions are not exhaustive, and there is limited, speculative discussion on the potential causes for and consequences of the findings.

DATA SOURCES

Brief descriptions of each data source used in this report are provided below. For more detailed information on the data sources, readers should contact the sponsoring organizations.

Census of the United States

The Census Bureau has conducted censuses of the population in the United States every 10 years since 1790. In the 1990 census, data were collected on sex, race, age, and marital status from 100 percent of the enumerated population. More detailed information such as income, education, housing, occupation, and industry were collected from a representative sample of the population. For most of the country, one out of six households received the more detailed questionnaire. In places of residence estimated to have a population of fewer than 2,500, 50 percent of households received the more detailed questionnaire.

For more information on the 1990 census, see U.S. Bureau of the Census, 1990 Census of the Population, General Population Characteristics, Series 1990, CP-1; or write U.S. Bureau of the Census, Population Division, Washington, DC 20233.

National Household Survey on Drug Abuse

The NHSDA collects data on trends for the use of marijuana, cigarettes, alcohol, and cocaine among persons ages 12 and older. The 1996 survey is the 16th in a series that began in 1971 under the auspices of the National Commission on Marihuana and Drug Abuse. From 1974 to September 1992, the survey was sponsored by NIDA. Since October 1992 the survey has been sponsored by SAMHSA.

Since 1991 the NHSDA has covered the U.S. civilian noninstitutionalized population ages 12 and older. This includes civilians living on military bases and persons living in noninstitutionalized group quarters, such as college dormitories, rooming houses, and shelters. Hawaii and Alaska were included for the first time in 1991. In 1994 the survey underwent major changes that affected the reporting of substance abuse prevalence rates. Because it was anticipated that this new methodology would affect the estimates of prevalence, the 1994 NHSDA

was designed to generate two sets of estimates. The first set, called the 1994-A estimates, was based on the same questionnaire and editing method as that used in 1993. The second set, called the 1994-B estimates, was based on the new questionnaire and editing methodology. To be able to describe long-term trends in drug use accurately, an adjustment procedure was developed and applied to the pre-1994 estimates. A description of the adjustment method can be found in *Advance Report Number 18*, Appendix A, available from SAMHSA.

The 1996 survey employed a multistage probability sample design. Young people (ages 12 to 34 years), black persons, and Hispanics were oversampled to improve the accuracy of estimates for those populations. The sample included 18,269 respondents. The screening and interview response rates were 93.0 percent and 79.0 percent, respectively.

For more information on the NHSDA, see "Preliminary Estimates From the 1996 National Household Survey of Drug Abuse," *Advance Report Number 1*6; or write Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Room 16C-06, 5600 Fishers Lane, Rockville, MD 20857.

Partnership Attitude Tracking Survey

The PATS measures the extent to which the PDFA's media campaign is successful in changing attitudes toward illegal drugs. Its purpose is to monitor, on an ongoing basis, the behavior and attitudes of young people and adults as they relate to drugs. PATS is the Nation's largest survey on attitudes toward illegal drugs and the only research tool for measuring the attitudes of students in grades 4–6. In the 1996 PATS studies, 12,292 interviews were conducted.

PATS consists of a series of studies from 1988 to 1996. Prior to 1993, studies were conducted by interviews in public locations. From 1993 to the present, all interviews were completed in schools and homes. The study is designed to be projectable to all students in grades 4–6 (youth) and 7–12 (teens). Surveys of children in grades 4–6 studied 2,265 children in 1993, 2,424 in 1995, and 2,569 in 1996. The surveys of teens in grades 7–12 studied 6,029 teens in 1993, 6,096 in 1995, and 8,924 in 1996. The sample of schools was drawn from all schools in the country. This sample was drawn in three parts: a national sample of 100 schools, a supplemental sample of 25 schools in heavily African American areas, and a supplemental sample of 25 schools in heavily Hispanic areas. In 1995, the PATS included an in-home survey of parents with children under age 19. Interviewers randomly selected a respondent from among all qualified parents living in the chosen household. Results are completely confidential. The sample size was 822 parents in 1995 and 799 in 1996. An independent contractor, in cooperation with the PDFA, developed questionnaires and administered interviews for the 1996 PATS. All surveys were anonymous self-reports.

For more information on the PATS, write to Partnership for a Drug Free America, 405 Lexington Avenue, New York, NY 10174.

Monitoring the Future Study

This large-scale epidemiological survey of drug abuse was initiated in 1975 and has been conducted annually through a NIDA grant awarded to the University of Michigan's Institute for Social Research. The survey is based on a nationally representative probability sample of public and private school students in the contiguous United States. The survey originally included only high school seniors, but 8th and 10th grade samples were added in the 1990–91 school year in

order to survey students who might drop out before graduating. The measures and procedures employed have been standardized and applied consistently to the data collection since 1975. The survey design also includes a longitudinal study of a subsample of each graduating class. This allows monitoring of the maturational factors associated with drug abuse. The followup data for high school graduates is divided into two groups: those who went to college and those who did not go to college after graduating from high school. The adult portion of the annual report provides many tables that allow comparisons to be made between these two groups.

This survey excludes school dropouts and absentees (on the day of the survey) and may therefore result in somewhat conservative estimates of drug abuse in the age group reflected by the student population. The stability of the survey provides excellent data for monitoring drug abuse trends, including incidence and prevalence rates as well as related changes in attitudes about drugs.

This survey is ongoing. The latest data available are from the 1996–1997 school year, the 22nd survey in this series. For the national survey of eighth graders, approximately 160 schools are sampled, and approximately 19,000 students are surveyed. For the 10th graders, approximately 130 high schools are sampled, and approximately 16,000 students are surveyed. For the 12th graders, approximately 140 schools are sampled and approximately 15,000 students are surveyed. The data are not available on a State or sub-State level. The data are released approximately 6 to 8 months after the end of a school year and are initially disseminated in the form of a press release (available from NIDA) and subsequently released in annual report format. The annual report includes long-term trend data. Data on 8th, 10th, and 12th graders are in one volume and data on the young adults and college students are published in a second volume.

For more information on the Monitoring the Future Study, see *National Survey Results on Drug Use from the Monitoring the Future Study, 1975–1996*. This report is an annual report from the National Institutes of Health. Or write the National Institute on Drug Abuse, Division of Epidemiology and Prevention Research, 5600 Fishers Lane, Rockville, MD 20857.

National Longitudinal Survey of Youth

The NLSY is an ongoing followup survey sponsored by the Bureau of Labor Statistics. Annual interviews have been conducted with a national sample of approximately 12,000 men and women who were 14 to 21 years of age in January of 1979. Yearly interviews have been conducted with more than 90 percent of the original respondents since 1979. The 1988, 1992, and 1994 surveys include information about drug use obtained in the 1984 interview along with complete pregnancy records for women, including information about prenatal care, alcohol and tobacco use during pregnancy, and the length and weight of each child at birth. An additional 5,500 children of the female participants have been evaluated in terms of cognitive, socioemotional, and physiologic aspects of their development. An interagency agreement was developed between NIDA and the Bureau of Labor Statistics to add three sets of questions about illicit drug use for the 1988, 1992, and 1994 rounds of the NLSY. These questions include the recency and frequency of marijuana and cocaine use. Also included are questions about the use of marijuana and cocaine during pregnancy for those who gave birth since 1987.

For more information on the National Longitudinal Survey of Market Experience of Youth, write to the Center for Human Resource Research, Ohio State University, 921 Chatham Lane, Suite 200, Columbus, OH 43221.

Dropout Statistics

The Department of Education's National Center for Education Statistics (NCES) collects and reports annually on statistics and other data related to education in the United States and other countries, including school dropout rates. Dropout data reported by NCES include event rates and status rates. The event rate measures the proportion of students who drop out of school in a single year without completing high school. The status rate measures the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

For more information on dropout statistics, see *Dropout Rates in the United States 1995*, National Center for Educational Statistics 97–473. Or write to the National Center for Educational Statistics, U.S. Department of Education, Office of Educational Research and Improvement, 555 New Jersey Avenue, NW, Washington, DC 20208.

American Indian/Alaskan Native Statistics

There is no single comprehensive Federal effort to collect data on drug use among American Indian/Alaskan Native populations. Consequently, data on American Indian/Alaskan Native populations were obtained for this report from publications by Beauvais and colleagues (1985b, 1989) and recent data from the MTF Study and NHSDA. Beauvais' research team has collected data on drug use rates among American Indian youth since 1975. In addition to monitoring levels of use, they have conducted a series of studies examining the etiology of drug and alcohol use in this population (Beauvais et al. 1989). The data for this project are gathered through anonymous self-report surveys administered in school classes. The survey includes questions about lifetime prevalence of 11 drugs. Current use, depth of involvement, and patterns of use are assessed for the more frequently used drugs. Other topic areas involve correlates of drug use including variables such as demographics, attitudes toward drugs, peer and family influence, general deviance, cultural identification, school adjustment, personal adjustment, and attitudes toward the future. This group initiated a new data collection effort in 1996; however, these data were not available for this report.

Due to the difficulty involved in obtaining permission to conduct the survey on individual reservations, researchers are not able to guarantee that the sample is nationally representative of the total American Indian/Alaskan Native population. To compensate for this problem, 2 years of data often are combined to increase the representativeness of the sample. The experience of the project is that drug use rates have proven to be consistent across tribes.

For more information on Native American data, write to the Tri-Ethnic Center for Prevention Research, C-78 Clark Building, Psychology Department, Colorado State University, Fort Collins, CO 80523.

Youth Risk Behavior Survey

The YRBS is a component of the Youth Risk Behavior Surveillance System (YRBSS), maintained by CDC. The YRBSS has the following three complementary components: (1) national school-based surveys, (2) State and local school-based surveys, and (3) a national household-based survey. Each of these components provides unique information about various subpopulations of adolescents in the United States.

The school-based survey first was conducted in 1990, and the household-based survey was initiated in 1992. The school-based survey is conducted biennially in odd-numbered years among national probability samples of 9th–12th graders from public and private schools. Schools with a large proportion of black and Hispanic students are oversampled to provide stable estimates for these subgroups.

For more information on the YRBSS, write to Centers for Disease Control and Prevention, 4770 Buford Highway, NE, Atlanta, GA.

Drug Abuse Warning Network

DAWN was operated by the Drug Enforcement Administration from 1973 through 1979 and by NIDA from 1980 through 1991. Since 1992 DAWN has been operated by SAMHSA. DAWN is a large-scale, ongoing, drug abuse data collection system based on information from emergency room (ER) and medical examiner facilities. DAWN collects information about drug abuse occurrences that have resulted in a medical crisis or death. The major objectives of the DAWN data system include monitoring drug abuse patterns and trends, identifying substances associated with drug abuse episodes, and assessing drug-related consequences and other health hazards.

Hospitals eligible for DAWN are non-Federal, short-stay general hospitals that have 24-hour ERs. Since 1988 the DAWN ER data have been collected from a representative sample of these hospitals, including 21 oversampled metropolitan area hospitals. The data from this sample are used to generate estimates of the total number of ER drug use episodes and drug mentions in all such hospitals.

Within each facility, a designated DAWN reporter is responsible for identifying drug abuse episodes by reviewing official records and transcribing and submitting data on each case. Data collected by DAWN include the drug(s) involved in the ER episode; sex, age, and race/ethnicity of patients; reasons for the ER visit; single or multiple drug use; and the route of administration.

For more information on DAWN, see *Drug Abuse Warning Network Annual Medical Examiner Data: 1995* or write to the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Room 16C-06, 5600 Fishers Lane, Rockville, MD 20857.

AIDS Surveillance Data

AIDS surveillance data are maintained by CDC using information collected by health departments in each State, Territory, and the District of Columbia. Although surveillance activities range from passive to active, most areas employ multifaceted active surveillance programs, which include the following four major reporting sources of AIDS information: hospitals and hospital-based physicians, physicians in nonhospital practice, public and private clinics, and medical record systems (e.g., death certificates, tumor registries, hospital discharge abstracts, and communicable disease reports). Using a standard confidential case report form, the health departments collect information without personal identifiers, which then is coded and computerized either at CDC or at health departments, which then transmit the information electronically to CDC.

AIDS surveillance data are used to detect epidemiologic trends to identify unusual cases requiring followup and for quarterly publication in CDC's *HIV/AIDS Surveillance Report*. Studies to determine the completeness of reporting of AIDS cases that meet the national surveillance

definition suggest reporting at greater than or equal to 90 percent. The number of deaths among AIDS cases reported to CDC's AIDS Surveillance System differs from the number of HIV infection deaths based on the National Vital Statistics System. The major reasons for these differences are (1) not all persons diagnosed with AIDS are reported to the AIDS Surveillance System, (2) not all deaths of persons with AIDS are due to AIDS, and (3) not all deaths due to HIV infection are reported as such on the death certificate.

For more information on AIDS surveillance, write to CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003 or to Chief, Surveillance Branch, Division of HIV/AIDS, National Center for HIV/AIDS, STD, and TB, Centers for Disease Control and Prevention, Atlanta, GA 30333.

Arrestee Drug Abuse Monitoring Program

The ADAM (formerly known as the Drug Use Forecasting system) measures recent drug use among booked arrestees at 24 sites in major metropolitan areas across the United States. The National Institute of Justice plans to expand the number of sites to 75 by the year 2000. The primary purpose of ADAM has been to monitor illegal drug use among booked arrestees in major American cities. It provides information about the effectiveness of local drug policies and practices and provides a solid basis for resource allocation decisions. By collecting urine samples and interviewing arrestees on a quarterly basis, ADAM has become a consistent tool for tracking drug use trends among this difficult-to-study population of users.

Arrestee participation is voluntary and anonymous. The ADAM sampling strategy is site specific, and participants are not statistically representative of all arrestees. All female arrestees are eligible to be included in the ADAM sample. However, the large numbers of male arrestees require that a selection be made. Males arrested for vagrancy, loitering, and traffic violations are excluded. Other arrestees are chosen by type of charge using the following priority: (1) nondrug felony charges, (2) nondrug misdemeanor charges, (3) drug felony charges, and (4) warrants for any charge. To prevent oversampling arrestees with a high propensity for drug use, only 20 percent of males arrested and charged with drug offenses are interviewed. It is likely that ADAM data underestimate the proportion of arrestees who have used drugs less recently, because urinalysis reveals the presence of most drugs only within 48 to 72 hours of their use.

On average, 90 percent of those recruited participate, and 80 percent provide a urine sample. The total sample of booked arrestees in the ADAM program from 1987 to 1995 included 213,898 adults, of which 156,159 were males and 57,739 were females. The ADAM sample is not a random sample; it was determined early in the ADAM program's development that selecting random samples would not be feasible in the environment in which the ADAM program would have to operate. In most sites, 225 males are now interviewed each quarter. For female arrestees, the goal is to interview at least 100. Research had shown that a sample of 200 could accurately predict results of as many as 4,000 urine tests.

For more information on the ADAM program, write to the U.S. Department of Justice, National Institute of Justice, 633 Indiana Avenue, N.W., Washington, DC 20531.

The following key lists the symbols used in the tables presented in this report.

Symbols Used in Tables	
¾	Data not available
*	Low precision, no estimate reported
---	No respondents
**	Based on 5 or fewer respondents in numerator
(no)	No reported use
N/A	Not applicable

ORGANIZATION OF THE REPORT

The remaining chapters of this report present detailed data on drug use among U.S. racial/ethnic groups. Chapter 2 presents basic population statistics from the Census Bureau and projections for racial/ethnic minorities in the United States. This information is useful for determining the relative size of racial/ethnic groups and for comparing demographic factors such as family income.

Chapter 3 provides an overview of drug use patterns for the total U.S. population and for racial/ethnic groups. Data presented in this chapter have been obtained from the NHSDA, the most comprehensive source of drug use prevalence data available in the United States. Included in this chapter are prevalence estimates on past-month, past-year, and lifetime use of illicit drugs, alcohol, and cigarettes. Illicit drugs include marijuana, cocaine, inhalants, hallucinogens, PCP (phencyclidine), heroin, and the nonmedical use of psychotherapeutics.

Chapter 4 examines drug use, attitudes about drugs, and drug-related behaviors among minority youth, and includes data on the overall prevalence of drug use among youth. These data originate from a number of sources including the Census Bureau, the Monitoring the Future Study, the NLSY, the NHSDA, and the PATS.

Chapter 5 presents data on risk behaviors such as dropping out of school, driving under the influence of alcohol or drugs, and engaging in high-risk sexual behaviors. Data sources for this chapter were the Department of Education, the NHSDA, and the YRBS.

Chapter 6 examines the adverse health consequences of drug use. Data sources for this chapter were DAWN and CDC's AIDS Surveillance System. This chapter presents prevalence estimates on drug-related medical emergencies, drug-related deaths, and information on the medical consequences of drug use.

Chapter 7 addresses drug use and crime. Data on the drug use history of booked arrestees and the percent of arrestees who committed their offense under the influence of drugs are presented in this chapter. Data were obtained from the ADAM program.

Chapter 8 summarizes this report and presents future drug abuse program and research needs. A discussion of limitations to the understanding of substance abuse among minorities is

provided, as well as a summary of issues that must be considered when conducting research and interpreting results on minority substance abuse.

Chapter 2. POPULATION STATISTICS FOR RACIAL/ETHNIC MINORITIES IN THE UNITED STATES

This chapter presents census data on the general population residing in the United States and projections for the population growth rate of racial/ethnic minorities. Also presented in this chapter are census data on the percentage of the population that lives below the poverty threshold. The distribution of racial/ethnic groups in the United States is anticipated to undergo major changes by the year 2050 (U.S. Bureau of the Census 1996). The non-Hispanic white share of the population is predicted to decline steadily as Asian, Hispanic, and African American populations increase. It is estimated that the African American population will approximately double in size from 33 million in 1995 to 61 million in 2050; the Hispanic population will more than triple in size from 27 million in 1995 to 97 million in 2050; and the Asian/Pacific Islander population also will more than triple in size from 9 million in 1995 to 34 million in 2050 (U.S. Bureau of the Census 1996).

Census data for 1990 indicate that minorities were overrepresented in central cities and metropolitan areas. Some data suggest that drugs of choice may differ dramatically in rural and urban contexts (Johnston et al. 1993). In addition, many cities have cultural/societal characteristics that affect drug use, such as laws and norms favorable to drug use, availability of drugs, economic deprivation, and disorganization of neighborhoods (Newcomb 1995). U.S. Bureau of the Census data for 1990 showed that one-half of the U.S. population lived in large metropolitan areas. Large metropolitan areas included standard metropolitan statistical areas (SMSAs) with a population in 1990 of 1,000,000 or more. Small metropolitan areas included SMSAs with a population in 1990 of 50,000 to 999,999. Nonmetropolitan areas were designated as areas of the coterminous United States not part of an SMSA as of 1990. They included small communities, rural nonfarm areas, and rural farm areas. Overall, African Americans account for approximately 12 percent of the total U.S. population; the majority (57 percent) live in central cities. Although whites account for approximately 84 percent of the total U.S. population, only 26 percent reside in central cities.

POPULATION STATISTICS

Table 1 presents estimated percentage distributions for the resident population of the United States by race/ethnicity for 1990 and 1995 and projections for selected years from 2000 to 2050. These data indicate that the Asian/Pacific Islander population experience the greatest change between 1990 and 2050, followed by persons of Hispanic origin. The U.S. population is projected to be nearly equal proportions of white and nonwhite residents in 2050.

Table 2 displays 1991, 1993, 1995, and 1997 weighted average poverty thresholds estimated from the 1980 and 1990 censuses by various sizes of family unit. Families or individuals with incomes below their appropriate thresholds are classified as below the poverty level. These thresholds are updated annually to reflect changes in the Consumer Price Index for all urban consumers. The table shows that in 1997, the average poverty threshold for a family of four was $16,404, an increase of 18 percent from 1991.

Table 3 presents the 1996 income thresholds below which people are classified as living in poverty, by family size and number of related children under age 18. In 1996 the poverty threshold for a single person under age 65 was $8,163 per year, and the poverty threshold for a family of four with two children under age 18 was $15,911 per year.

Table 4 presents the percentage and number of people in the United States living below poverty level by racial/ethnic group, as shown in Census Bureau data from 1973 to 1996. The proportion of individuals who are classified below the poverty level has increased between 1973 and 1996, from 11.1 percent to 13.7 percent. A comparison of poverty level by race/ethnicity indicates that slightly less than one-third of African Americans were living in poverty in 1996. This proportion has remained relatively stable throughout the period from 1973 to 1996, though it reached its lowest rate in 1996 (28.4 percent). The proportion of Hispanic people living in poverty has risen from 21.9 percent in 1973 to 29.4 percent in 1996. Whites have the lowest proportion of people living in poverty; however, this proportion also has increased, from 8.4 percent in 1973 to 12.2 percent in 1993. As with African Americans and Hispanics, this proportion decreased slightly in 1996 to 11.2 percent.

Table 4 also presents the proportions of female-headed families with children under age 18 who are living in poverty. In 1996 more than one-half of African American and Hispanic households with children under age 18 and no husband present lived below the poverty level (51.0 percent and 59.7 percent, respectively). Furthermore, African American and Hispanic children under age 18 were two to three times more likely than white children to live below the poverty level (39.5 percent and 39.9 percent, respectively, compared with 15.5 percent for whites) in 1996.

SUMMARY

Data from the U.S. census indicate that the distribution of racial/ethnic minorities in the U.S. population is undergoing significant change. Comparison of population growth rates show the non-Hispanic white population experienced the slowest growth rate between 1980 and 2000, while the Asian/Pacific Islander population showed the greatest percent change, followed next by persons of Hispanic origin.

Ethnic/racial minorities are at greater economic disadvantage compared with whites. Whites have the lowest proportion of people living in poverty, while about one-third of African American and Hispanic people were living in poverty in 1996. In addition, more than one-half of African American and Hispanic households with children under age 18 and no husband present lived below the poverty level and African American and Hispanic children under age 18 were two to three times more likely than white children to live below the poverty level.

Table 1

Estimated percentage distribution of the U.S. population, by race/ethnicity and Hispanic origin, 1990–2050

Year	Total population (thousands)	Non-Hispanic				Hispanic
		African American	Asian American/ Pacific Islander	American Indian*	White	
1990	249,402	11.8	2.8	0.7	75.6	9.0
1995	262,820	12.0	3.3	0.7	73.6	10.2
2000	274,634	12.2	3.9	0.7	71.8	11.4
2005	285,981	12.4	4.4	0.8	69.9	12.6
2010	297,716	12.6	4.8	0.8	68.0	13.8
2020	322,792	12.9	5.7	0.8	64.3	15.3
2050	393,931	13.6	8.2	0.9	52.8	24.5

* Includes Eskimos and Aleuts.

SOURCE: U.S. Bureau of the Census (1996a).

Table 2

Weighted average poverty thresholds in 1991, 1993, 1995, and 1997 by size of family

Size of family	Weighted average poverty threshold (in dollars)			
	1991	1993	1995	1997
1 person (unrelated individual)	6,932	7,363	7,763	8,178
Under 65 years	7,086	7,518	7,710	8,350
65 years and over	6,532	6,930	7,108	7,698
2 persons	8,865	9,414	9,661	10,468
Householder under 65 years	9,165	9,728	9,976	10,806
Householder 65 years and over	8,241	8,740	8,976	9,709
3 persons	10,860	11,522	11,821	12,803
4 persons	13,924	14,763	15,141	16,404
5 persons	16,456	17,449	17,900	19,387
6 persons	18,587	19,718	20,235	21,880
7 persons	21,058	22,383	22,923	24,825
8 persons	23,605	24,836	25,427	27,713
9 persons or more	27,942	29,529	30,300	32,705

SOURCE: U.S. Bureau of the Census (1996b).

Table 3

Poverty thresholds in 1996, by size of family and number of related children under 18 years of age (in dollars)

Size of family	Weighted average poverty threshold	Related children under 16 years								
		None	One	Two	Three	Four	Five	Six	Seven	Eight or more
One person (unrelated individual)	7,995									
Under 65 years	8,163	8,163								
65 years and over	7,525	7,525								
Two persons	10,233									
Householder under 65 years	10,564	10,507	10,815							
Householder 65 years and over	9,491	9,484	10,774							
Three persons	12,516	12,273	12,629	12,641						
Four persons	16,036	16,183	16,448	15,911	15,967					
Five persons	18,952	19,516	19,800	19,194	18,725	18,438				
Six persons	21,389	22,447	22,536	22,072	21,627	20,965	20,573			
Seven persons	24,268	25,828	25,990	25,434	25,046	24,324	23,482	22,558		
Eight persons	27,091	28,887	29,142	28,617	28,158	27,506	26,678	25,816	25,597	
Nine persons or more	31,971	34,749	34,917	34,453	34,063	33,423	32,542	31,746	31,548	30,333

SOURCE: U.S. Bureau of the Census (1996b).

Table 4

Persons and families living below poverty level, according to selected characteristics, race, and Hispanic origin: United States, selected years 1973–96

Selected characteristics and race/ethnicity	1973	1980[1]	1985	1989	1990	1991	1992	1993	1994	1995	1996
	Percent below poverty										
All persons											
All races	11.1	13.0	14.0	12.8	13.5	14.2	14.5	15.1	14.5	13.8	13.7
White	8.4	10.2	11.4	10.0	10.7	11.3	11.6	12.2	11.7	11.2	11.2
Black	31.4	32.5	31.3	30.7	31.9	32.7	33.3	33.1	30.6	29.3	28.4
Hispanic	21.9	25.7	29.0	26.2	28.1	28.7	29.3	30.6	30.7	30.3	29.4
Related children under 18 years of age in families											
All races	14.2	17.9	20.1	19.0	19.9	21.1	21.1	22.0	21.2	20.2	19.8
White	9.7	13.4	15.6	14.1	15.1	16.1	16.0	17.0	16.3	15.5	15.5
Black	40.6	42.1	43.1	43.2	44.2	45.6	46.3	45.9	43.3	41.5	39.5
Hispanic	27.8	33.0	39.6	35.5	37.7	39.8	38.8	39.9	41.1	39.3	39.9
Families with female householder, no husband present, and children under 18 years of age											
All races	43.2	42.9	45.4	42.8	44.5	47.1	45.7	46.1	44.0	41.5	41.9
White	35.2	35.9	38.7	36.1	37.9	39.6	39.1	39.6	38.3	35.6	36.9
Black	58.8	56.0	58.9	53.9	56.1	60.5	57.2	57.7	53.9	53.2	51.0
Hispanic	---	57.3	64.0	57.9	58.2	60.1	57.4	60.5	59.2	59.3	59.7
	Number below poverty (in thousands)										
All persons											
All races	22,973	29,272	33,064	31,528	33,585	35,708	36,880	39,265	38,059	36,425	36,529
White	15,142	19,399	22,860	20,785	22,326	23,747	24,523	26,226	25,379	24,423	24,650
Black	7,388	8,579	8,926	9,302	9,837	10,242	10,613	10,877	10,196	9,872	9,694
Hispanic	2,366	3,491	5,236	5,430	6,006	6,339	6,655	8,126	8,416	8,574	8,697
Related children under 18 years of age in families											
All races	9,453	11,114	12,483	12,001	12,715	13,658	13,876	14,961	14,610	13,999	13,764
White	5,462	6,817	7,838	7,164	7,696	8,316	8,333	9,123	8,826	8,474	8,488
Black	3,822	3,906	4,057	4,257	4,412	4,637	4,850	5,030	4,787	4,644	4,411
Hispanic	1,364	1,718	2,512	2,496	2,750	2,977	2,946	3,666	3,966	3,938	4,090
Families with female householder, no husband present, and children under 18 years of age											
All races	1,987	2,703	3,131	3,190	3,426	3,767	3,761	4,034	3,816	3,634	3,755
White	1,053	1,433	1,812	1,671	1,814	1,969	1,980	2,123	2,064	1,980	2,032
Black	905	1,217	1,384	1,415	1,513	1,676	1,659	1,780	1,591	1,533	1,593
Hispanic	---	288	489	491	536	584	543	706	700	735	760

[1] Data for Hispanic families with female householder, no husband present, and children under 18 years are for 1979.

NOTES: The race groups, white and black, include persons of both Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

SOURCE: U.S. Bureau of the Census (1996b).

Chapter 3. DRUG USE IN THE GENERAL POPULATION

This chapter provides an overview of drug use patterns for the U.S. population according to the National Household Survey on Drug Abuse (NHSDA) and presents attitudes and perceptions toward drug use according to the Partnership for a Drug-Free America's Partnership Attitude Tracking Survey (PATS). Included in this chapter are prevalence estimates on past-month, past-year, and lifetime use of illicit drugs, alcohol, and cigarettes. Illicit drugs included marijuana, cocaine, inhalants, hallucinogens, PCP (phencyclidine), heroin, and the nonmedical use of psychotherapeutics. Estimates are presented for the general population, for racial/ethnic groups, and for women of childbearing age. Also included in this chapter are data regarding the attitudes and perceived risks associated with drug use and the availability of illicit drugs, alcohol, and cigarettes.

This information is important for understanding general patterns of drug use in the United States. In addition to presenting data by race and ethnicity, the report presents data by age and sex. These data provide a framework for comparing drug use among race, age, and sex groups. While race/ethnicity is the focus of this report, it is important to note both age and sex differences occur irrespective of race or ethnicity. Use of many drugs peaks in late adolescence and early adulthood. Consequently, youth often are targeted as a high-risk group for drug abuse. Sex differences in rates of drug use also are found in many surveys. Except for cigarettes, boys tend to initiate drug use earlier then do girls and to use slightly greater quantities; for many drugs this pattern is maintained throughout much of adulthood.

This chapter also presents data on drug use among Asians and detailed data for Hispanics. Many researchers argue that lumping together all data regarding Hispanics sacrifices many important distinctions that exist among these sometimes diverse ethnic subgroups. Grouping people by geographic origin or ethnicity is preferable when the data are available. Ethnicity is thought to serve as a proxy for many important cultural differences such as diet and daily activities, which can have biological and behavioral implications (Begley 1995).

PREVALENCE OF DRUG USE

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) NHSDA is the primary source for prevalence data on drug use in the United States. Using confidential (self-administered) answer sheets, respondents in the 1996 NHSDA were asked to report their use of illicit drugs and nonmedical use of prescription stimulants, sedatives, tranquilizers, and analgesics, as well as their use of alcohol and cigarettes. Drug use is reported for three types of prevalence: use of a drug at least once in the respondent's lifetime (i.e., lifetime use); use of a drug at least once in the 12 months prior to the interview (i.e., past-year use); and use of a drug at least once in the 30 days prior to the interview (i.e., past-month or current use).

Sample sizes for the 1996 NHSDA and the corresponding U.S. civilian noninstitutionalized population by age, sex, and race/ethnicity are presented in Table 5. The nationally representative sample for the 1996 NHSDA was 18,269 individuals, with oversampling for African Americans, Hispanics, and young people. Estimates of the prevalence

of drug abuse obtained from the NHSDA should be viewed as conservative because potentially high-risk subgroups were not included in the sample (e.g., persons with no fixed residence and prison inmates). Because drug use is an illicit activity and social tolerance for drug use has diminished considerably over time, it also is expected that some respondents underreported their drug use. The male portion of NHSDA population was 47.5 percent white (non-Hispanic), 21.6 percent African American (non-Hispanic), 27.4 percent Hispanic, and 3.5 percent other races. The female portion was 45.6 percent white (non-Hispanic), 25.7 percent African American (non-Hispanic), 25.8 percent Hispanic, and 2.9 percent other races.

Data from the 1996 NHSDA on lifetime and past-month prevalence of drug use among members of the general population ages 12 and older are presented in Table 6. An estimated 74.4 million people ages 12 and older have used an illicit drug at some point in their lifetime, and an estimated 13.0 million people had used an illicit drug in the month prior to the survey.

Marijuana has remained the most commonly used illicit drug. It has been called a gateway drug because it has been shown to be related to subsequent use of other illicit drugs (Kandel et al. 1987). Furthermore, long-term marijuana use, like long-term cigarette smoking, can cause adverse health consequences (Tashkin et al. 1990). About one-third (32.0 percent) of all Americans ages 12 and older have used marijuana at least once in their lifetime, and an estimated 4.7 percent had used marijuana in the month prior to the NHSDA survey (see Table 6).

Cocaine is one of the most powerfully addictive drugs. Clinicians have estimated that approximately 10 percent of individuals who start using the drug for recreational purposes will go on to serious, heavy use (National Institute on Drug Abuse [NIDA] 1989). Cocaine is the second most frequently used illicit drug, with an estimated 10.3 percent of the population using cocaine in their lifetime and 2.2 percent using crack-cocaine.

Hallucinogens, inhalants, and prescription sedatives are abused more frequently by youth and young adults than by older adults. General population estimates of lifetime use of these drugs are 9.7 percent for hallucinogens, 5.6 percent for inhalants, and 2.7 percent for prescription sedatives. Less than 1 percent of persons ages 12 and older reported using these drugs in the month preceding the survey.

Alcohol is by far the most frequently used drug in the United States. In addition to its purchase and consumption being legal for those age 21 and older, alcoholic beverages are readily available, socially acceptable, and generally inexpensive. Data from the NHSDA indicate that 82.6 percent of the population ages 12 and older have tried alcohol in their lifetime, and more than one-half of the population (51.0 percent) had consumed alcohol in the month prior to the survey (see Table 6).

Although smoking is not an illegal behavior, tobacco is of concern because of its recognized addictive qualities and negative effects on health. In addition, etiologic studies implicate early use of tobacco as a risk factor for later use of illicit drugs (Kandel and Davies 1991). According to the 1996 NHSDA, nearly three-quarters (71.6 percent) of Americans have smoked cigarettes at some point in their lifetime, and more than one-quarter (28.9 percent) are current smokers (see Table 6).

The nonmedical use of prescription drugs also is quite substantial, particularly among women (NIDA 1994b). More than 5 percent of the population has used analgesics for purposes other than medical need (see Table 6). Prescription drugs—stimulants, tranquilizers, and

sedatives—were taken for nonmedical reasons by 4.7 percent, 3.6 percent, and 2.7 percent of the population, respectively.

The prevalence of past-month drug use by age and sex is presented in Table 7. Past-month drug use included any illicit drug, marijuana, cocaine, alcohol, heavy alcohol use (i.e., consuming 5 or more drinks on the same occasion on 5 or more days in the past month), and cigarettes. Use of any illicit drug, marijuana, cocaine, and cigarettes and heavy alcohol use are highest for persons ages 18–25. There is a diminution in use of illicit drugs, marijuana, and cocaine by persons ages 35 and older. Nonheavy use of alcohol shows a slightly different pattern by age, with high prevalences among persons ages 26–34 and a less dramatic decline in use among persons age 35 and older. Comparison of drug use by sex indicated that men have higher prevalence rates than women in every drug category. The prevalences are most similar, as might be expected, for legal substances; for alcohol, prevalence among men was 58.9 percent, and among women it was 43.6 percent; for cigarettes, prevalence among men was 31.1 percent, and among women it was 26.7 percent.

Data on past-month drug use by race and age and by race and sex are presented in Table 8. Asians/Pacific Islanders have the lowest prevalence of past-month use for nearly all drug categories across all age and sex groupings. The prevalence of any illicit drug use among racial/ethnic groups was 3.7 percent for Asians/Pacific Islanders, compared with 6.1 percent for whites, 5.3 percent for Hispanics, 7.6 percent for African Americans, and 11.3 percent for American Indians/Alaskan Natives. American Indians/Alaskan Natives had the highest prevalence of past-month use for all drug categories, with the exception of alcohol use.

Data on past-month use of any illicit drug by age indicated that use is highest among persons ages 18–25 for all racial categories. Current use of illicit drugs drops off considerably in persons ages 35 and older. For example, the prevalence of use of any illicit drug among African Americans ages 26–34 is 10.6 percent, compared with 3.8 percent for African Americans ages 35 and older. Use of illicit drugs by sex indicates that males have a higher prevalence of use compared with females for all racial/ethnic groupings.

Past-month use of marijuana was highest among American Indian/Alaskan Natives for all age groups. Use peaked among American Indian/Alaskan Natives ages 18–25 but was also quite high among persons ages 12–17. Marijuana use also peaked among this age group across all other races and ethnicities. As with the use of any illicit drug, use of marijuana by sex indicates that males have a higher prevalence of use compared with females for all racial/ethnic groupings. Among whites, African Americans, and Hispanics, men were two times more likely to use marijuana compared with females.

Data on past-month use of cocaine indicated that African Americans and Hispanics have the highest prevalence of use (1.1 percent) compared with whites (0.8 percent). Use of cocaine is highest for African Americans ages 26–35 and highest for whites and Hispanics ages 18–25. Prevalence of cocaine use is approximately twice as high for males as for females, and prevalence of use for Hispanic males is nearly three times that for Hispanic females.

Data on past-month drug use among Hispanics by age and sex are presented in Table 9. (The table breaks the population down into Puerto Rican, Mexican, Cuban, Central American, South American, and other.) The overall prevalence of past-month drug use showed some differences between Hispanic subgroups for the drugs presented. Puerto Ricans have the highest prevalence of past-month use of illicit drugs, marijuana, and cigarettes (i.e., 7.0 percent for any illicit drug use, compared with 5.2 percent for all Hispanics, and

5.4 percent for marijuana, compared with 3.8 percent for all Hispanics, and 29.4 percent for cigarettes, compared with 24.7 for all Hispanics). Persons of South American ancestry had the highest prevalence of alcohol use (49.3 percent, compared with 44.2 percent for all Hispanics). Persons of Mexican ancestry reported the highest prevalence of heavy alcohol use (6.6 percent, compared with 6.0 percent for all Hispanics). Hispanic females have a lower prevalence of drug use for all drug categories compared with males. In most cases, Hispanic males are two to three times more likely to have used drugs when compared with Hispanic females. In particular, marijuana and heavy alcohol use are considerably lower for females (2.4 percent and 1.9 percent, respectively, compared with 5.2 percent and 10.1 percent for males).

Women ages 15–44 are considered to be of childbearing age. Table 10 presents NHSDA estimates of the percentage of drug use among women ages 15–44 by age, race/ethnicity, and metropolitan/nonmetropolitan location. Estimates for lifetime use of any illicit drug indicate that use is highest among white women (51.8 percent), followed by African American women (35.1 percent), Hispanic women (26.2 percent), and women of other races (18.2 percent). Past-month drug use showed a different pattern across races, with a slightly higher prevalence of illicit drug use among African American women (7.8 percent), compared with white women (7.4 percent) and Hispanic women (4.7 percent). In general, rates for past-month use of any illicit drug, marijuana, and cocaine were highest among women ages 15–24. The exception to this finding was the prevalence of cocaine use among African American women, which was highest in the 30–44 age group.

Data from U.S. natality statistics for 1989 through 1995 indicate that the percentage of live-born infants' mothers who reported smoking during pregnancy declined 29 percent across all race/ethnicity groups (Table 11). The largest declines were among Hispanics (46 percent), African Americans (38 percent), and Asian Americans (33 percent). Twenty-one percent fewer non-Hispanic white mothers reported smoking during pregnancy in 1995 compared to 1989.

Use of illicit drugs generally is higher for white and African American women living in metropolitan areas than for those living in nonmetropolitan areas. Lifetime use of marijuana was 51.7 percent for white women living in metropolitan areas compared with 40.6 percent for white women living in nonmetropolitan areas. Similarly, lifetime use of marijuana for African American women was 32.5 percent for those living in metropolitan areas compared with 20.4 percent for African American women living in nonmetropolitan areas. Conversely, rates of using any illicit drug, marijuana, and cigarettes by Hispanic women are slightly higher for those living in nonmetropolitan areas. Lifetime use of marijuana was 21.9 percent for Hispanic women living in metropolitan areas, compared with 29.2 percent for Hispanic women living in nonmetropolitan areas. Use of any illicit drug, marijuana, and cigarettes by women in the other race category was slightly higher for those living in nonmetropolitan areas. Lifetime use of marijuana among women in the other race category was 17.0 percent for those living in metropolitan areas compared with 19.6 percent for women living in nonmetropolitan areas.

ATTITUDES AND PERCEPTIONS

The measure of attitudes about and perceived risk of drug use has a direct relation to actual prevalence of use. When people perceive there are risks attached to certain behaviors, they are less likely to engage in those behaviors. On a national level, when perceived risk of drug use increases, use of that drug tends to decrease. Analysis of perceived risk is quite useful for identifying population groups, such as youth, that might benefit from drug abuse and alcohol abuse prevention programs.

The PATS analyzes drug-related attitudes and behavior among children, teens, and parents through self-reports. Youth are interviewed in schools across the country, while parents receive the survey at home. The youth survey population represents students in grades 4 through 6, and the teen population represents students in grades 7 through 12. Funded in large part by a major organizational grant from the Robert Wood Johnson Foundation, PATS consists of a series of studies, of which the 1996 wave is the ninth.

The percentage of youth and teens reporting that marijuana and cocaine/crack are easy for them to get is presented in Table 12. Table 12 also displays the percentage of parents who perceive marijuana and cocaine/crack as easy for their children to obtain. The percentage of white youth who report marijuana is easy for them to get increased by 7 percentage points (78 percent increase) between 1993 and 1996, while the percentage of African American youth who made that claim increased by 6 percentage points (43 percent) between 1993 and 1995 and decreased by 4 percentage points (-20 percent) between 1995 and 1996. Hispanic youth reporting marijuana is easy for them to get increased slightly over the reporting period.

The percentage of white and African American teens who report marijuana is very easy for them to get increased by 12 and 9 percentage points respectively, between 1993 and 1996, while the percentage of Hispanic youth reporting marijuana is very easy for them to get increased by 9 percentage points between 1993 and 1995 but remained stable in 1996. African American teens were more likely than white or Hispanic teens to report marijuana is very easy to get in 1996 (62 percent).

Between 1995 and 1996, the percent of white parents reporting marijuana is very easy for their children to obtain remained stable at 21 percent. The percentage of African American parents reporting marijuana is very easy for their children to obtain was 17 and 19 percentage points higher (1995 and 1996) than that of white parents. The percentage of Hispanic parents reporting marijuana is very easy for their children to obtain decreased by 4 percentage points during the reporting period but was higher than that reported by white parents and lower than that reported by African American parents. The percentages of white, African American, and Hispanic parents who believe marijuana is very easy to obtain are higher than those reported by youth of all races; however, they are much lower than the percentages reported by teens.

The percentage of white youth reporting that cocaine and crack are easy for them to get doubled from 6 to 12 percent between 1993 and 1996. The percentage of African American youth reporting cocaine and crack are easy for them to get showed a less dramatic increase but was higher than that reported by whites. The percentage of white parents who believe cocaine/crack is easy for their children to obtain exceeded the percentage of white youth reporting cocaine/crack is easy for them to get in 1995 but was lower than the percentage of white youth who reported in 1996. The percentage of African American parents who believe cocaine/crack is easy for their children to obtain is about twice the percentage reported by African American youth. The percentage of Hispanic parents who believe cocaine/crack is easy for their children to obtain is very close to the percentage reported by Hispanic youth.

Perception of risk is quantified in PATS by the percentage of youth, teens, and parents who associate great risk or danger with the use of various drugs (see Table 13). The percentage of African American youth who reported using marijuana is very dangerous increased by 9 percentage points between 1993 and 1996, while the percentage of white and Hispanic youth reporting the same decreased by 2 percentage points. The percentage of Hispanic, African American, and white teens who perceive great risk with marijuana use

decreased by 9, 8, and 5 percentage points, respectively, between 1993 and 1995 but increased by 5, 7, and 3 percentage points, respectively, between 1995 and 1996.

The percentage of white, African American, and Hispanic parents who perceive great risk with marijuana use increased by 8, 2 and 3 percentage points, respectively, between 1995 and 1996. The percentage of parents in all racial/ethnic groups who believe their child sees great risk associated with marijuana use is lower than the percentage of youth who report great risk with marijuana use. Apparently, youth see more risk in marijuana use than their parents think they do.

PATS asked youth to report their perceptions of the risks and dangers of cocaine and crack use separately, while teens and adults were asked to report their perceptions of cocaine and crack as a single entity. White youths' perception of great danger associated with cocaine use remained high and relatively stable between 1993 and 1996 (86 to 88 percent). Hispanic youths' perceptions also remained stable but at slightly lower percentages than those of whites (83 to 86 percent). The percentage of African American youth reporting great danger associated with cocaine and crack use increased between 1993 and 1995 but decreased between 1995 and 1996. Overall, African American youths' perception of great danger associated with crack use remained stable at levels at or higher than those reported by white and Hispanic youth. The percentage of white teens reporting great risk associated with crack/cocaine use has remained high and stable from 1993 to 1996 (86 to 88 percent). Hispanic teens' perceptions also have remained stable but at lower percentages than whites (77 to 78 percent). The percentage of African American teens reporting great risk associated with crack/cocaine use decreased only slightly between 1993 and 1995 and increased between 1995 and 1996. The percentage of white teens reporting great risk associated with crack/cocaine use is about 10 percent higher than that for Hispanic and African American teens. The percentage of white and Hispanic parents reporting great risk associated with crack/cocaine use decreased between 1993 and 1995 and increased between 1995 and 1996, while the percentage of African American parents reporting great risk decreased in both 1995 and 1996. Overall, parents seem to perceive greater risk associated with crack/cocaine use than do their children.

PATS also reports the percentage of youth who perceive the use of inhalants and heroin as very dangerous (see Table 13). The percentage of white and African American youth reporting inhalant use as very dangerous increased between 1993 and 1996, while the percentage of Hispanic youth reporting inhalant use as very dangerous decreased slightly during this period. The data on perceived risk associated with heroin use decreased between 1995 and 1996 for all racial and ethnic groups, but less than half of Hispanic youth reported great danger associated with heroin use. The data on heroin and inhalant use indicated these drugs were perceived as dangerous less frequently than were marijuana and cocaine/crack.

The percentages of youth from all racial/ethnic groups reporting they are afraid of taking drugs are much higher than those recorded by teens (Table 14). The percentages of teens reporting they are afraid of taking drugs dropped each successive year between 1993 and 1996. Overall, the percentage of Hispanic, white, and African American teens reporting taking drugs scares them decreased by 17, 13, and 11 percentage points, respectively, between 1993 and 1996.

The percentage of youth who reported smoking marijuana is okay sometimes is lower than the percentage of teens and parents who reported the same for all years. Parents agree with greater frequency than do youth and teens that smoking marijuana is okay sometimes. The percentage of white parents who agreed that if they use marijuana their child is likely to use it decreased between 1995 and 1996, while the percentage of African American and

Hispanic parents who reported the same increased by 16 and 17 percentage points, respectively. In 1995 the percentage of white parents who reported that if they use marijuana their child is likely to use it was 11 percentage points higher than the percentage for African American parents and 10 percentage points higher than that for Hispanic parents. However, in 1996 the percentage of white parents who believed their child is likely to use marijuana if they use it was 8 percentage points lower than that for African American parents and 10 percentage points lower than that for Hispanic parents.

PATS respondents also were asked if they want to hang around people who use drugs. The results of this question are presented in Table 14. Generally, youth and teens reported declining disapproval of friends' drug use between 1993 and 1996. Percentages of white and Hispanic youth reporting disapproval decreased by 6 and 10 percentage points, respectively, while the percentage of African American youth reporting disapproval increased between 1993 and 1995 and then decreased to its 1993 level in 1996. White, African American, and Hispanic teens all reported declining disapproval of hanging around people who use drugs between 1993 and 1996. The decreases in disapproval are most apparent among white youth and teens, followed by African Americans and Hispanics. Overall, the decreases in disapproval were much more dramatic among teens than among youth.

Data on youths' and teens' attitudes toward selling drugs to make money also are presented in Table 14. A much greater percentage of teens feel it is okay to sell drugs to make money compared with youth. This finding is consistent across racial/ethnic groupings. Comparison of the percentage of youth and teens in different racial/ethnic groups who feel it is okay to sell drugs indicates a higher percentage of African Americans respond positively to this question. For example, 28 percent of African American teens felt it was okay to sell drugs in 1996 compared with 17 percent of white teens and 23 percent of Hispanic teens.

SUMMARY

General population statistics on drug use from the NHSDA indicate in 1996 Asians/ Pacific Islanders had the lowest prevalence of past-month use for nearly all drug categories across all age and sex groupings. American Indians/Alaskan Natives had the highest prevalence of past-month use for all drug categories, with the exception of alcohol use, for which whites reported the highest prevalence. Data on past-month use of cocaine indicated African Americans and Hispanics have a slightly higher prevalence of use compared with that for whites.

NHSDA data also were used to examine drug prevalence estimates among Hispanic subgroups and among women of childbearing age. The data on Hispanic subgroups indicated some differences in the overall prevalence of past-month drug use; use of any illicit drugs, marijuana, and cigarettes was more prevalent among persons of Puerto Rican ancestry compared with all other Hispanics. Estimates for lifetime use of any illicit drug among women indicate that use is highest among white women, followed by African American women, Hispanic women, and women of other races. Use of illicit drugs generally is slightly higher for white and African American women living in metropolitan areas than for those living in nonmetropolitan areas.

PATS data were examined to ascertain information on attitudes of youth, teens, and parents about drug use. Youth, teens, and parents were asked about the perceived ease of obtaining several illicit drugs. The percentage of white youth reporting cocaine and crack are easy for them to get doubled between 1993 and 1996. The percentage of African American

youth reporting cocaine and crack are easy for them to get showed a less dramatic increase but was higher than that reported by whites. The percentage of Hispanic youth reporting cocaine and crack are easy to get decreased slightly in this same time period.

Youth and teens also were asked about the dangers they perceive with using various drugs. The percentage of African American youth who reported using marijuana is very dangerous increased between 1993 and 1996, while the percentage of Hispanic youth reporting the same decreased. The percentage of white teens reporting great risk associated with crack/cocaine use was higher than that reported by Hispanic and African American teens and was stable between 1993 and 1996.

Parents were asked to judge their children's attitudes about the risk of using drugs. The percentage of parents in all racial/ethnic groups who believed their children see great risk associated with marijuana use was lower than the percentage of teens who reported great risk with marijuana use. Apparently, teens see more risk in marijuana use than their parents think they do. Conversely, parents seem to overestimate the risk that their children associate with crack/cocaine use.

Table 5

NHSDA sample sizes and United States civilian noninstitutionalized population totals, by sex and age across race/ethnicity for ages 12 and older: 1996

Sex and age	White		Black		Hispanic		Other	
	Sample	Population estimate (in thousands)	Sample	Population estimate (in thousands)	Sample	Population estimate (in thousands)	Sample	Population estimate (in thousands)
Sex								
Male	3,694	77,386	1,678	10,799	2,133	10,550	269	4,192
Female	4,787	82,972	2,694	13,254	2,708	10,263	306	4,631
Age								
12–17	2,092	15,243	1,073	3,288	1,225	2,909	148	1,072
18–25	1,858	18,764	1,134	3,778	1,213	3,882	161	1,373
26–4	2,614	24,948	1,134	4,282	1,334	4,504	180	1,740
35+	1,917	101,403	1,031	12,706	1,069	9,518	86	4,638
Total	8,481	160,358	4,372	24,053	4,841	20,813	575	8,823

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.

Table 6

Prevalence of use for selected drugs among persons ages 12 and older in the United States: 1996

Drug	Ever Used		Used in Past Month	
	Percent	Population Estimate (in thousands)	Percent	Population Estimate (in thousands)
Any illicit drug use	34.8	74,390	6.1	13,035
Marijuana	32.0	68,571	4.7	10,095
Hallucinogens	9.7	20,699	0.6	1,316
Inhalants	5.6	11,909	0.4	961
Cocaine	10.3	22,130	0.8	1,749
Crack	2.2	4,628	0.3	668
Heroin	1.1	2,444	0.1	216
Nonmedical use of:				
Stimulants	4.7	10,075	0.4	763
Sedatives	2.7	4,866	0.1	232
Tranquilizers	3.6	7,774	0.4	952
Analgesics	5.5	11,799	0.9	1,184
Alcohol	82.6	176,707	51.0	109,149
Cigarettes	71.6	153,252	28.9	61,759

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.

Table 7

Prevalence of past-month drug use in the United States, by age and sex: 1996

Type of drug	Age group				Sex		All ages, both sexes
	12–17	18–25	26–34	35+	Male	Female	
Any illicit drug use	9.0	15.6	8.4	2.9	8.1	4.2	6.1
Marijuana	7.1	13.2	6.4	2.0	6.5	3.1	4.7
Cocaine	0.6	2.0	1.5	0.4	1.1	0.5	0.8
Alcohol	18.6	60.0	61.7	51.8	58.9	43.6	51.0
Heavy alcohol	2.9	12.9	7.1	3.8	9.3	1.9	5.4
Cigarettes	18.3	38.3	35.0	27.0	31.1	26.7	28.9

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.

Table 8

Prevalence of past-month drug use in the United States, by age, sex, and race/ethnicity, represented in percentages: 1996

Type of drug	Age group				Sex		All ages, both sexes
	12–17	18—25	26–34	35+	Male	Female	
Any illicit drug use							
White	9.2	17.0	8.8	2.9	8.1	4.1	6.1
Black	8.6	15.7	10.6	3.8	9.9	5.7	7.6
Hispanic	9.2	10.9	5.7	1.5	6.7	3.8	5.3
American Indian/Alaskan Native	18.4	25.4	18.9	3.7	15.1	8.0	11.3
Asian/Pacific Islander	5.5	7.1	2.0	2.9	5.1	2.5	3.7
Marijuana							
White	7.3	14.4	6.6	1.9	6.4	2.9	4.6
Black	7.3	13.9	9.2	3.3	9.1	4.5	6.6
Hispanic	6.9	8.3	3.6	1.0	4.7	2.7	3.7
American Indian/Alaskan Native	18.4	25.4	12.6	3.7	14.3	6.4	10.0
Asian/Pacific Islander	*	6.1	*	*	*	1.6	2.7
Cocaine							
White	0.5	2.3	1.3	0.4	1.1	0.5	0.8
Black	*	1.1	3.1	0.6	1.4	0.8	1.1
Hispanic	1.1	2.1	1.4	0.6	1.6	0.6	1.1
American Indian/Alaskan Native	*	*	*	*	*	*	*
Asian/Pacific Islander	*	*	*	*	*	*	*
Alcohol							
White	20.4	65.6	66.0	54.3	61.2	47.7	54.2
Black	14.7	49.6	55.7	42.0	52.3	33.5	41.9
Hispanic	19.9	49.8	50.6	44.0	54.8	31.1	43.2
American Indian/Alaskan Native	8.1	67.0	49.4	13.2	40.2	18.2	28.2
Asian/Pacific Islander	5.2	39.5	41.9	42.1	44.7	29.8	36.9
Heavy alcohol							
White	3.2	14.9	7.9	3.6	9.4	2.0	5.5
Black	1.7	7.4	5.8	5.5	9.1	2.3	5.3
Hispanic	3.4	10.6	5.8	5.4	10.2	2.1	6.2
American Indian/Alaskan Native	*	*	7.1	0.0	12.2	*	6.4
Asian/Pacific Islander	*	*	0.9	1.0	*	*	1.3
Cigarettes							
White	20.8	42.9	37.5	26.8	30.8	28.9	29.8
Black	11.9	28.5	33.5	34.7	36.1	25.7	30.4
Hispanic	14.8	30.1	26.3	24.7	31.0	28.2	24.7
American Indian/Alaskan Native	44.2	62.4	51.2	35.0	64.7	25.1	43.2
Asian/Pacific Islander	6.7	17.9	20.0	10.0	19.5	6.6	12.8

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.

*Low precision, no estimate reported.

Table 9

Prevalence of past-month drug use among Hispanics in the United States, by age and sex, represented in percentages : 1995 and 1996 combined

Type of drug	Age group				Sex		All ages, both sexes
	12–17	18–25	26–34	35+	Male	Female	
Any illicit drug							
Hispanic	9.3	9.6	6.0	1.7	6.8	3.5	5.2
Puerto Rican	9.7	12.6	11.4	2.4	9.9	4.8	7.0
Mexican	10.1	9.3	4.9	1.5	6.6	3.6	5.2
Cuban	*	13.8	*	*	6.3	1.8	4.2
Central American	5.7	6.2	4.8	*	5.0	2.5	3.8
South American	6.4	*	13.2	*	10.2	*	6.7
Other	3.6	7.7	6.1	*	5.5	2.0	3.7
Marijuana							
Hispanic	7.3	7.7	3.9	1.1	5.2	2.4	3.8
Puerto Rican	7.8	12.1	6.7	1.9	7.8	3.7	5.4
Mexican	7.9	7.1	3.3	1.1	5.1	2.5	3.9
Cuban	*	11.4	*	*	3.8	*	2.5
Central American	*	5.2	*	*	3.3	*	2.5
South American	*	*	9.8	*	7.3	*	4.3
Other	3.6	7.3	4.0	*	4.3	1.5	2.9
Alcohol							
Hispanic	19.3	49.6	52.0	45.9	57.0	31.2	44.2
Puerto Rican	14.8	48.3	52.0	43.6	55.6	30.6	41.3
Mexican	20.9	50.0	52.9	46.8	57.8	31.0	44.9
Cuban	18.0	55.7	58.6	48.9	68.6	26.6	48.5
Central American	18.6	38.3	44.2	38.7	47.7	27.7	38.0
South American	12.6	62.1	55.3	51.5	57.3	43.6	49.3
Other	17.0	55.7	50.6	43.1	54.3	361.3	42.8
Heavy alcohol							
Hispanic	2.8	8.9	6.7	5.5	10.1	1.9	6.0
Puerto Rican	*	6.3	6.7	7.1	11.5	1.9	6.0
Mexican	3.0	9.2	7.0	6.4	10.7	2.2	6.6
Cuban	*	10.8	6.0	*	7.1	*	3.9
Central American	*	6.4	4.6	5.5	8.2	1.4	4.9
South American	*	16.5	6.3	*	8.0	*	4.2
Other	*	7.4	7.5	3.0	8.4	*	4.4
Cigarettes							
Hispanic	15.2	29.1	26.5	25.0	31.2	18.1	24.7
Puerto Rican	16.2	42.8	34.9	27.1	32.1	27.4	29.4
Mexican	16.5	27.9	25.7	24.8	31.4	16.8	24.4
Cuban	8.7	23.4	40.8	23.3	29.2	19.1	24.4
Central American	10.6	25.2	21.3	25.8	33.4	11.7	22.9
South American	7.6	38.6	27.0	25.2	30.0	22.0	25.3
Other	10.6	21.3	22.7	23.4	27.5	15.3	21.4

*Low precision, no estimate reported.

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.

Table 10

Percentage of women of childbearing age (15–44) using drugs, by age, race/ethnicity, and population density: 1996

Age	Race/ethnicity	Population density	Any illicit drug			Marijuana			Cocaine			Cigarettes		
			Lifetime	Past year	Past month	Lifetime	Past year	Past month	Lifetime	Past year	Past month	Lifetime	Past year	Past month
All (15–44)	All	Total U.S.	44.9	13.0	7.0	41.9	10.3	5.3	13.6	2.3	1.0	69.3	36.1	31.9
		Metro	46.0	13.8	7.8	43.0	11.0	5.9	14.5	2.6	1.1	67.5	34.4	30.1
		Nonmetro	40.7	10.0	3.7	37.6	7.8	2.9	10.3	1.4	0.5	76.3	42.6	38.8
	White, non-Hispanic	Total U.S.	51.8	13.8	7.4	49.0	11.1	5.6	16.2	2.3	1.0	77.1	40.1	35.7
		Metro	54.5	14.9	8.6	51.7	12.1	6.4	17.7	2.6	1.1	76.2	38.6	34.0
		Nonmetro	43.6	10.4	3.8	40.6	7.9	3.0	11.5	1.4	0.5	79.9	44.6	41.1
	Black, non-Hispanic	Total U.S.	35.1	14.2	7.8	30.9	10.9	6.2	8.5	2.9	1.2	57.3	32.4	29.2
		Metro	36.9	14.8	8.3	32.5	11.3	6.7	9.2	3.2	1.2	57.1	31.8	28.7
		Nonmetro	23.6	10.3	3.9	20.4	8.3	2.8	4.0	0.9	0.7	58.7	36.7	32.6
	Hispanic	Total U.S.	26.2	9.1	4.7	22.7	7.0	3.5	7.0	2.0	0.8	49.1	25.4	21.1
		Metro	25.4	9.5	5.1	21.9	7.1	3.7	7.2	2.1	0.9	48.3	24.7	20.7
		Nonmetro	32.9	5.6	1.7	29.2	5.6	1.3	5.0	0.7	0.4	55.7	31.7	25.1
	Other, non-Hispanic	Total U.S.	18.2	7.4	4.2	17.3	6.0	2.9	6.6	1.9	0.8	40.1	16.5	12.4
		Metro	18.0	7.4	3.9	17.0	5.8	2.9	6.8	1.5	0.8	36.8	15.3	11.5
		Nonmetro	20.3	7.9	5.8	19.6	7.3	2.6	4.9	4.3	0.6	64.6	25.2	19.4
15–24	All	Total U.S.	39.6	23.0	12.2	35.5	19.3	10.0	7.0	3.1	1.3	60.0	38.1	31.0
		Metro	41.2	24.3	13.5	36.7	20.6	11.1	7.3	2.9	1.3	58.0	36.8	29.3
		Nonmetro	33.8	18.1	7.7	30.9	14.5	6.3	6.1	3.5	1.3	67.3	42.9	37.6
	White, non-Hispanic	Total U.S.	45.0	25.4	13.6	41.2	21.4	11.3	8.3	3.5	1.5	68.3	44.8	37.5
		Metro	48.6	27.9	15.6	44.1	23.8	13.1	8.8	3.3	1.6	67.2	44.5	36.0
		Nonmetro	35.1	18.7	7.9	33.1	14.8	6.6	6.9	4.0	1.5	71.3	45.9	41.4
	Black, non-Hispanic	Total U.S.	29.0	19.8	10.7	24.0	16.5	8.8	1.7	0.8	0.4	41.3	24.3	19.3
		Metro	29.7	20.4	11.2	24.9	17.2	9.5	1.7	0.8	0.4	40.2	23.7	18.9
		Nonmetro	24.3	15.9	7.5	18.4	12.0	4.6	1.6	0.4	0.4	48.3	28.5	21.7
	Hispanic	Total U.S.	31.4	16.4	8.6	25.9	13.9	6.3	7.1	3.4	1.4	46.3	26.2	18.7
		Metro	30.6	16.6	9.0	25.7	13.8	6.6	7.5	3.6	1.4	45.5	25.1	18.3
		Nonmetro	38.8	14.3	5.0	27.9	14.3	3.8	3.4	2.2	1.1	53.4	36.1	22.3
	Other, non-Hispanic	Total U.S.	24.2	18.4	8.7	22.1	14.9	6.6	6.0	3.6	1.0	45.8	24.4	16.6
		Metro	25.0	15.3	8.6	22.6	14.8	6.2	6.2	3.5	1.2	45.5	24.9	17.0
		Nonmetro	17.7	12.4	10.1	17.7	15.3	10.1	4.4	4.4	0.0	48.9	19.6	13.3

Table 10 (continued)

Percentage of women of childbearing age (15–44) using drugs, by age, race/ethnicity, and population density: 1996

Age	Race/ethnicity	Population density	Any illicit drug			Marijuana			Cocaine			Cigarettes		
			Lifetime	Past year	Past month	Lifetime	Past year	Past month	Lifetime	Past year	Past month	Lifetime	Past year	Past month
25–29	All	Total U.S.	44.5	12.4	6.2	41.8	9.8	4.6	13.1	3.0	0.9	67.0	38.0	32.6
		Metro	45.3	13.2	7.0	42.5	10.4	5.1	13.9	3.5	1.0	65.7	36.1	30.8
		Nonmetro	41.0	8.6	2.7	38.8	6.9	2.2	9.5	0.6	0.1	73.2	46.4	40.7
	White, non-Hispanic	Total U.S.	53.3	14.0	6.9	51.0	11.2	5.1	15.6	3.4	0.9	76.0	44.1	38.0
		Metro	55.8	15.6	8.1	53.4	12.4	5.9	17.1	4.3	1.1	75.8	42.5	36.3
		Nonmetro	44.7	8.7	2.9	42.7	7.1	2.6	10.4	0.4	0.0	76.4	49.4	44.1
	Black, non-Hispanic	Total U.S.	34.3	12.7	7.1	29.7	10.0	5.6	8.3	2.6	1.4	59.8	32.6	29.0
		Metro	36.4	13.3	8.0	32.0	10.6	6.3	9.0	2.8	1.5	60.9	33.3	29.5
		Nonmetro	17.4	8.2	0.0	11.0	6.0	0.0	2.4	1.8	0.0	51.2	27.1	24.9
	Hispanic	Total U.S.	18.6	7.0	3.2	15.3	5.4	2.3	7.3	1.9	0.5	43.2	21.2	16.8
		Metro	19.4	7.3	3.5	15.8	5.6	2.5	7.8	2.0	0.5	43.0	20.7	17.3
		Nonmetro	6.4	2.9	0.0	6.4	2.9	0.0	0.0	0.0	0.0	45.8	28.0	9.3
	Other, non-Hispanic	Total U.S.	18.6	3.2	2.0	17.1	1.3	0.0	7.1	0.4	0.4	26.6	12.9	9.0
		Metro	16.9	2.4	1.6	15.3	0.8	0.0	6.4	0.0	0.0	24.6	12.8	8.8
		Nonmetro	83.5	35.7	16.5	83.5	19.2	0.0	32.8	16.5	16.5	100.0	16.5	16.5
30–44	All	Total U.S.	48.0	7.6	4.3	45.4	5.5	2.8	17.4	1.7	0.8	75.2	34.5	32.2
		Metro	48.9	8.1	5.0	46.6	5.8	3.3	18.6	2.1	1.0	73.3	32.6	30.4
		Nonmetro	44.5	5.7	1.7	41.1	4.2	1.1	13.0	0.4	0.1	82.2	41.5	39.0
	White, non-Hispanic	Total U.S.	54.9	7.9	4.4	52.3	5.8	2.8	20.4	1.4	0.7	81.9	36.5	34.2
		Metro	57.1	8.4	5.3	54.9	6.3	3.3	22.2	1.8	0.9	80.7	34.6	32.3
		Nonmetro	48.1	36.1	1.7	44.2	4.3	1.1	14.4	0.3	0.0	85.7	42.5	40.1
	Black, non-Hispanic	Total U.S.	39.7	10.8	5.9	36.1	7.3	4.4	13.4	4.5	1.6	67.6	37.9	36.2
		Metro	41.9	11.4	6.4	37.8	7.5	4.8	14.4	4.9	1.7	67.5	36.8	35.1
		Nonmetro	24.9	6.6	2.3	24.7	6.2	2.1	6.3	1.1	1.1	68.9	45.8	43.3
	Hispanic	Total U.S.	25.2	4.5	2.4	23.1	2.5	1.8	6.8	0.9	0.5	53.3	26.4	24.5
		Metro	23.9	5.0	2.8	21.5	2.8	2.1	6.8	1.1	0.6	52.5	26.0	23.7
		Nonmetro	34.4	0.8	0.0	34.4	0.8	0.0	6.9	0.0	0.0	59.0	29.7	29.7
	Other, non-Hispanic	Total U.S.	14.8	2.6	2.3	14.6	2.5	1.7	6.7	1.3	0.8	41.1	13.2	11.2
		Metro	14.2	2.4	2.1	14.2	2.3	2.1	7.3	0.9	0.9	36.0	10.5	9.2
		Nonmetro	17.9	3.6	3.6	16.8	3.6	0.0	3.6	3.6	0.0	68.6	27.8	21.8

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1998.

Table 11

Percentage of live-born infants' mothers who reported smoking during pregnancy, by year and race/ethnicity, U.S. final natality statistics, 1989–95

	1989	1990	1991	1992	1993	1994	1995
Race of mother[1]							
African American	17.1	15.9	14.6	13.8	12.7	11.4	10.6
American Indian and Alaska Native	23.0	22.4	22.6	22.5	21.6	21.0	20.9
Asian American and Pacific Islander[2]	5.7	5.5	5.2	4.8	4.3	3.6	3.4
Chinese	2.7	2.0	1.9	1.7	1.1	0.9	0.8
Filipino	5.1	5.3	5.3	4.8	4.3	3.7	3.4
Hawaiian and part Hawaiian	19.3	21.0	19.4	18.5	17.2	16.0	15.9
Japanese	8.2	8.0	7.5	6.6	6.7	5.4	5.2
Other Asian American or Pacific Islander	4.2	3.8	3.8	3.6	3.2	2.9	2.9
White	20.4	19.4	18.8	17.9	16.8	15.6	15.0
Hispanic origin of mother[3]							
Hispanic origin	8.0	6.7	6.3	5.8	5.0	4.6	4.3
Cuban	6.9	6.4	6.2	5.9	5.0	4.8	4.1
Central and South American	3.6	3.0	2.8	2.6	2.3	1.8	1.8
Mexican American	6.3	5.3	4.8	4.3	3.7	3.4	3.1
Other and unknown Hispanic	12.1	10.8	10.7	10.1	9.3	8.1	8.2
Puerto Rican	14.5	13.6	13.2	12.7	11.2	10.9	10.4
African American, non-Hispanic	17.2	15.9	14.6	13.8	12.7	11.5	10.6
White, non-Hispanic	21.7	21.0	20.5	19.7	18.6	17.7	17.1
Total	19.5	18.4	17.8	16.9	15.8	14.6	13.9

[1]Includes data for 43 States and the District of Columbia (DC) in 1989, 45 States and DC in 1990, and 46 States and DC in 1991–95. Excludes data for California, Indiana, New York (but includes New York City), and South Dakota in 1994 and 1995; Oklahoma in 1989–90; and Louisiana and Nebraska in 1989, which did not require the reporting of mother's tobacco use during pregnancy on the birth certificate. White and African American racial groups include persons of Hispanic and non-Hispanic origin.

[2]Maternal tobacco use during pregnancy was not reported on the birth certificates in California and New York, which together accounted for 43–66 percent of the births in each Asian subgroup (except Hawaiian) during 1989–91.

[3]Includes data for 42 States and DC in 1989, 44 States and DC in 1990, 45 States and DC in 1991–92, and 46 States and DC in 1993–95. Excludes data for California, Indiana, New York (but includes New York City), and South Dakota in 1994 and 1995; Oklahoma in 1989–90; and Louisiana and Nebraska in 1989, which did not require the reporting of either Hispanic origin of mother or tobacco use during pregnancy on the birth certificate. Persons of Hispanic origin may be of any race.

SOURCES: National Center for Health Statistics 1996; Ventura et al. 1996, 1997.

Table 12

Percentage of respondents who believe that selected drugs are easy to get for themselves (youth and teens) and for their children (parents), by race/ethnicity: 1993, 1995, and 1996

	White			Black			Hispanic		
	1993	1995	1996	1993	1995	1996	1993	1995	1996
Marijuana									
Youth	9	12	16	14	20	16	14	15	16
Teens	47	57	59	53	59	62	49	57	57
Parents	N/A	21	21	N/A	38	40	N/A	30	26
Cocaine									
Youth	6	8	12	10	13	13	14	11	12
Crack									
Youth	6	9	12	12	14	15	16	11	15
Cocaine/crack									
Parents	N/A	11	8	N/A	32	30	N/A	12	14

N/A: Not available.

SOURCE: Partnership Attitude Tracking Survey, Partnership for a Drug Free America, 1996.

Table 13

Percentage of respondents who associate danger/great risk with the use of selected drugs, by race/ethnicity: 1993, 1995, and 1996

	White			Black			Hispanic		
	1993	1995	1996	1993	1995	1996	1993	1995	1996
Marijuana									
Youth	86	88	84	77	84	86	85	79	83
Teens	67	61	64	61	53	60	63	54	59
Parents	N/A	64	72	N/A	64	66	N/A	69	72
Cocaine									
Youth	88	88	86	86	90	87	86	83	84
Crack									
Youth	86	72	79	86	88	85	83	77	79
Cocaine/crack									
Teens	88	86	88	74	72	78	77	78	78
Parents	92	88	93	93	86	82	85	76	88
Inhalants									
Youth	58	66	64	61	68	66	57	55	56
Heroin									
Youth	N/A	57	54	N/A	57	56	N/A	53	47

N/A: Not available.

SOURCE: Partnership Attitude Tracking Survey, Partnership for a Drug Free America, 1996.

Table 14

Percentage of respondents who agree with selected statements concerning various drugs by race/ethnicity: 1993, 1995, and 1996

	White			Black			Hispanic		
	1993	1995	1996	1993	1995	1996	1993	1995	1996
	Taking drugs scares respondent.								
Youth	74	71	72	77	76	72	73	71	71
Teens	45	34	32	54	44	43	50	35	33
	Smoking marijuana is okay sometimes.								
Youth	9	11	12	18	19	17	12	17	17
Teens	11	16	16	10	17	15	9	14	16
Parents	26	24	18	35	21	21	21	19	19
	If parents use marijuana, their children are likely to use marijuana.								
Parents	N/A	70	67	N/A	59	75	N/A	60	77
	It's really hard to give my child reasons not to use marijuana.								
Parents	N/A	17	14	N/A	20	23	N/A	33	28
	Don't want to hang around people who use drugs.								
Youth	84	78	76	74	79	74	81	71	72
Teens	54	37	35	63	48	45	49	36	34
	It's okay to sell drugs to make money.								
Youth	3	5	6	13	14	12	7	15	8
Teens	15	18	17	27	33	28	16	26	23

N/A: Not available.

SOURCE: Partnership Attitude Tracking Survey, Partnership for a Drug Free America, 1996.

Chapter 4. PREVALENCE OF DRUG USE AMONG YOUTH

This chapter presents data on drug use among minority youth, including age at first use; prevalence of lifetime, past-month and past-year use; and longitudinal trends in prevalence of drug use. This chapter also includes a special section on drug use among American Indian youth.

The most extensive surveys of drug use among U.S. adolescents have been the National Household Survey on Drug Abuse (NHSDA) sponsored by the Substance Abuse and Mental Health Services Administration and the Monitoring the Future (MTF) Study sponsored by the National Institute on Drug Abuse (NIDA). These surveys provide some of the best data available for prevalence estimates of drug use among teenagers in this country; however, they have several limitations. The main limitations of these surveys include underrepresentations of truants and dropouts; limited access to high-risk groups, such as homeless and inner-city gang members; and little information on drug use frequency and quantity. Also contained in this chapter are data from the Youth Risk Behavior Survey, the National Longitudinal Survey of Youth (NLSY), and the Tri-Ethnic Center for Prevention Research.

A substantial amount of money and effort is expended on youth drug abuse prevention for youth in the United States. Despite this attention, recent findings indicate that young people's negative attitudes toward drug use are lessening, and there has been a general increase in illicit drug use among youth over the past few years. Findings from the 1996 NHSDA indicate 9.0 percent of youth ages 12–17 and 15.6 percent of youth ages 18–25 used an illicit drug in the month preceding the survey. Trend data from the MTF Study indicate the use of many drugs has increased. A detailed report from the MTF Study cited that there is a reduction in perceived risk and harm from using marijuana and cocaine and significant increases have been found in the use of marijuana, cocaine, crack, LSD, other hallucinogens, stimulants, and inhalants (Johnston et al. 1997). However, data released at the end of 1997 showed mixed results for drug use among teenagers. The dramatic increases observed between 1992 and 1996 slowed, and there were some significant decreases observed among 8th graders for the use of selected substances.

Repeated cross-sectional epidemiological surveys of the general population have documented strong age-related trends in patterns of drug use. The most important aspects of these trends are the onset of experimentation with drugs in early adolescence and an apparent peak in the use of illicit drugs from ages 18–22 (Kandel and Logan 1984). From a social and public health perspective, it is important to monitor the trends and patterns of drug use among youth because drug use has been linked with numerous problems including delinquency, family dysfunction, poor academic achievement, truancy, and school dropout. For many youth, drug use is part of a syndrome of unconventional behavior that involves marijuana use, early sexual activity, drinking, and risk-taking.

AGE AT FIRST USE

Despite some improvement in recent years, the majority of drug abusers begin using drugs before age 14. Data from the NHSDA on average age at first use of cigarettes, alcohol, and marijuana for adolescents ages 12–17 during the period from 1990 to 1996 are presented in Table 15. Trends in the sequencing of drugs used and in the average age of first use were similar across

all races for most of the drugs presented. Although the data fluctuates somewhat between 1990 and 1996, changes in age at first use for specific substances have been relatively small.

Comparison of age of first use by type of drug indicates average age at initiation for cigarettes rose from 1990 to 1996 for all race/ethnicity groups. For example, cigarette use began at an average age of 10.8 years in 1990 for African American youth compared with 12.6 years in 1996. The age of first use for marijuana also increased between 1990 and 1996. The increase in average age of first using marijuana rose one-half year for African American youth during this time period. Average age of first use of alcohol decreased for African American youth but increased slightly for white and Hispanic youth. In 1990 age of first use for alcohol was 12.8 years for white youth compared with 13.1 years in 1996. Use of cocaine by youth ages 12–17 indicated average age of first use has decreased slightly among white youth and increased among African American and Hispanic youth between 1990 and 1996. The increase is most notable among African American adolescents, for whom average age of first using cocaine increased from 12.5 years in 1990 to 14.3 years in 1996.

PREVALENCE TRENDS

This section presents prevalence trends for lifetime, past-month, and past-year use of drugs among minority youth. Data are for secondary school students, American Indian youth, and youth ages 12–21.

Secondary School Students

The MTF Study, funded by NIDA, is administered to 8th, 10th, and 12th graders, as well as to college students and young adults. One of the major purposes of the survey is to develop an accurate picture of drug use and related attitudes and behaviors among youth (Johnston et al. 1997). Data presented in this report are from the secondary school population only.

Examination of racial/ethnic drug use among 8th–12th graders indicates that although Hispanics have the highest rates of use for most drugs in 8th grade, white students have the highest rates of use for many drugs in 12th grade (see Table 16). Among 8th graders, 26.6 percent of Hispanic students report having ever used marijuana compared with 22.0 percent of white students and 21.7 percent of African American students. For cocaine use the lifetime prevalence for Hispanic 8th graders is 7.5 percent compared with 4.4 percent for whites and 1.1 percent for African Americans. For lifetime cigarette use, the prevalence for Hispanic 8th graders is 51.1 percent compared with 49.7 percent for whites and 42.1 percent for African Americans.

Among 12th graders, 48.6 percent of Hispanic students report having ever used marijuana compared with 48.3 percent of white students and 41.3 percent of African American students. For LSD the lifetime prevalence of use for white 12th graders is 15.0 percent compared with 11.8 percent for Hispanics and 8.3 percent for African Americans. For lifetime cigarette use, the prevalence for white 12th graders is 68.3 percent compared with 63.9 percent for Hispanics and 46.1 percent for African Americans. As anticipated, the overall prevalence of lifetime use of all the drugs listed in Table 16 is highest for alcohol, followed next by cigarettes and marijuana. Of note is the reported high lifetime use of inhalants (24.0 percent of white 8th graders and 20.9 percent of Hispanic 8th graders), hallucinogens and LSD (16.6 percent and 15.0 percent of white 12th graders, respectively), cocaine (18.0 percent of Hispanic 12th graders), and stimulants (19.8 percent for white 10th graders).

Data for 30-day drug use indicates a similar pattern of greater use among Hispanic 8th graders for most drugs presented in Table 16. For marijuana 13.1 percent of Hispanic 8th graders and 10.6 percent of white 8th graders were using, compared with 9.0 percent for African American 8th graders. A similar high percentage of white and Hispanic 8th graders were using inhalants (6.5 and 5.5 percent, respectively). Past-month (i.e., 30-day) use of stimulants also was high among white and Hispanic 8th graders (4.8 and 3.9 percent, respectively). African American 8th–12th graders had the lowest 30-day prevalence in use of all drugs. Past-month use of many drugs increased vastly between successive age groups. For example, the prevalence of past-month use of hallucinogens increased from 2.0 percent for white 8th graders to 3.4 percent for white 10th graders and 4.3 percent for white 12th graders. The sole drug associated with increased prevalence among younger students was inhalants. Use of inhalants was highest among 8th graders for all race/ethnicity groups.

Data on daily cigarette use indicate that among 12th graders, 27.8 percent of whites smoke daily compared with 14.0 percent of Hispanic 12th graders and 7.2 percent of African American 12th graders. Binge drinking (as determined by 5 or more drinks in the past 2 weeks) is lowest among African Americans at all grade levels, although the difference between racial/ethnic groups is greatest in the 12th grade, where 35.1 percent of whites and 27.6 percent of Hispanics report binge drinking compared with only 13.4 percent of African Americans. In the 8th and 10th grade populations, Hispanics had the highest rate of binge drinking (20.7 percent for 8th graders and 27.5 percent for 10th graders) compared with 15.1 percent for white 8th graders, 26.9 percent for white 10th graders, 9.8 percent for African American 8th graders, and 12.7 percent for African American 10th graders.

Trend data on drug use for 12th graders by race/ethnicity are shown in Figures 1–5. Trend data on 8th and 10th graders were not available because annual surveys of students in these grades were not initiated until 1991. White 12th graders have the highest rates of use of marijuana, inhalants, LSD, alcohol, and cigarettes, and Hispanics have the highest use of cocaine. For cigarettes, marijuana, and LSD, the trends in use indicate a decline through the 1980s and an increase through the 1990s. For virtually all of the drugs presented, the three racial/ethnic groups tended to parallel each other (i.e., all showed declines or inclines at roughly the same points in time). Because white 12th graders showed the highest level of use on a number of drugs, they also showed the largest declines; African Americans have had the lowest rates and, therefore, the smallest declines.

In a recent study, the Surgeon General's office reported that cigarette smoking prevalence increased in the 1990s among African American and Hispanic youth after several years of substantial decline (CDC, 1998). This increase, the report states, "is particularly striking among African American youth, who had the greatest decline of the four groups during the 1970s and 1980s" (p. 6). The prevalence of cigarette smoking among African American adolescents in the 1980s and 1990s has been lower than the prevalence among any other racial/ethnic group (see Table 17). Data from CDC's Youth Risk Behavior Surveillance System (YRBSS) show a similar pattern in the decline of prevalence of cigarette smoking among African Americans compared with other racial/ethnic groups. Also important to note in the MTF and CDC data is that American Indian/Alaskan Native 12th graders had the highest prevalence of cigarette smoking between 1976 and 1994 while Asian Americans/Pacific Islanders had the second lowest prevalence rates.

Of note are the trend data on marijuana, inhalant, and LSD use. Data on the use of marijuana are presented in Figure 2. These data indicate a decline in past-year marijuana use of nearly 20 percentage points for white and African American youth from the late 1970s to the

early 1990s. Current use is still lower than that reported in the 1970s; however, since 1993, use of marijuana has increased for all three racial/ethnic groups. Data on the use of inhalants are presented in Figure 3. These data indicate a fairly steady increase in use among white 12th graders since 1977, with the prevalence nearly doubling. Increases in the prevalence of inhalant use among Hispanic and African American 12th graders were less dramatic. The use of LSD has remained steady and low for African American 12th graders; however, LSD use is on the rise for white 12th graders (see Figure 5). LSD use decreased among Hispanic youth until 1989, and increased dramatically to 1996.

Data on trends in drug use for 8th and 12th graders by gender and race/ethnicity are presented in Table 18. The use of cigarettes among 12th graders has generally decreased for females and African Americans and increased for males and whites between 1980 and 1992. Since 1993 use of cigarettes has been increasing among all 12th graders (males and females, whites and African Americans). An increase in the use of cigarettes by 8th graders (data available since 1991) indicates that use was up for all students regardless of gender or race/ethnicity until 1996, and then it fell in 1997. The largest increase in cigarette use is for white 8th graders—from 15.0 percent in 1991 to 22.8 percent in 1997.

Use of marijuana showed some interesting trends since 1980. Marijuana use decreased for 12th graders in all gender/race categories through 1992 but has increased since then (except for black 12th graders, who experienced a slight decline in 1997). Among 8th graders, use increased in all gender/race categories through 1996 but decreased in 1997.

Similarly, cocaine use decreased for 12th graders in all gender/race categories through 1993 but has increased since that time; cocaine use increased for 8th graders in all gender/race categories from 1993 through 1996 and decreased in 1997. Inhalant use increased between 1992 and 1995 for white 8th and 12th graders but fluctuated for African American 8th and 12th graders.

Past-2-week alcohol use indicated a decline among 12th graders for both genders and for whites from 1988 through 1993, an increase in 1994 and 1995, a slight decrease in 1996, and an increase again in 1997. Among African Americans, the past-month alcohol use rates fluctuated from 1988 through 1995 and have declined in 1996 and 1997. The past-month alcohol use rates among 8th graders fluctuated between 1991 and 1997. The trends in binge drinking among 12th graders showed a general decline from 1988 through 1993 and increases from 1994 through 1997 (except for blacks, who showed declines in 1996 and 1997). Among 8th graders, the overall trend shows increased rates from 1991 through 1996 and a decline in 1997; among black 8th graders, the rates have fluctuated between 9 and 12 percent.

The trend data for 8th graders, which generally indicates that use of cigarettes, marijuana, and cocaine steadily increased from 1991 through 1996, is of concern. In particular, use of marijuana and cocaine tripled between 1991 and 1996 and fell slightly in 1997, with 3.2 percent of 8th graders using marijuana in 1991 (compared with 10.2 percent in 1997) and 0.5 percent of 8th graders using cocaine in 1991 (compared with 1.1 percent in 1997). The increase in use of most drugs is similar for white 8th graders compared with African American 8th graders, but use rates are higher for white students in these drug categories.

MTF data have also been analyzed to explore possible interactions between smoking among African American and white youth and use of alcohol and other drugs. Table 19 shows that between 1976 and 1994, the percentage of African American 12th graders who did not use

cigarettes or other illicit drugs in the previous month was higher than for white 12th graders and increased more rapidly in every category of drug use. Trends in the use of cigarettes, alcohol, and other substances among 12th graders indicate that among smokers and nonsmokers, African Americans were generally less likely than whites to use substances other than cigarettes. Furthermore, concurrent use of cigarettes and other illicit drugs was lower and decreased more rapidly among African American 12th graders than white 12th graders between 1976 and 1994.

The YRBSS monitors health risk behaviors among youth and young adults, including the use of alcohol, tobacco, and other drugs. The YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention, as well as surveys conducted by State and local education agencies. The percentage of high school students who drank alcohol, used marijuana, or used cocaine by sex, race/ethnicity, and grade level is presented in Table 20. Of those ages 15 years and younger, Hispanic males report the highest lifetime and past-month use of most drugs (more black males report past-month marijuana use than do Hispanic males). For example, more than three-quarters of Hispanic males report lifetime use of alcohol by age 15 (77.5 percent), compared with 66.9 percent for white males and 60.5 percent for African American males. By ages 16–17, however, white males surpass Hispanics in lifetime alcohol use (80.8 percent for whites compared with 80.2 percent for Hispanics).

In 1995 white females in nearly all age groups reported the highest lifetime and past-month alcohol use whereas Hispanic females in all age groups reported higher lifetime cocaine and crack-cocaine use. (Hispanic females ages 15 and younger reported the highest lifetime alcohol use of any race.) Hispanic females ages 18 and older also reported the highest lifetime and past-month marijuana use (53.7 and 32.3 percent, respectively) of any race. Estimates for use of cocaine and crack-cocaine by African American females in 1995 were either of low precision or no estimate was reported. However, African American females in every age group had the lowest reported lifetime and past-month alcohol use, while African American females ages 15 and younger reported the highest lifetime and past-month use of marijuana of any race (40.1 percent and 21.9 percent, respectively, compared with 28.7 percent and 18.2 percent, respectively, for whites and 34.5 percent and 21.2 percent, respectively, for Hispanics).

American Indians

Since 1975 an ongoing survey of American Indian 7th–12th graders enrolled in Indian reservation schools has been supported by NIDA grants. Results from the 1975 through 1993–94 school year surveys are provided in Tables 21, 22, and 23. Since no data were collected between 1994 and 1996, the information in this report will remain the same as that in the 1995 edition. A new data collection effort, initiated in late 1996, will be included in the next edition of this report.

Although prevalence rates of drug use are higher for American Indian youth on reservations than for non-Indian youth, the general trends in both groups have been parallel over the last 20 years. A pattern of large increases in the late 1970s, a leveling off in the 1980s, and modest declines in the 1990s have been shown for both American Indian and non-Indian youth. However, among non-Indian adolescents, there have been increases in drug use, especially marijuana, since 1992 (NIDA 1996). So far, American Indian youth on reservations have continued to indicate modest declines in drug use, even for marijuana.

Trends in lifetime drug use among American Indian 7th–12th graders are shown in Table 21. Lifetime use for the majority of the drugs surveyed peaked in 1980–81, after which prevalence generally began to decline. The exception to this pattern was for use of psychedelics, which has

shown an increase since 1982–83 and reached an all-time high of 22 percent in 1991–92. The percentage of American Indian youth reporting lifetime alcohol use has decreased, but the percentage that reported getting drunk has steadily increased since 1984-85.

Table 21 also contains rates of drug use that account for the drug use of school dropouts. To obtain these rates, a sample of American Indian high school dropouts was surveyed, and their drug use rates were determined. As with other school-based surveys, drug use information is affected by the lack of data on dropouts. It is recognized that dropouts as a group tend to have more social problems, including drug use. Although there are minimal data, estimates of the dropout rate among American Indian youth living on or near reservations are very high. These estimates are highly variable, but Beauvais (1995) used a rate of 50 percent, based on a review of dropout studies by Chavers (1991). These rates were applied to the school-based results for the most current data (1992–94) and are shown in the last column of Table 23.

Data on the lifetime prevalence of use of alcohol and cigarettes, as well as illicit and non-medical use of licit psychoactive drugs, are presented for American Indian 12th graders in Table 22. These data are compared with data for non-Indian 12th graders from the MTF Study. American Indian 12th graders had higher lifetime and past-month prevalence rates than non-Indian youth for most substances surveyed. In particular, American Indian youth reported substantially higher use of marijuana, cocaine, stimulants, and psychedelics. Of 222 American Indian youth, 83 percent reported trying marijuana by their senior year (compared with 35 percent for non-Indian youth); 23 percent reported trying cocaine (compared with 6 percent for non-Indian youth); 37 percent reported trying stimulants (compared with 12 percent for non-Indian youth); and 27 percent reported trying psychedelics (compared with 4 percent for non-Indian youth).

The prevalence of lifetime use of alcohol, inhalants, cigarettes, and smokeless tobacco also was high but was comparable to that reported by non-Indian youth. Past-month alcohol use rates were similar for American Indian (56 percent) and non-Indian (51 percent) youth, but past-month use of marijuana, cocaine, stimulants, and psychedelics was more than twice as high among American Indian youth than it was among non-Indian youth. When school dropouts are included, the rate of drug use among all American Indians is higher than that for American Indians attending school (except for legal stimulants and smokeless tobacco).

The percentages of lifetime use of various drugs among American Indian 4th and 6th graders are shown in Table 23. The percentage of 4th–6th graders reporting use of marijuana has been steadily decreasing, from 23 percent in 1980–81 to 7 percent in 1992–94. The use of alcohol has been decreasing as well, from 33 percent in 1980–81 to 17 percent in 1992–94. Cigarette use, however, has hovered around 30 to 34 percent.

LONGITUDINAL TRENDS

Data on drug use for a cohort of young adults participating in the NLSY (Bureau of Labor Statistics 1996) are presented in Table 24. To control for potential attrition effects, only those respondents remaining in the 1994 sample were used for the analysis of all 4 years. Additionally, calculation of lifetime drug use was achieved by summing the drug use reported for each of the individual survey years.

Lifetime, past-year, and past-month use of marijuana are presented for white, African American, and other races. Past-year use of marijuana decreased in each subsequent year from

1984 to 1994 for white non-Hispanic respondents and respondents of other races but increased slightly for African American (non-Hispanic) respondents between 1992 and 1994. Past-month use of marijuana decreased in each subsequent year for respondents in all racial/ethnic groups. Comparison of lifetime use of marijuana between 1984 and 1994 showed that the vast majority of individuals using marijuana had initiated this use in or prior to 1984. For example, 66.5 percent of white, non-Hispanic respondents reported marijuana use in 1984, and 77.9 percent reported use in 1994. Consequently, only 11.4 percent of respondents reported "new" usage of marijuana during this 10-year timespan.

Lifetime, past-year, and past-month use of cocaine for white, African American, and other races also are presented in Table 24. Examination of past-year cocaine use indicates that use decreased for whites and other races between 1984 and 1992 but increased from 1992 to 1994. A similar trend is evident in the past-month data. Past-year and past-month data on cocaine use among African Americans indicates that use increased in 1988, decreased in 1992, and increased again in 1994. Lifetime use of cocaine showed considerable increases during the reporting period; the prevalence of lifetime use for white and other races doubled between 1984 and 1994 and tripled for African Americans.

SUMMARY

Data from the NHSDA indicate that, despite some improvement in recent years, the majority of drug abusers begin using drugs before age 14. This finding has important implications for drug abuse prevention and indicates that youth in grade school are at high risk for initiation of use.

Examination of racial/ethnic drug use among 8th–12th graders from the MTF Study indicates that, even though Hispanics have the highest rates of use for most drugs in 8th grade, white students surpass most of these figures and have the highest rates in 12th grade.

Youth drug use has risen over time. Data on the use of inhalants indicate a fairly steady increase between 1977 and 1995 (prevalence nearly doubled for whites during this time period) with decreases in 1996 and 1997. LSD use remained steady and low for African American 12th graders through 1993 and has since been on the rise. Between 1989 and 1996, LSD use increased for whites and Hispanics; in 1997 the trend reversed among Hispanics.

The trend data for 8th graders indicate that use of cigarettes, marijuana, and cocaine steadily increased from 1991 to 1996 and declined in 1997. Alcohol use fluctuated but remained at approximately 25 percent in the same period. In particular, use of marijuana and cocaine has more than doubled for 8th graders since 1991. The increase in use is similar for whites compared with African Americans; however, rates are higher for white 8th graders in all drug categories.

Data collected on American Indian 12th graders indicate higher lifetime and past-month drug use for American Indian versus non-Indian youth for most substances surveyed. In particular, American Indian youth reported substantially higher use of marijuana, cocaine, stimulants,andpsychedelics.

Table 15

Average age of first use of cigarettes, alcohol, and marijuana for youth ages 12–17 by race/ethnicity: 1990, 1991, 1993, 1995, and 1996

Types of drug and race/ethnicity of student	1990	1991	1993	1995	1996
Cigarettes					
White	11.6	11.4	11.8	12.2	12.3
Black	10.8	11.3	11.8	12.7	12.6
Hispanic	11.7	12.0	12.0	12.8	12.8
Alcohol					
White	12.8	12.6	12.9	12.8	13.1
Black	13.3	12.9	13.2	13.1	13.2
Hispanic	12.8	12.8	13.0	13.1	13.3
Marijuana					
White	13.3	14.4	13.9	13.8	14.0
Black	13.4	13.7	14.0	14.1	13.9
Hispanic	14.1	13.1	13.7	13.9	13.6
Cocaine					
White	15.1	14.3	14.6	14.6	14.7
Black	12.5	14.0	14.5	—	14.3
Hispanic	13.9	14.4	14.3	14.3	14.9

— Data not available.

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, (selected years).

Table 16

Prevalence of lifetime, annual, 30-day, and daily use of selected drugs, by race/ethnicity for 8th, 10th, and 12th graders (percent): 1997

	Marijuana			Inhalants[b]			Hallucinogens			LSD			Cocaine		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
Lifetime															
White	22.0	41.1	48.3	24.0	21.3	18.9	6.3	11.9	16.6	5.5	10.7	15.0	4.4	6.7	8.1
Black	21.7	38.1	41.3	8.9	6.2	6.4	1.0	1.6	2.6	0.9	1.4	8.3	1.1	1.3	1.4
Hispanic	26.6	46.5	48.6	20.9	17.3	13.7	6.3	11.0	13.0	5.7	10.1	11.8	7.5	12.7	18.0
Annual															
White	17.8	35.3	38.7	14.1	10.4	8.6	4.5	8.9	11.6	3.9	7.9	10.1	3.0	4.4	5.5
Black	15.3	28.4	30.4	3.8	2.3	1.9	0.7	1.0	1.9	0.6	0.9	1.6	0.5	0.8	0.9
Hispanic	21.8	36.8	36.4	11.4	7.9	4.7	4.2	7.3	7.3	3.9	6.7	6.3	4.3	8.5	7.6
30-day															
White	10.6	21.2	23.6	6.5	3.5	3.0	2.0	3.4	4.3	1.6	2.9	3.2	1.2	1.7	2.2
Black	9.0	16.5	18.5	1.9	1.2	0.9	0.4	0.6	0.9	0.5	0.6	0.5	0.3	0.4	0.5
Hispanic	13.1	21.3	21.2	5.5	2.9	1.7	2.3	3.3	2.9	2.1	2.9	2.9	2.1	3.6	3.3
Daily															
White	1.1	3.7	5.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Black	1.3	2.8	3.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hispanic	1.8	8.5	4.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NOTE: Percents represent averages of 1996 and 1997 data

NOTE: The following sample sizes are based on the 1996 and 1997 surveys combined.

	8th graders	10th graders	12th graders
White	21,400	20,900	19,800
Black	4,700	3,200	3,600
Hispanic	4,200	3,200	2,800

Source: Monitoring the Future Study, University of Michigan.

Table 16 (continued)

Prevalence of lifetime, annual, 30-day, and daily use of selected drugs, by race/ethnicity for 8th, 10th, and 12th graders (percent): 1997

	Crack-cocaine			Other cocaine			Heroin			Other opiates			Stimulants		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
Lifetime															
White	2.7	3.5	3.5	3.6	5.6	7.6	2.4	2.2	2.1	N/A	N/A	10.8	14.3	19.8	10.3
Black	0.8	0.6	0.7	0.8	1.1	1.1	0.7	0.2	0.7	N/A	N/A	2.8	5.6	5.7	5.2
Hispanic	4.7	5.8	6.6	6.3	11.5	12.0	2.8	2.5	2.2	N/A	N/A	5.7	13.0	15.8	12.9
Annual															
White	1.7	2.2	2.2	2.5	3.7	5.0	1.6	1.4	1.2	N/A	N/A	7.1	9.9	14.2	11.4
Black	0.4	0.4	0.5	0.3	0.6	0.7	0.4	0.2	0.5	N/A	N/A	1.8	3.0	3.1	2.8
Hispanic	2.8	3.7	4.2	3.3	7.5	6.9	1.7	1.3	1.1	N/A	N/A	3.1	8.1	9.8	7.3
30-day															
White	0.7	0.8	0.9	0.9	1.9	1.9	0.6	0.5	0.5	N/A	N/A	2.5	4.8	5.1	5.1
Black	0.3	0.2		0.2	0.9	0.9	0.3	0.1	0.5	N/A	N/A	0.9	1.9	1.4	1.4
Hispanic	1.3	3.5	3.1	1.7	3.3	2.7	1.0	0.7	0.5	N/A	N/A	1.9	3.9	4.2	3.3
Daily															
White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Black	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hispanic	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 16 (continued)

Prevalence of lifetime, annual, 30-day, and daily use of selected drugs, by race/ethnicity for 8th, 10th, and 12th graders (percent): 1997

	Barbiturates			Tranquilizers			Alcohol			Been drunk			5+ drinks		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
Lifetime															
White	N/A	N/A	7.9	4.5	6.2	7.6	54.8	78.1	82.7	27.3	52.3	88.0	N/A	N/A	N/A
Black	N/A	N/A	2.9	2.5	1.8	2.3	51.3	63.7	72.1	28.0	31.0	39.3	N/A	N/A	N/A
Hispanic	N/A	N/A	6.7	6.3	5.7	6.4	61.3	76.0	80.5	30.2	50.5		N/A	N/A	N/A
Annual															
White	N/A	N/A	5.9	3.4	5.6	5.5	47.6	67.7	77.0	20.6	44.7	58.7	N/A	N/A	N/A
Black	N/A	N/A	1.0	1.2	0.9	0.8	37.0	50.8	60.2	10.7	20.5	26.8	N/A	N/A	N/A
Hispanic	N/A	N/A	3.7	3.5	3.5	3.8	51.5	68.3	72.7	21.8	38.1	46.2	N/A	N/A	N/A
30-day															
White	N/A	N/A	2.1	1.3	1.7	1.8	26.7	43.0	56.4	9.7	25.0	37.7	N/A	N/A	N/A
Black	N/A	N/A	0.7	0.5	0.5	0.6	17.9	24.6	34.3	4.6	8.6	13.8	N/A	N/A	N/A
Hispanic	N/A	N/A	1.4	1.4	1.5	1.1	29.8	42.8	48.2	10.4	19.5	26.9	N/A	N/A	N/A
2-week															
White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	15.1	26.9	35.1
Black	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9.8	12.7	13.4
Hispanic	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	20.7	27.5	27.6
Daily															
White	N/A	N/A	N/A	N/A	N/A	N/A	0.9	1.0	4.1	N/A	N/A	N/A	N/A	N/A	N/A
Black	N/A	N/A	N/A	N/A	N/A	N/A	0.6	0.7	1.6	N/A	N/A	N/A	N/A	N/A	N/A
Hispanic	N/A	N/A	N/A	N/A	N/A	N/A	1.4	2.0	4.0	N/A	N/A	N/A	N/A	N/A	N/A

Table 16 (continued)

Prevalence of lifetime, annual, 30-day, and daily use of selected drugs, by race/ethnicity for 8th, 10th, and 12th graders (percent): 1997

	Cigarettes			Smokeless tobacco			Steroids		
	8th	10th	12th	8th	10th	12th	8th	10th	12th
Lifetime									
White	49.7	63.7	68.3	21.9	31.2	33.2	1.7	2.1	2.1
Black	42.1	45.1	46.1	8.1	9.8	7.7	1.0	0.9	1.8
Hispanic	51.1	60.1	63.9	14.2	17.7	16.7	2.6	1.8	2.9
Annual									
White	N/A	N/A	N/A	N/A	N/A	N/A	0.9	1.3	1.2
Black	N/A	N/A	N/A	N/A	N/A	N/A	0.6	0.5	1.5
Hispanic	N/A	N/A	N/A	N/A	N/A	N/A	1.4	1.2	1.6
30-day									
White	22.8	34.4	40.7	7.6	10.4	12.2	0.5	0.6	0.6
Black	10.9	12.8	14.3	2.6	2.8	2.2	0.5	0.5	0.9
Hispanic	19.1	23.0	25.9	4.6	4.6	5.3	0.7	0.4	0.9
Daily									
White	11.4	21.4	27.8	1.5	2.5	5.0	N/A	N/A	N/A
Black	3.7	5.6	7.2	0.5	0.4	0.2	N/A	N/A	N/A
Hispanic	8.1	10.8	14.0	0.9	1.3	1.9	N/A	N/A	N/A

Table 17

Trends in the percentage of 12th graders who were previous-month smokers, by race/ethnicity and gender, Monitoring the Future Surveys, United States, 1976–79, 1980–84, 1985–89, and 1990–94

	1976–79	1980–84	1985–89	1990–94
Males				
African American	33.1	19.4	15.6	11.6
American Indian and Alaskan Native	50.3	39.5	36.8	41.1
Asian American and Pacific Islander	20.7	21.5	16.8	20.6
Hispanic	30.3	23.8	23.3	28.5
White	35.0	27.5	29.8	33.4
Females				
African American	33.6	22.8	13.3	8.6
American Indian and Alaskan Native	55.3	50.0	43.6	39.4
Asian American and Pacific Islander	24.4	16.0	14.3	13.8
Hispanic	31.4	25.1	20.6	19.2
White	39.1	34.2	34.0	33.1

NOTE: The Institute for Social Research usually reports the *N* (weighted), which is approximately equal to the sample size. Cases are weighted to account for differential probability of selection and then normalized to average 1.0. For males, the ranges of the *N* (weighted) for each of the cells in this table are 2,916–4,393 for African Americans, 342–587 for American Indians and Alaskan Natives, 242–1,166 for Asian Americans and Pacific Islanders, 893–2,808 for Hispanics, and 24,931–31,954 for whites. For females, the ranges of the *N* (weighted) for each of the cells in this table are 3,982–5,716 for African Americans, 299–586 for American Indians and Alaskan Natives, 223–1,143 for Asian Americans and Pacific Islanders, 940–2,723 for Hispanics, and 25,627–31,933 for whites.

SOURCES: Bachman et al. 1991; Institute for Social Research, University of Michigan, unpublished data.

Table18

Use of selected substances in the past month and binge drinking in the past 2 weeks among 12th graders and 8th graders, by sex and race/ethnicity (percent): 1980–97

Substance, sex, race, and grade in school	1980	1985	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Cigarettes													
All 12th graders	30.5	30.1	29.4	28.7	28.6	29.4	28.3	27.8	29.9	31.2	33.5	34.0	36.5
Male	26.8	28.2	27.0	28.0	27.7	29.1	29.0	29.2	30.7	32.9	34.5	34.9	37.3
Female	33.4	31.4	31.4	28.9	29.0	29.2	27.5	26.1	28.7	29.9	32.0	32.4	35.2
White	31.0	31.7	32.2	32.3	32.1	32.5	31.8	31.8	34.6	35.9	37.3	38.9	40.7
Black	25.2	18.7	13.9	12.8	12.4	12.0	9.4	8.2	10.9	11.0	15.0	13.5	14.3
All 8th graders	N/A	N/A	N/A	N/A	N/A	N/A	14.3	15.5	16.7	18.6	19.1	21.0	19.4
Male	N/A	N/A	N/A	N/A	N/A	N/A	15.5	17.9	17.2	19.3	18.8	20.6	19.1
Female	N/A	N/A	N/A	N/A	N/A	N/A	13.1	15.9	16.3	17.9	19.0	21.1	19.5
White	N/A	N/A	N/A	N/A	N/A	N/A	15.0	17.4	18.1	19.8	21.7	23.8	22.8
Black	N/A	N/A	N/A	N/A	N/A	N/A	5.3	5.3	7.7	9.6	8.2	11.3	10.9
Marijuana													
All 12th graders	33.7	25.7	21.0	18.0	16.7	14.0	13.8	11.9	15.5	19.0	21.2	21.9	23.7
Male	37.8	28.7	23.1	20.7	19.5	16.1	16.1	13.4	18.2	23.0	24.6	25.1	26.4
Female	29.1	22.4	18.6	15.2	13.8	11.5	11.2	10.2	12.5	15.1	17.2	18.3	20.3
White	34.2	26.4	22.3	19.9	18.6	15.6	15.0	13.1	16.7	20.1	21.5	22.5	23.6
Black	26.5	21.7	12.4	9.8	9.4	5.2	6.5	5.6	10.8	15.9	17.8	18.8	18.5
All 8th graders	N/A	N/A	N/A	N/A	N/A	N/A	3.2	3.7	5.1	7.8	9.1	11.3	10.2
Male	N/A	N/A	N/A	N/A	N/A	N/A	3.8	3.8	6.1	9.5	9.8	12.1	11.4
Female	N/A	N/A	N/A	N/A	N/A	N/A	2.6	3.5	4.1	6.0	8.2	10.2	8.9
White	N/A	N/A	N/A	N/A	N/A	N/A	3.0	3.5	4.6	6.7	9.0	11.0	10.6
Black	N/A	N/A	N/A	N/A	N/A	N/A	2.1	1.9	3.7	6.2	7.0	9.3	9.0
Cocaine													
All 12th graders	5.2	6.7	4.3	3.4	2.8	1.9	1.4	1.3	1.3	1.5	1.8	2.0	2.3
Male	6.0	7.7	4.9	4.2	3.6	2.3	1.7	1.5	1.7	1.9	2.2	2.6	2.8
Female	4.3	5.6	3.7	2.6	2.0	1.3	0.9	0.9	0.9	1.1	1.3	1.4	1.6
White	5.4	7.0	4.4	3.7	2.9	1.8	1.3	1.2	1.2	1.5	1.7	2.1	2.2
Black	2.0	2.7	1.8	1.4	1.2	0.5	0.8	0.5	0.4	0.6	0.4	0.4	0.5
All 8th graders	N/A	N/A	N/A	N/A	N/A	N/A	0.5	0.7	0.7	1.0	1.2	1.3	1.1
Male	N/A	N/A	N/A	N/A	N/A	N/A	0.7	0.6	0.9	1.2	1.1	1.2	1.2
Female	N/A	N/A	N/A	N/A	N/A	N/A	0.4	0.8	0.6	0.9	1.2	1.4	1.0
White	N/A	N/A	N/A	N/A	N/A	N/A	0.4	0.6	0.5	0.9	1.0	1.4	1.2
Black	N/A	N/A	N/A	N/A	N/A	N/A	0.4	0.4	0.3	0.3	0.4	0.4	0.3

Table 18 (continued)

Use of selected substances in the past month and binge drinking in the past 2 weeks among 12th graders and 8th graders, by sex and race/ethnicity (percent): 1980–97

Substance, sex, race, and grade in school	1980	1983	1985	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Inhalants														
All 12th graders	1.4	1.7	2.2	2.8	2.6	2.3	2.7	2.4	2.3	2.5	2.7	3.2	2.5	2.5
Male	1.8	2.4	2.8	3.4	3.2	3.1	3.5	3.3	3.0	3.2	3.6	3.9	3.1	3.3
Female	1.0	0.9	1.7	2.2	2.0	1.5	2.0	1.6	1.6	1.7	1.9	2.5	2.0	1.8
White	1.4	1.8	2.4	3.0	2.9	2.4	3.0	2.4	2.4	2.7	2.9	3.7	2.9	3.0
Black	1.0	1.0	0.8	1.8	1.8	1.1	1.5	1.5	1.5	1.3	1.8	1.1	0.9	0.9
All 8th graders	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.4	4.7	5.4	5.6	6.1	5.8	5.6
Male	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.1	4.4	4.9	5.4	5.6	4.8	5.1
Female	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.7	2.9	6.0	5.8	6.6	6.6	5.8
White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.5	5.0	5.8	6.1	7.0	6.6	6.5
Black	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2.3	2.4	2.9	2.6	2.3	1.7	1.9
Alcohol [1]														
All 12th graders	72.0	69.4	65.9	66.4	63.9	60.0	57.1	54.0	51.3	48.6	50.1	51.3	50.8	52.7
Male	77.4	74.4	69.8	69.9	68.0	65.1	61.3	58.4	55.8	54.2	55.5	55.7	54.8	56.2
Female	66.8	64.3	62.1	63.1	59.9	54.9	52.3	49.0	46.8	43.4	45.2	47.0	46.9	48.9
White	75.8	73.5	70.2	71.8	69.5	65.3	62.2	57.7	56.0	53.4	54.8	54.8	54.7	56.4
Black	47.7	49.3	43.6	38.5	40.9	38.1	32.9	34.4	29.5	35.1	33.1	37.4	35.7	34.3
All 8th graders	N/A	N/A	N/A	N/A	N/A	N/A	N/A	25.1	26.1	24.3	25.5	24.6	26.2	24.5
Male	N/A	N/A	N/A	N/A	N/A	N/A	N/A	26.3	26.3	25.3	26.5	25.0	26.6	25.2
Female	N/A	N/A	N/A	N/A	N/A	N/A	N/A	23.8	25.9	28.7	24.7	24.0	25.8	23.9
White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	26.0	27.3	25.1	25.4	25.4	27.7	26.7
Black	N/A	N/A	N/A	N/A	N/A	N/A	N/A	17.8	19.2	17.7	20.2	17.3	19.0	17.9

Table 18 (continued)

Use of selected substances in the past month and binge drinking in the past 2 weeks among 12 graders and 8th graders, by sex and race/ethnicity (percent): 1980–97

Substance, sex, race, and grade in school	1980	1983	1985	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Binge drinking [2]														
All 12th graders	41.2	40.8	36.8	34.7	34.7	33.0	32.2	29.8	27.9	27.5	28.2	29.8	30.2	31.3
Male	52.1	50.4	45.3	46.1	43.0	41.2	39.1	37.8	35.6	34.6	37.0	36.9	37.0	37.9
Female	30.5	31.0	28.2	29.2	26.5	24.9	24.4	21.2	20.3	20.7	20.2	23.0	23.5	24.4
White	44.6	44.4	40.1	41.2	38.8	36.9	36.2	32.9	31.3	31.3	31.7	32.9	34.0	35.1
Black	17.0	19.8	16.7	15.5	14.9	16.6	11.6	11.8	10.8	14.6	14.2	15.5	15.1	13.4
All 8th graders	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12.9	13.4	13.5	14.5	14.5	15.6	14.5
Male	N/A	N/A	N/A	N/A	N/A	N/A	N/A	14.3	13.9	14.8	16.0	15.1	16.5	15.3
Female	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11.4	12.8	12.3	13.0	13.9	14.5	13.5
White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12.6	12.9	12.4	13.4	14.5	15.7	15.1
Black	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9.9	9.3	11.9	11.8	10.0	10.9	9.8

[1] In 1993 the alcohol question was changed to indicate that a “drink” meant “more than a few sips.” 1993 data are based on a half sample.

N/A Not applicable.

SOURCE: Monitoring the Future Study, University of Michigan.

Table 19

Percentage of African American and white 12th graders who reported recently using or not using cigarettes and other selected substances,[1] Monitoring the Future surveys, United States, 1976–94 aggregate data

	Cigarette use among African Americans[2]							
	1976–79		1980–84		1985–89		1990–94	
Characteristic	Yes	No	Yes	No	Yes	No	Yes	No
Alcohol use								
Yes	22.7	25.6	15.2	31.2	11.0	29.5	7.2	26.2
No	9.7	41.7	5.3	48.4	3.1	56.4	2.6	64.1
Marijuana use								
Yes	17.2	11.9	11.2	14.2	6.4	7.8	3.1	5.8
No	15.0	55.9	9.3	65.3	7.6	78.2	6.6	84.5
Cocaine use								
Yes	1.4	0.6	1.4	1.3	1.0	1.0	0.3	0.2
No	31.7	66.3	19.7	77.6	13.3	84.8	9.6	89.8
Any illicit drug use[3]								
Yes	17.6	12.9	11.4	15.2	6.6	9.3	3.3	6.8
No	14.0	55.5	8.8	64.6	7.0	77.1	6.2	83.7
	Cigarette use among whites[4]							
	1976–79		1980–84		1985–89		1990–94	
Characteristic	Yes	No	Yes	No	Yes	No	Yes	No
Alcohol use								
Yes	33.7	40.5	28.2	46.0	28.6	40.9	27.5	29.7
No	3.3	22.4	2.7	23.1	3.6	26.8	5.7	37.1
Marijuana use								
Yes	22.4	13.7	16.9	12.8	14.4	8.1	11.8	4.4
No	14.3	49.6	13.8	56.5	17.5	60.0	21.3	62.5
Cocaine use								
Yes	2.6	1.1	3.5	2.0	3.4	1.4	1.2	0.2
No	34.3	62.0	27.3	67.2	28.5	66.6	31.9	66.7
Any illicit drug use[3]								
Yes	23.3	14.8	18.9	15.5	16.1	10.0	13.3	5.9
No	13.3	48.6	11.7	53.9	15.7	58.3	19.6	61.2

[1]Refers to use of these substances in the last 30 days.

[2]Entries are percentages of the entire African American 12th-grade population.

[3]Any illicit drug use includes any use of marijuana, hallucinogens, cocaine, or heroin or any use of other opiates, stimulants, barbiturates, methaqualone, or tranquilizers not under a physician's orders. Methaqualone is excluded from the definition of illicit drugs for 1990–94 survey data.

[4]Entries are percentages of the entire white 12th-grade population.

SOURCE: Survey Research Center, Institute for Social Research, University of Michigan, public use data tapes, 1976–94.

Table 20

Prevalence of youth ages 12 and older having used alcohol, marijuana, cocaine, or crack-cocaine in lifetime or past month, by age, sex, and race/ethnicity (percent): 1995

Use prevalence by drug and race/ethnicity	Male			Female		
	12–15	16–17	18+	12–15	16–17	18+
Use in lifetime						
Alcohol						
White	66.9	80.8	86.4	70.0	80.9	85.8
Black	60.5	66.7	75.8	60.5	69.7	61.5
Hispanic	77.5	80.2	81.6	73.2	75.9	75.1
Marijuana						
White	33.9	46.1	45.7	28.7	41.2	48.5
Black	43.9	56.4	57.8	40.1	43.8	33.4
Hispanic	53.2	50.0	54.4	34.5	47.4	53.7
Cocaine						
White	7.9	9.1	8.6	4.4	4.9	4.6
Black	2.0	5.6	4.0	*	0.6	*
Hispanic	14.3	19.0	16.2	13.2	17.9	9.9
Crack-cocaine						
White	6.0	5.1	4.6	2.6	3.2	*
Black	6.2	4.1	2.7	*	*	*
Hispanic	*	9.6	5.9	7.5	14.4	8.6
Use in past month						
Alcohol						
White	45.3	55.1	62.9	46.7	52.8	62.3
Black	35.9	45.2	47.1	33.9	36.6	29.8
Hispanic	51.2	52.5	49.1	45.2	50.3	53.8
Marijuana						
White	22.0	29.1	26.9	18.2	23.7	24.9
Black	31.3	38.3	34.5	21.9	23.0	17.3
Hispanic	30.3	29.5	35.4	21.2	20.9	32.3
Cocaine						
White	4.3	3.0	4.5	1.3	1.6	*
Black	*	3.4	2.9	*	*	*
Hispanic	8.2	10.9	6.6	4.5	9.3	6.5

* Low precision, no estimate reported.

SOURCE: Youth Risk Behavior Survey, Centers for Disease Control, 1995.

Table 21

Percentage of American Indian 7th–12th graders living on reservations reporting lifetime use of drugs during various years from 1975 through 1994

Drug/activity	1975	1977–78 1978–79	1980–81 1981–82	1982–83 1983–84	1984–85 1985–86	1986–87 1987–88	1988–89 1989–90	1990–91 1991–92	1992–93 1993–94	Corrected
Alcohol	76	79	85	81	79	81	75	75	68	71 *
Get drunk	N/A	N/A	N/A	N/A	46	49	55	62	51	55 *
Marijuana	41	53	74	70	57	61	55	56	50	54 *
Inhalants	16	26	30	31	21	24	24	25	21	25 *
Cocaine	6	7	11	6	7	8	9	12	9	12 *
Stimulants [1]	10	15	24	22	21	25	17	18	13	17 *
Legal stimulants	N/A	N/A	N/A	N/A	14	15	13	15	14	12 *
Sedatives [1]	6	10	9	7	10	11	7	6	4	5
Heroin	3	4	5	2	5	5	4	3	3	4 *
Psychedelics	7	9	9	6	9	10	13	22	19	21
Tranquilizers [1]	N/A	9	6	3	7	7	3	2	2	3
PCP	N/A	N/A	N/A	N/A	10	10	7	3	3	6 *
Cigarettes	N/A	N/A	N/A	N/A	79	78	71	74	71	73
Smokeless tobacco	N/A	N/A	N/A	N/A	N/A	58	56	52	45	43
Sample size	1,235	3,105	2,159	1,411	1,510	2,683	5,300	1,710	2,096	

[1] Only illicit or nonprescribed use is included.

* $p < 0.5$.

N/A Not applicable.

SOURCE: Tri-Ethnic Center for Prevention Research, Colorado State University, 1995.

Table 22

Percentage of American Indians and non-Indian high school seniors who have ever tried drugs in their lifetime and in the past month: 1991–93

Drug	Ever tried		Used in past month	
	Indian[1] 1991–93	Non-Indian[2] 1993	Indian[1] 1991–93	Non-Indian[2] 1993
Alcohol	93	87	56	51
Marijuana	83	35	38	16
Inhalants	22	17	<1	3
Cocaine	23	6	7	1
Stimulants	37	12	9	4
Heroin	3	1	0	<1
Psychedelics	27	4	6	3
Tranquilizers	2	6	2	1
PCP	3	3	<1	1
Cigarettes	78	62	—	30
Smokeless tobacco	58	31	—	11
Sample size	222	17,000	222	17,000

— Data not available.

SOURCES: [1]Tri-Ethnic Center for Prevention Research, Colorado State University.
[2]Johnston et al. 1994.

Table 23

Percentage of American Indian 4th–6th graders reporting lifetime use of drugs: 1980–81, 1987–88, 1989–90, 1990–91, and 1992–94.

Drug	1980–81	1987–88	1989–90	1990–91	1992–94
Alcohol	33	22	21	18	17
Marijuana	23	16	10	8	7
Inhalants	14	14	15	12	10
Cigarettes	34	33	32	30	31

SOURCE: Tri-Ethnic Center for Prevention Research, Colorado State University, 1995.

Table 24

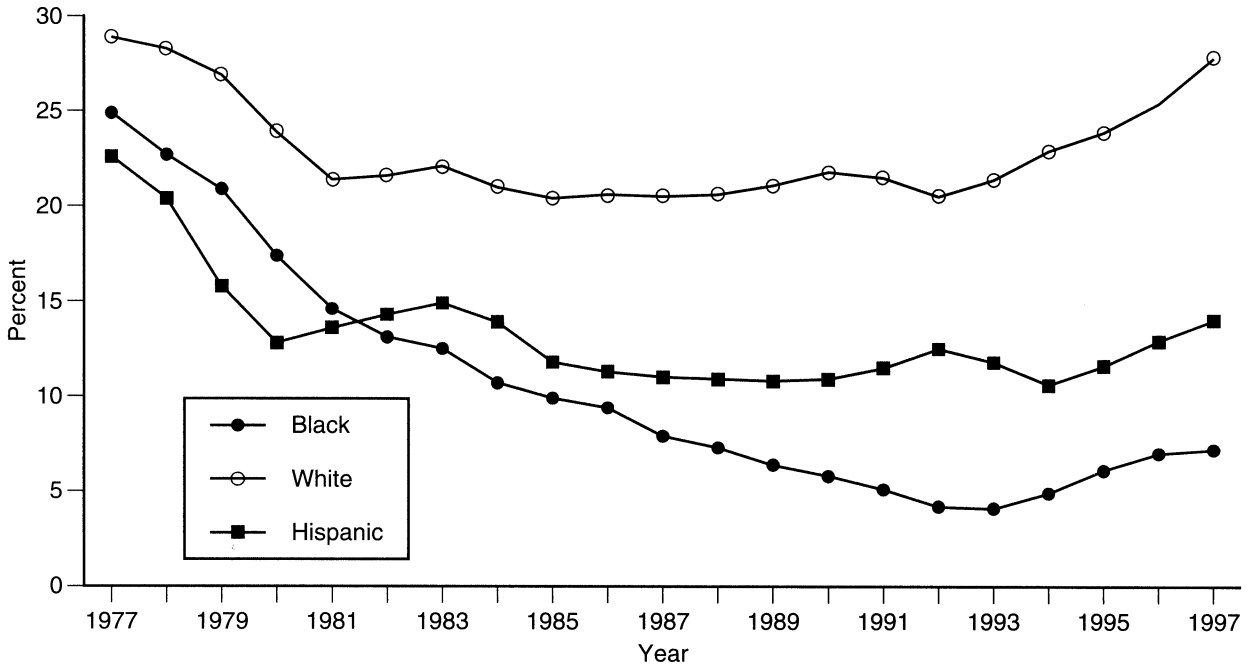
Percentage of National Longitudinal Survey of Youth cohorts admitting to use of marijuana and cocaine, by race/ethnicity and year

Drug and race/ethnicity	1984			1988		1992		1994		
	Lifetime	Past Year	Past Month	Past Year	Past Month	Past Year	Past Month	Lifetime	Past Year	Past Month
Marijuana										
White, non-Hispanic	66.5	33.8	19.5	23.3	12.7	14.1	8.3	77.9	12.8	5.4
Black, non-Hispanic	57.7	31.5	21.0	20.4	11.4	10.5	4.9	75.0	11.5	4.4
Other	53.8	29.5	17.5	16.0	9.0	11.2	6.9	68.9	9.5	4.7
Cocaine										
White, non-Hispanic	19.5	12.1	4.8	10.8	3.2	3.8	1.2	39.9	6.3	2.1
Black, non-Hispanic	10.2	6.8	2.8	8.2	3.5	4.8	1.9	32.7	7.4	3.1
Other	17.4	10.6	4.7	9.4	3.3	4.4	1.7	36.5	7.4	2.2

SOURCE: National Longitudinal Survey of Youth, Bureau of Labor Statistics, 1996.

Figure 1

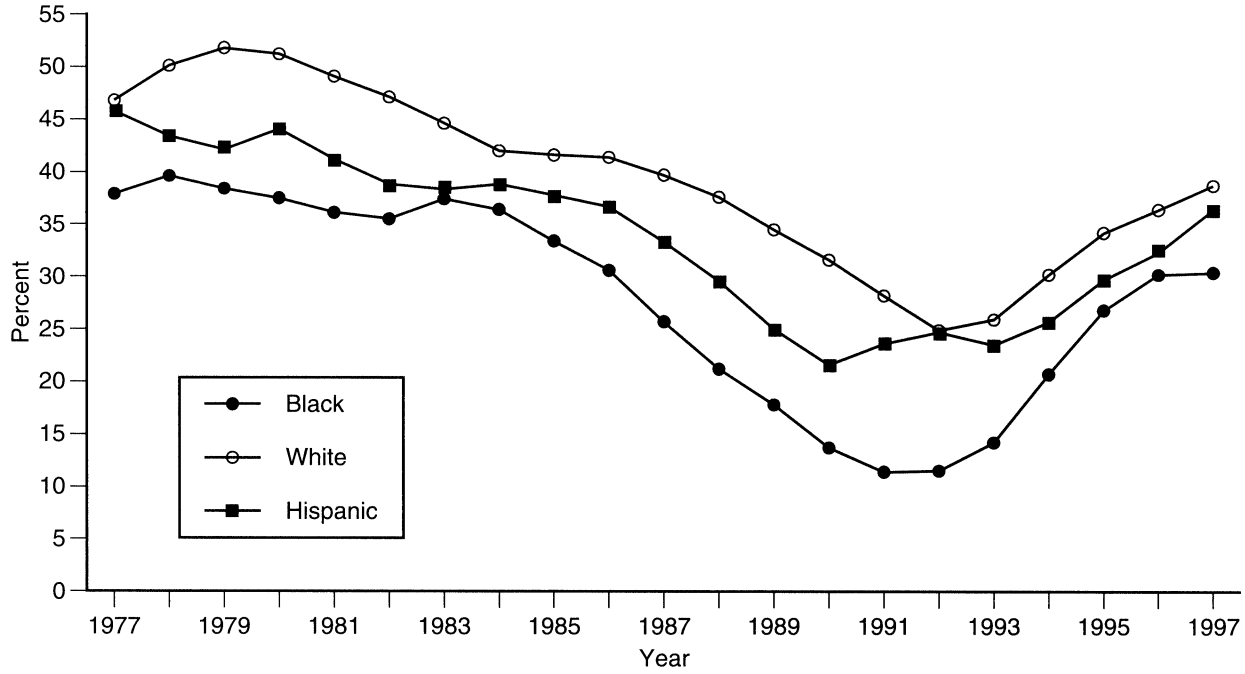
Trends in the prevalence of daily cigarette use among 12th graders, by race/ethnicity: 1977–97



SOURCE: Monitoring the Future Study, University of Michigan, 1997.

Figure 2

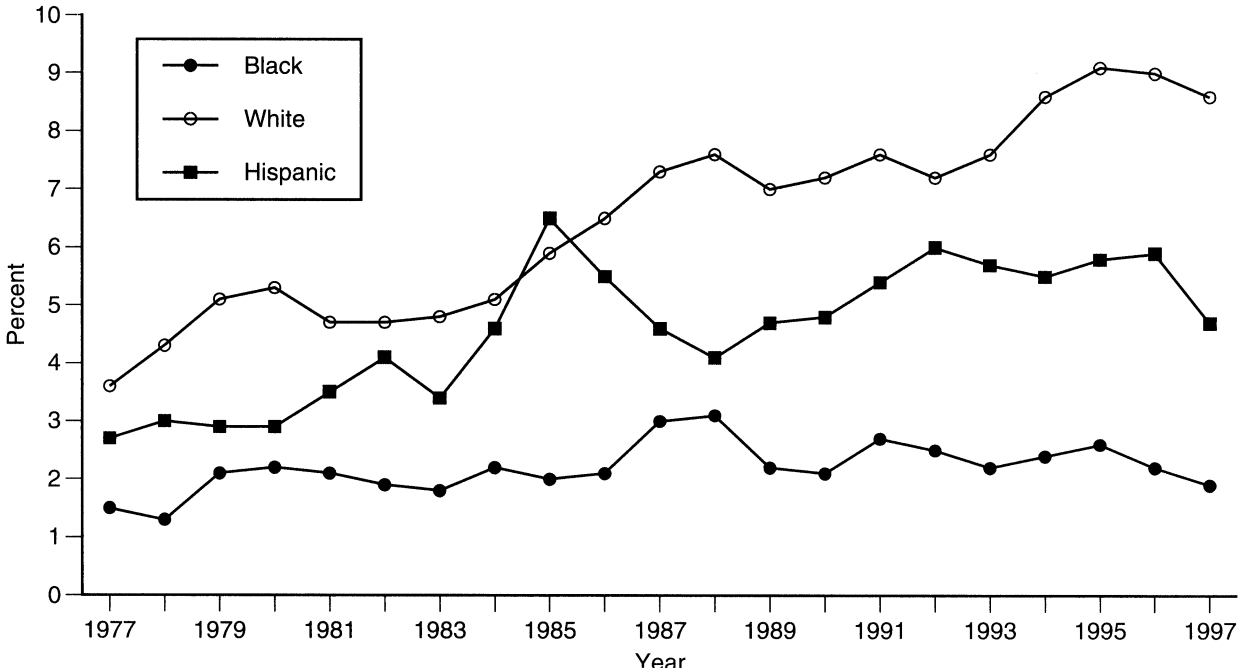
Trends in the prevalence of marijuana use in the past year among 12th graders, by race/ethnicity: 1977–97



SOURCE: Monitoring the Future Study, University of Michigan, 1997.

Figure 3

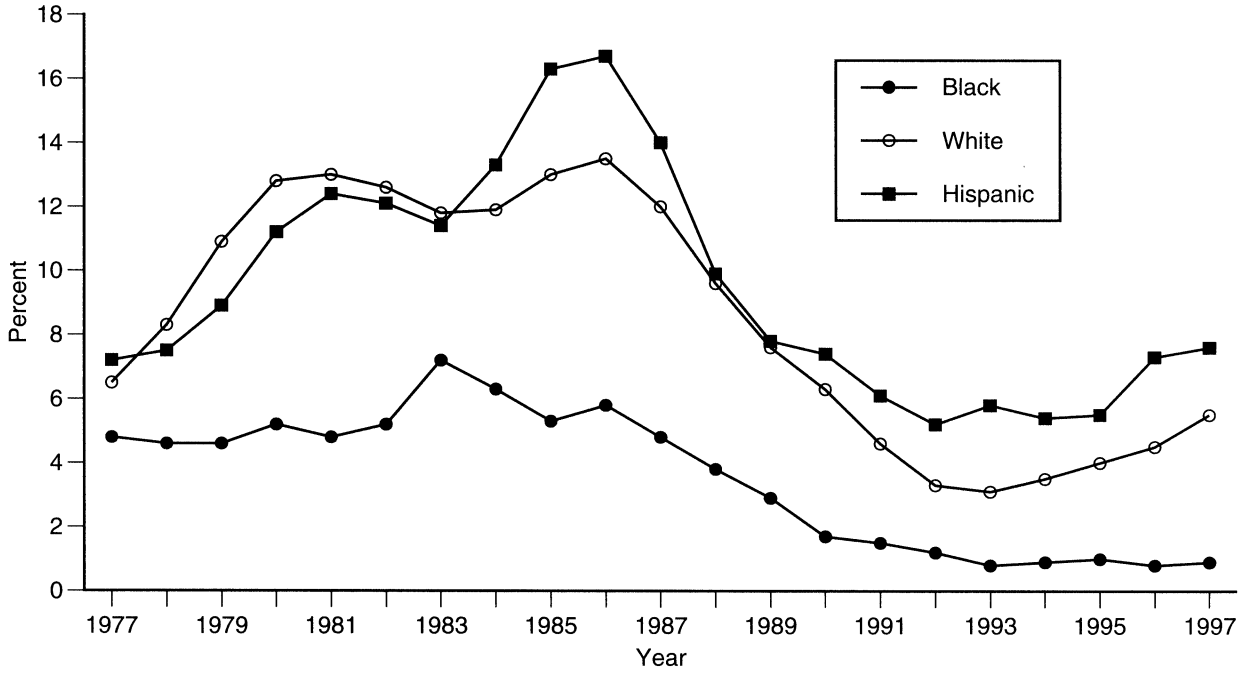
Trends in the prevalence of inhalant use in the past year among 12th graders, by race/ethnicity: 1977–97



SOURCE: Monitoring the Future Study, University of Michigan, 1997.

Figure 4

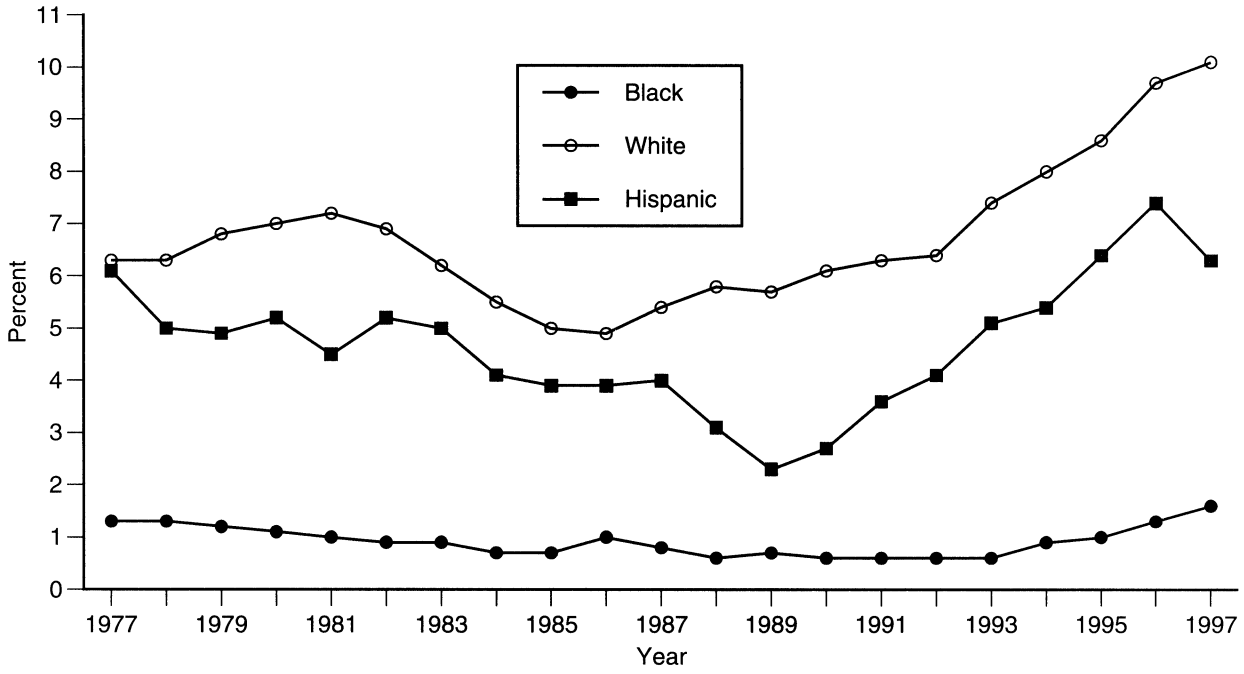
Trends in the prevalence of cocaine use in the past year among 12th graders, by race/ethnicity: 1977–97



SOURCE: Monitoring the Future Study, University of Michigan, 1997.

Figure 5

Trends in the prevalence of LSD use in the past year among 12th graders, by race/ethnicity: 1977–97



SOURCE: Monitoring the Future Study, University of Michigan, 1997.

Chapter 5. YOUTH DRUG USE AND RISK BEHAVIORS

This chapter presents data from the U.S. Department of Education on school dropout trends and data from the Youth Risk Behavior Survey (YRBS) on risk behaviors such as fighting, carrying a weapon, and engaging in sexual activity. The use of alcohol and other drugs by youth is associated with many social and health problems. The leading causes of death among adolescents are accidents, homicides, and suicides, all of which are linked to use of alcohol and other drugs. Alcohol use is a factor in approximately one-half of deaths from motor vehicle crashes, homicides, and suicides (Kolbe et al. 1993). Alcohol and other drug use increases the risk of dropping out of school, contracting sexually transmitted diseases, and getting into trouble with law enforcement officials.

In many studies risk-taking behaviors have been shown to cluster (Kokatailo 1995). Interrelationships have been found between drug abuse and many delinquent behaviors in a number of longitudinal studies, but it is not entirely clear whether the covariation of risk behaviors is the causal effect of one behavior on another or the fact that the behaviors result from a common set of risk factors (Ryan and Irwin 1992). The interaction of socioeconomic and environmental factors with the use of alcohol and other drugs has many implications. Educational attainment is known to be associated with overall health status and with the use of alcohol and other drugs (Jillson-Boostrom 1993). Dropping out of school may precede many life problems including unemployment, poverty, poor health, and greater complications arising from alcohol or other drug abuse.

SCHOOL DROPOUT TRENDS

Because of this Nation's history of compulsory education for children, individuals who drop out of school have long been a concern and an area of interest for researchers. In the 1980s the dropout issue became particularly important because of increasing awareness of the exceptionally high dropout rates among inner-city and Hispanic youth (Dryfoos 1990). This issue is of particular interest to drug use researchers because the relationship between dropping out of school and using drugs has been well documented (National Institute on Drug Abuse [NIDA] 1993).

Several distinct methods aid researchers in computing dropout rates. The methods involve calculation of (1) the event dropout rate, (2) the status dropout rate, and (3) the cohort dropout rate. The event dropout rate measures the number of students dropping out of school during any given year. This rate calculates only the number of students leaving a given school district and may not take into account students who enroll in other school districts or students who leave school, return, and then leave again. The status dropout rate attempts through major surveys to evaluate the proportion of individuals in a given age group who have completed school or are enrolled in school at one time. Because of its increased sensitivity to the cumulative annual event rate, the status dropout rate always appears higher than the event rate. The cohort dropout rate is obtained by following a single group of students across time and evaluating their school completion rates (Chavez 1993).

The 1996 dropout rates for youth from various races/ethnicities and selected demographic characteristics are presented in Table 25. These data show Hispanic youth are at the greatest risk of dropping out of school. Although Hispanics comprise about 13.8 percent of the population, they account for 37.6 percent of all dropouts. The status dropout rate among Hispanic youth (29.4 percent) is more than twice as high as rates for African American youth (13.0 percent) and more than four times as high as rates for white youth (7.3 percent). In addition, youth from low-income families are at considerably greater risk than those from high-income families (22.1 percent for low-income youth compared with 2.6 percent for high-income youth). Those living in the South or West are at higher risk than those living in the Northeast and Midwest. The status dropout rate is 13.0 percent for children in the South, 13.9 percent for children in the West, 7.7 percent for children in the Midwest, and 8.3 percent for children in the Northeast.

Status dropout rates by income level and race/ethnicity for youth ages 16–24 are shown in Table 26. These data show dropping out of school is closely related to income and that youth from lower income households are at greater risk for dropout compared with those from higher income households. The prevalence of status dropout for white youth increases from 7.3 percent for all white youth to nearly twice that figure (13.9 percent) when stratified by low family income. This same pattern exists for African American and Hispanic youth; 13.0 percent of all African American youth drop out of school, but 21.9 percent of African American youth in the low-income category drop out, and 29.4 percent of all Hispanic youth drop out of school, but 42.4 percent of Hispanic youth in the low-income category drop out.

Trend data on the event dropout rates for youth in grades 10–12 are presented by sex and race/ethnicity in Table 27. These figures reflect the percentages of students who had not graduated from high school but were not enrolled at the beginning of a new school year. As with the data on status dropout rates, Hispanic youth consistently show the highest rates of dropout, followed next by African American youth. The changes in dropout rate by year show that event dropout decreased slightly from 1972 to 1996 for Hispanic youth (11.2 percent in 1972 and 9.0 percent in 1996) and decreased for African American youth (9.5 percent in 1972 and 6.7 percent in 1996) and white youth (5.3 percent in 1972 and 4.1 percent in 1996).

Students drop out of school for a variety of reasons (see Table 28). A large percentage of all students who dropped out of school in 1992 cited they did not like school and they were failing their classes (42.9 and 38.7 percent, respectively). More African American students reported being suspended or expelled from school (24.4 percent) compared with 15.4 percent for whites and 10.1 percent for Hispanic students. African American and Hispanic students were more likely than white students to cite not feeling safe at school as an explanation for dropping out (8.5 and 8.3 percent for African American and Hispanic students, respectively, compared with 4.8 percent for white students). White students were more likely than African American and Hispanic students to report a drug or alcohol problem as their reason for dropping out (5.9 percent for whites compared with 2.1 and 1.8 percent for African Americans and Hispanics, respectively). A large percentage of female dropouts reported pregnancy as the reason (26.8 percent), and the distribution of pregnancy by race/ethnicity indicated that African Americans (34.5 percent) and Hispanics (30.6 percent) dropped out more frequently due to pregnancy than did white students (25.6 percent).

High school completion rates and method of completion by race/ethnicity for the period from 1990 to 1996 are shown in Table 29. These data indicate that throughout this period, approximately 14.0 percent of persons ages 18–22 did not complete high school (85.6 percent in 1990 and 86.2 percent in 1996). Among those completing high school, all but about 5 to 10

percent graduated from high school with a diploma (those individuals earned a general equivalency diploma). Whites have the highest overall completion rates (91.5 percent in 1996), followed by African Americans (83.0 percent in 1996) and Hispanics (61.9 percent in 1996).

Trend data on completion rates and status dropout by race/ethnicity for 1972 through 1996 are presented in Figures 6 and 7. The trends in completion rates and status dropout by race/ethnicity showed minor fluctuations during this 23-year period. A slightly greater percentage of blacks completed high school in 1996 (83 percent) than did so in 1972 (78 percent), and the completion rates for whites followed a similar pattern (88 percent in 1972 and 92 percent in 1996). Furthermore, these data indicate that although there are differences in the levels of status dropout rates of whites, African Americans, and Hispanics, the gap between the rates for African Americans and whites is closing.

RISK BEHAVIOR TRENDS

The use of alcohol and drugs by youth can threaten their physical and mental health and can alter social development. Information obtained from the YRBS indicates many high school students are establishing patterns of behaviors that place them at risk for motor vehicle crash injury, other unintentional injury, homicide, suicide, heart disease, and cancer (Kann et al. 1993). Transmission of HIV (Human Immunodeficiency Virus) and other sexually transmitted diseases also can occur indirectly as a consequence of alcohol and other drug use, which can impair judgment and reduce inhibitions about engaging in sexual intercourse (Blanken 1993).

Comparison of YRBS data for youth who have used marijuana, cocaine, or crack-cocaine and youth who have never used these drugs shows a consistent pattern of increase in risky behaviors with drug use (see Table 30). Youth who report no use of drugs report the lowest overall rates of risk behavior, followed by users of marijuana and users of cocaine. The highest rates of risk behavior are reported among youth who have used crack-cocaine. Of note are the data on aggressive behaviors such as fighting and carrying a weapon. Among white youth who have never used marijuana, an estimated 27.4 percent report a fight in the last 12 months compared with 48.2 percent of white youth who have used marijuana in their lifetime, 66.7 percent who have used cocaine in their lifetime, and 73.2 percent who have used crack-cocaine in their lifetime. Similar patterns are seen with data on prevalence of carrying a weapon in the last 30 days; however, carrying a weapon is more strongly associated with cocaine or crack/cocaine use than it is with marijuana use.

Rates of risky sexual practices also increase with drug use. More than one-third (38.4 percent) of African American youth who used marijuana in the past month had multiple sex partners during the last 3 months compared with 9.5 percent of African American youth who have never used marijuana. Furthermore, a large percentage of youth who used marijuana or cocaine in the month preceding the survey had not used a condom during their last sexual encounter. For example, 43 percent of Hispanic youth who used marijuana and 54.5 percent of Hispanic youth who used cocaine in the month preceding the survey had not used a condom during their last sexual encounter.

SUMMARY

The relationship between dropping out of school and using drugs has been well documented (NIDA 1993). Knowledge of this relationship has stimulated research efforts in the field of drug abuse. Data from the National Educational Longitudinal Study indicate that white

students were more likely than African American and Hispanic students to report a drug or alcohol problem as reason for dropping out of school. Although indirectly related to drug use, pregnancy is the reason a large percentage of female dropouts give for leaving school . The distribution of pregnancy by race/ethnicity indicated that African American and Hispanic students dropped out more frequently due to pregnancy than did white students.

YRBS data on youth who have used marijuana, cocaine, or crack-cocaine and on youth who have never used these drugs shows a correlation between drug use and a consistent pattern of increase in risky behaviors. The data on aggressive behaviors such as fighting and carrying a weapon showed strong associations with marijuana and cocaine use. Carrying a weapon was more strongly associated with cocaine or crack/cocaine use than with marijuana use.

Rates of risky sexual practices also were found to increase with drug use. More than one-third of African American youth who used marijuana in the past month had multiple sex partners during the last 3 months. Furthermore, a large percentage of youth who used marijuana or cocaine in the month preceding the survey had not used a condom during their last sexual encounter.

Table 25

Rate, number, and distribution of status dropouts,
by sex, race/ethnicity, family income, region, and metropolitan status: 1996

Sex, race/ethnicity, family income, region, and metropolitan status	Status dropout rate (percent)	Number of status dropouts (in thousands)	Population (in thousands)	All dropouts (percent)	Population (percent)
Total	11.1	3,611	32,452	100.0	100.0
Sex					
Male	11.4	1,854	16,296	51.3	50.2
Female	10.9	1,757	16,156	48.7	49.8
Race/ethnicity[1]					
White, non-Hispanic	7.3	1,569	21,527	44.8	66.3
Black, non-Hispanic	13.0	615	4,745	17.6	14.6
Hispanic	29.4	1,315	4,481	37.6	13.8
Family income[2]					
Low income level	22.1	1,398	6,322	38.7	19.5
Middle income level	10.8	2,025	8,804	56.1	57.9
High income level	2.6	188	7,326	5.2	22.6
Region					
Northeast	8.3	482	5,816	13.4	17.9
Midwest	7.7	589	7,623	16.3	23.5
South	13.0	1,505	11,582	41.7	35.7
West	13.9	1,035	7,430	28.7	22.9

[1] Due to a relatively small sample size, American Indian/Alaskan Natives and Asian/Pacific Islanders are included in the total but are not shown separately.
[2] Family income in current residence. Low income is defined as the bottom 20 percent of all family incomes for 1994; middle income is between 20 and 80 percent of all family incomes; and high income is the top 20 percent of all family incomes.

NOTE: Percentages may not sum to 100 due to rounding.

SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, October 1995, unpublished data.

Table 26

Status dropout rate for persons ages 16-24, by family income and race/ethnicity: 1996

Family Income	Total	Race/ethnicity[1]		
		White, non-Hispanic (percent)	Black, non-Hispanic (percent)	Hispanic (percent)
Total	11.1	7.3	13.0	29.4
Family income[2]				
Low income level	22.1	13.9	21.9	42.4
Middle income level	10.8	8.3	9.0	24.9
High income level	2.6	2.0	2.5	11.0

[1]Non-Hispanics who are neither black nor white are not shown separately but are included in the total.
[2]Family income in current residence. Low income is defined as the bottom 20 percent of all family incomes for 1994; middle income is between 20 and 80 percent of all family incomes; and high income is the top 20 percent of all family incomes.

SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, October 1994, unpublished data.

Table 27

Event dropout rates[1] for those in grades 10–12 and/or ages 15–24,
by sex and race/ethnicity, represented in percentages: selected Octobers 1972–96

October in selected years	Total	Sex		Race/ethnicity[2]		
		Male	Female	Hispanic	Black, non-Hispanic	White, non-Hispanic
1972	6.1	5.9	6.3	11.2	9.5	5.3
1974	6.7	7.4	6.0	9.9	11.6	5.8
1976	5.9	6.6	5.2	7.3	7.4	5.6
1978	6.7	7.5	5.9	12.3	10.2	5.8
1980	6.1	6.7	5.5	11.7	8.2	5.2
1982	5.5	5.8	5.1	9.2	7.8	4.7
1984	5.1	5.4	4.8	11.1	5.7	4.4
1986	4.7	4.7	4.7	11.9	5.4	3.7
1988	4.8	5.1	4.4	10.4	5.9	4.2
1990	4.0	4.0	3.9	7.9	5.0	3.3
1991	4.0	3.8	4.2	7.3	6.0	3.2
1992	4.4	3.9	4.9	8.2	5.0	3.7
1993	4.5	4.6	4.3	6.7	5.8	3.9
1994[3]	5.3	5.2	5.4	10.0	6.6	4.2
1995[3]	5.7	6.2	5.3	12.4	6.4	4.5
1996	5.0	5.0	5.1	9.0	6.7	4.1

[1]The event dropout rate is the percentage of those in grades 10–12, ages 15–24 who were enrolled the previous October but were not enrolled and had not graduated the following October.
[2]Included in the total but not shown separately are dropouts from other racial/ethnic groups.
[3]In 1994 new survey collection techniques and population weighting were used.

SOURCE: U.S. Department of Education, National Center for Education Statistics, Dropout Rates in the United States: 1996 (based on the October supplement to the *Current Population Survey*).

Table 28

Reasons for dropping out of school, by sex and race/ethnicity represented in percentages: 1992

Reasons for dropping out	Total	Sex		Race/ethnicity		
		Male	Female	Hispanic	Black, non-Hispanic	White, non-Hispanic
School-related:						
Did not like school	42.9	43.6	42.2	48.0	28.8	45.5
Could not get along with teachers	22.8	24.6	21.1	24.6	27.8	21.5
Could not get along with students	14.5	17.7	11.6	15.6	18.4	13.6
Did not feel safe at school	6.0	7.0	5.1	8.3	8.5	4.8
Felt I didn't belong	24.2	25.8	22.7	16.0	25.9	26.6
Could not keep up with schoolwork	31.3	32.7	29.9	35.0	25.6	30.3
Was failing school	38.7	43.4	34.5	40.6	39.5	36.6
Changed school and did not like new school	10.6	10.5	10.7	12.3	9.1	10.2
Was suspended/expelled from school	15.5	21.6	10.0	10.1	24.4	15.4
Job-related:						
Could not work and go to school at same time	22.8	26.9	19.1	20.4	15.4	24.6
Found a job	28.5	35.9	21.8	34.1	19.1	27.5
Family-related:						
Had to support family	11.2	10.4	11.9	15.8	11.8	9.9
Wanted to have family	7.5	6.4	8.4	9.1	4.6	8.2
Was pregnant	26.8	N/A	26.8	30.6	34.5	25.6
Became parent	14.7	7.7	21.0	19.6	21.0	12.4
Got married	12.1	3.7	19.7	13.4	2.0	15.1
Had to care for family member	11.9	9.5	14.0	8.5	14.7	10.7
Other:						
Wanted to travel	8.1	8.2	8.0	6.6	7.3	7.1
Friends dropped out	8.0	8.5	7.5	7.6	6.7	8.6
Had a drug and/or alcohol problem	4.4	6.1	2.8	1.8	2.1	5.9

N/A Not applicable.

SOURCE: National Educational Longitudinal Study of 1988 Second Followup Survey, National Center for Education Statistics, 1992, unpublished data.

Table 29

High school completion rates and method of completion for persons ages 18 through 22 not enrolled in high school, by race/ethnicity[1]: October 1990–October 1996

Race ethnicity and completion method	Percentage of students who completed high school in:						
	1990	1991	1992[2]	1993[2]	1994[2,3]	1995[2,3]	1996[2,3]
Total[1]							
Completed	85.6	84.9	86.4	86.2	85.8	85.3	86.2
Diploma	81.0	80.9	81.5	81.3	79.4	77.9	76.4
Alternative	4.6	4.0	4.9	4.9	6.4	7.4	9.8
White, non-Hispanic							
Completed	89.6	89.4	90.7	90.1	90.7	89.8	91.5
Diploma	85.0	85.2	85.7	85.4	84.6	82.9	81.0
Alternative	4.6	4.2	5.0	4.7	6.1	6.9	10.5
Black, non-Hispanic							
Completed	83.2	82.5	82.0	81.9	83.3	84.5	83.0
Diploma	78.0	77.4	76.8	75.9	75.7	75.9	73.0
Alternative	5.2	5.1	5.2	6.0	7.6	8.5	10.0
Hispanic							
Completed	59.1	56.5	62.1	64.4	61.8	62.8	61.9
Diploma	56.5	54.4	58.0	58.5	56.5	54.2	55.2
Alternative	2.6	2.1	4.1	5.9	5.3	8.6	6.7

[1]Due to relatively small sample sizes, American Indian/Alaskan Natives and Asian/Pacific Islanders are included in the total but are not shown separately.
[2]Numbers for these years reflect new wording of the educational attainment item in the Current Population Survey.
[3]Numbers in these years reflect changes in the Current Population Survey due to newly instituted computer-assisted interviewing and/or due to change in population controls to the 1990 Census-based estimates, with adjustment.

NOTE: Because of rounding, details may not add to totals.

SOURCE: Current Population Survey, Bureau of the Census, October (various years).

Table 30

Percentage of youth engaging in risk behaviors, by drug users and nonusers and race/ethnicity: 1995

Drug, type of use, and race/ethnicity	Fight in last 12 months	Carried a weapon in last 30 days	Rarely wears a seat belt	Multiple sex partners during last 3 months	Ridden in car while driver was drinking	Used drugs or alcohol before last sexual encounter	Used no condom during last sexual encounter
Marijuana							
Lifetime use							
White	48.2	26.8	31.4	14.8	55.7	25.0	33.6
Black	51.4	32.7	42.0	30.9	52.7	22.3	28.5
Hispanic	61.4	37.3	24.7	18.3	63.6	23.3	37.8
Other	57.5	37.3	26.8	18.2	56.6	25.2	33.7
No lifetime use							
White	27.4	13.2	13.1	2.2	25.5	3.7	11.2
Black	30.5	11.3	22.6	9.5	23.7	1.8	16.9
Hispanic	32.3	12.1	12.5	4.1	36.2	2.3	17.6
Other	32.5	8.0	14.1	4.8	22.9	1.9	11.3
Used last 30 days							
White	51.9	32.4	36.0	19.2	65.3	33.3	36.1
Black	56.0	39.1	46.9	38.4	64.5	33.5	27.2
Hispanic	67.7	46.4	31.3	24.4	74.5	31.5	43.0
Other	63.2	46.1	36.6	22.0	71.0	33.8	41.4
No use last 30 days							
White	30.6	14.2	15.5	3.4	28.7	5.5	15.1
Black	34.0	14.2	25.6	12.0	26.4	2.7	20.3
Hispanic	38.6	16.2	13.6	6.1	40.3	5.4	21.6
Other	36.8	12.4	14.3	6.9	26.7	4.9	14.3

Table 30 (continued)

Percentage of youth engaging in risk behaviors, by drug users and nonusers and race/ethnicity: 1995

Drug, type of use, and race/ethnicity	Fight in last 12 months	Carried a weapon in last 30 days	Rarely wears a seat belt	Multiple sex partners during last 3 months	Ridden in car while driver was drinking	Used drugs or alcohol before last sexual encounter	Used no condom during last sexual encounter
Cocaine							
Lifetime use							
White	66.7	51.0	46.8	35.6	71.7	51.6	46.1
Black	65.6	77.2	55.3	73.6	65.3	41.9	29.0
Hispanic	66.7	43.8	32.2	25.8	73.0	33.2	51.2
Other	72.6	56.6	39.5	37.8	82.4	39.0	35.5
No lifetime use							
White	33.5	16.3	18.6	5.2	35.1	9.4	18.3
Black	39.5	19.9	31.0	18.1	36.4	10.6	22.1
Hispanic	42.5	20.6	15.8	8.2	45.0	8.5	22.8
Other	40.0	16.7	17.5	7.8	32.6	8.9	19.0
Used last 30 days							
White	83.4	69.8	47.7	54.3	84.7	73.5	47.8
Black	59.3	77.0	62.8	82.9	67.8	48.5	26.8
Hispanic	68.1	57.2	41.2	33.9	82.4	38.1	54.5
Other	61.0	65.5	60.7	30.9	90.9	53.0	38.6
No use last 30 days							
White	34.5	17.3	19.7	6.0	36.4	10.6	19.5
Black	39.9	20.4	31.1	18.5	36.6	10.8	22.2
Hispanic	44.6	21.6	16.6	9.1	46.8	10.3	25.2
Other	41.9	18.1	17.6	9.4	34.4	9.7	19.6

Table 30 (continued)

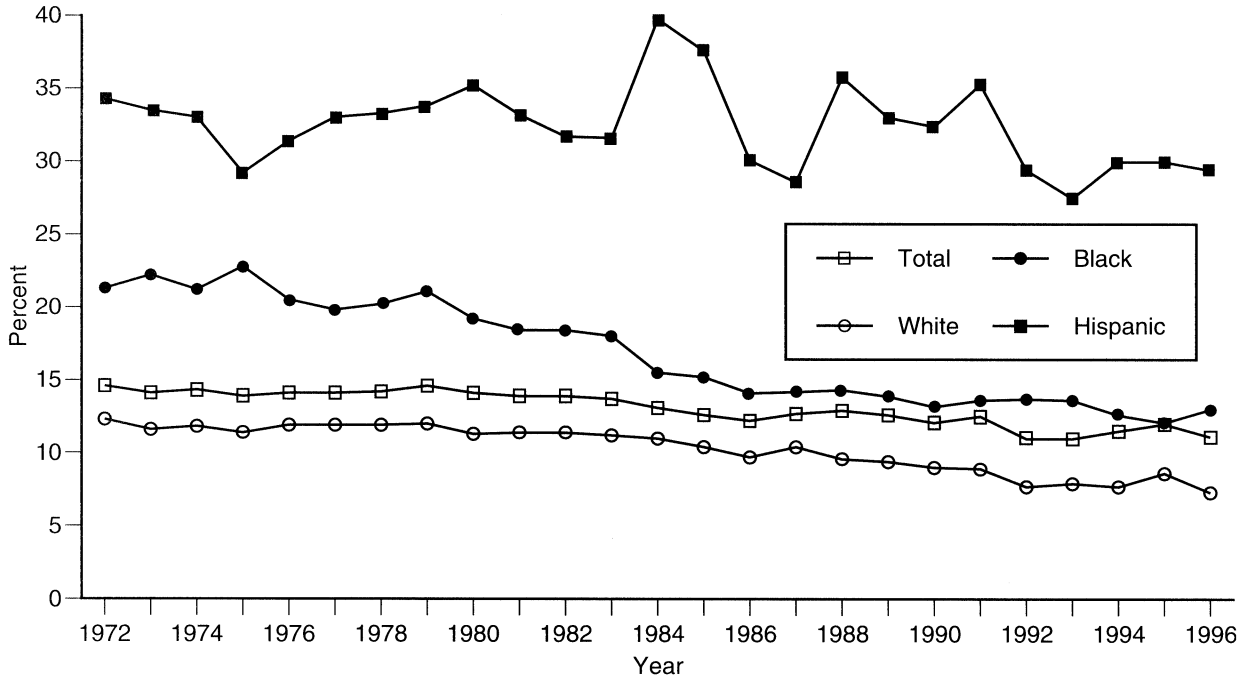
Percentage of youth engaging in risk behaviors, by drug users and nonusers and race/ethnicity: 1995

Drug, type of use, and race/ethnicity	Fight in last 12 months	Carried a weapon in last 30 days	Rarely wears a seat belt	Multiple sex partners during last 3 months	Ridden in car while driver was drinking	Used drugs or alcohol before last sexual encounter	Used no condom during last sexual encounter
Crack							
Lifetime Use							
White	73.2	58.8	46.9	42.4	73.6	56.0	45.3
Black	64.0	80.2	56.2	75.1	64.1	44.3	24.7
Hispanic	65.8	45.7	34.4	27.3	73.7	34.0	51.4
Other	63.3	55.3	51.0	33.4	87.8	48.3	28.5
No lifetime Use							
White	34.1	16.9	19.3	5.7	36.0	10.4	19.1
Black	39.7	20.2	31.1	18.5	36.6	10.7	22.2
Hispanic	44.1	21.8	16.6	9.1	46.7	9.9	24.6
Other	41.8	18.4	17.8	9.2	34.3	9.7	20.0
No marijuana or cocaine use							
last 30 days							
White	30.4	14.1	15.4	3.2	28.5	5.4	15.0
Black	34.0	14.2	25.6	12.0	26.5	2.6	20.3
Hispanic	38.7	15.7	13.4	5.9	39.5	4.7	21.0
Other	36.9	12.4	14.4	6.9	26.2	4.8	14.2

SOURCE: Youth Risk Behavior Survey, Centers for Disease Control and Prevention, 1995.

Figure 6

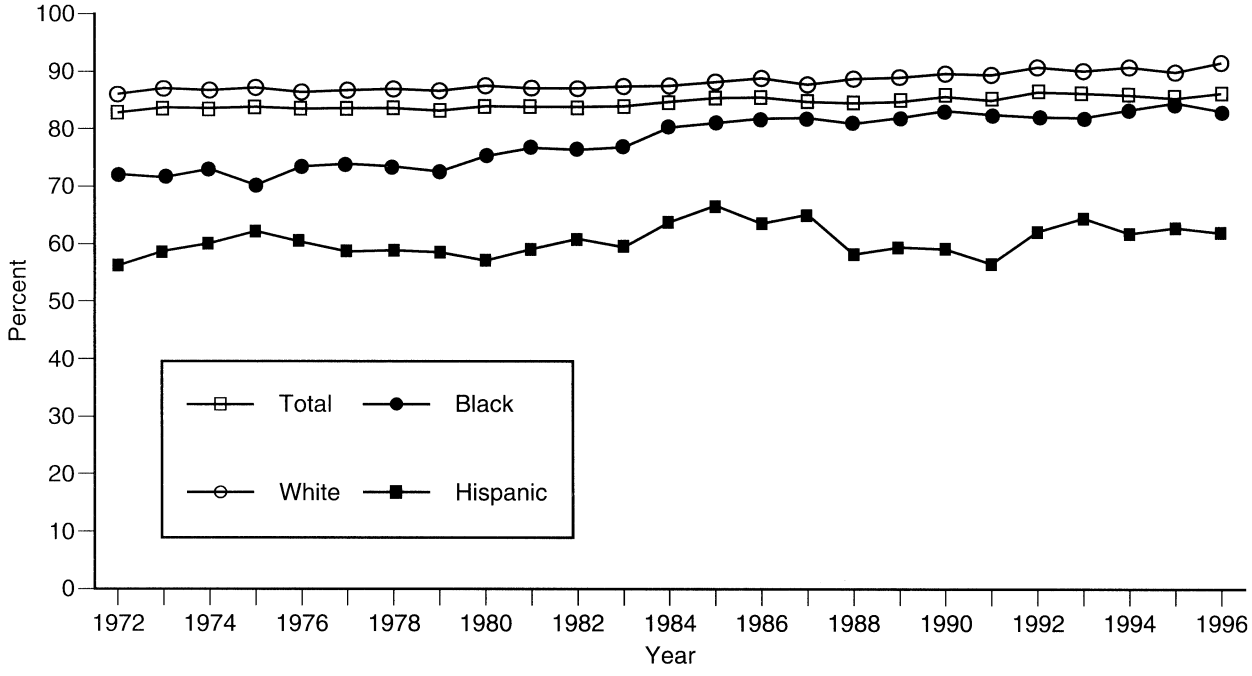
Status dropout rates for persons ages 16–24, by race/ethnicity: October 1972 through October 1996



SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, October (various years), unpublished data.

Figure 7

Completion rates for persons ages 18–24 not currently enrolled in high school or below, by race/ethnicity: October 1972 through October 1996



SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, October (various years), unpublished data.

Chapter 6. ADVERSE HEALTH CONSEQUENCES

This chapter presents data on AIDS (acquired immunodeficiency syndrome) cases from the Centers for Disease Control and Prevention (CDC), drug-related emergency room (ER) episodes, and drug-related deaths from the Drug Abuse Warning Network (DAWN). Drug use behavior can cause many negative health-related consequences, including fatal and nonfatal overdose, infection, and the transmission of AIDS and other sexually transmitted diseases. Drug use also may increase the risk of accidents and injuries (intentional and unintentional), maternal complications of pregnancy, adverse birth outcomes such as low birthweight and birth defects, and other psychiatric problems.

The claims of association between drug use and many of these negative consequences are based primarily on case studies or case reports. Few known methodologically sound, epidemiologic case-control or prospective studies have been done in either white or nonwhite populations to explore these relationships. What is known to date, however, suggests that minority populations may be overrepresented among those who suffer from the adverse health consequences of drug abuse. HIV (human immunodeficiency syndrome) infection and homicides are among the leading causes of death for young black males. In 1995 the homicide rate for young black males was eight times that for young white males (National Center for Health Statistics 1997). In addition, in 1995 the death rate for HIV infection in black females was nine times that for white females, and the rate for black males was four times that for white males (National Center for Health Statistics 1997).

The U.S. Department of Health and Human Services Task Force on African American and Minority Health found that among African Americans, mortality rates for chronic disease and cirrhosis were nearly twice as high as the rates among whites, and that in the 1980s cocaine-related deaths among African Americans tripled but only doubled among whites (Arkin and Funkhouser 1990). Similarly, the health status of American Indian/Alaskan Natives is reported to be below that of other Americans in many epidemiologic reports. In 1995 death rates for American Indians under age 45 substantially exceeded those for whites of the same age. Unintentional injuries, which often are associated with alcohol and drug use, were the leading cause of death for American Indians ages 15–34 (National Center for Health Statistics [NCHS] 1997). In 1995 death rates for Hispanic males ages 15–24 and 25–44 were estimated to be 20 percent greater than for white males of the same age. HIV infection was the second leading cause of death among Hispanics ages 25–44, with a death rate more than 40 percent higher than for whites of the same age (NCHS 1997).

ACQUIRED IMMUNODEFICIENCY SYNDROME

AIDS surveillance data are maintained by the CDC, which uses information collected by health departments in each State, Territory, and the District of Columbia. Between 1987 and 1995 the age-adjusted death rate for HIV infection more than doubled, from 5.5 to 11.3 deaths per 100,000 population. During this period, HIV infection rose from 15th to 8th for leading causes of death. In 1996, for the first time, deaths among persons with AIDS decreased substantially. However, during 1995 HIV infection remained the leading cause of death among persons ages 25–44, accounting for 19 percent of deaths from all causes in this age group.

Through December 1997, a total of 633,000 AIDS cases have been reported by State and local health departments in the United States (CDC 1997). Tables 31 and 32 display the percentage of AIDS cases by exposure category and race/ethnicity for females (see Table 31) and males (see Table 32). African Americans and Hispanics continue to represent increasing proportions of persons reported with AIDS, especially persons who contracted the disease through injecting drug use. Most striking is the finding that although African Americans and Hispanics together comprise about 23 percent of the U.S. population, they account for about 54 percent of the reported cases of AIDS. African Americans in particular are overrepresented among total AIDS cases. Although African American males account for approximately 12 percent of the total male population, they represent 32 percent of AIDS cases among men. The number of Hispanics with AIDS also is sizable. More than 17 percent of AIDS cases among males and 20 percent of AIDS cases among females cases involve Hispanics.

Injecting drug use is listed as the exposure category for a large proportion of the group that has contracted AIDS. As a high-risk group, injecting drug users are second only to men who have sex with men. Furthermore, injecting drug use is the primary mode of transmission for HIV infection in heterosexual and pediatric AIDS cases. In the United States, 161,872 (26 percent) of the 633,000 AIDS cases reported through December 1997 (among persons ages 13 and older) have resulted directly from injecting drugs. An additional 40,534 AIDS cases were a result of men having sex with men and injecting drugs.

As of December 1997, the largest proportion of AIDS cases among women were the result of injecting drug use among whites (43 percent), African Americans (45 percent), and American Indians/Alaskan Natives (46 percent). For Asian/Pacific Islander women and Hispanic women, the leading route of exposure was heterosexual contact (46 and 47 percent, respectively). Among men with AIDS, the leading route of exposure listed in December 1997 was homosexual contact, regardless of race/ethnicity; however, more than one-third of AIDS cases among African American men (35 percent) and Hispanic men (36 percent) were contracted through injecting drug use.

The estimated number of AIDS deaths in 1996 was 13 percent less than the 1995 estimate. The number of AIDS deaths declined most among American Indians/Alaskan Natives (32 percent), followed next by non-Hispanic whites (21 percent), Hispanics (10 percent), Asian/Pacific Islanders (10 percent). Non-Hispanic African Americans showed the smallest decline in death rate due to AIDS (2 percent).

DRUG-RELATED EMERGENCY ROOM EPISODES

Drug-related hospital ER cases provide one measure of the health risks associated with drug use. Over time they indicate increases or decreases in the incidence of problems associated with a particular drug or combinations of drugs. These trends may be influenced by a number of factors including changes in prevalence of use, dosages, potency, frequency of use, aging of existing users, routes of administration, the combined use of two or more drugs, and access to care.

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) DAWN is the primary source of data on drug-related ER visits. DAWN is a large-scale, ongoing drug abuse data collection system that monitors the adverse consequences of drug abuse as reported by participating hospital emergency rooms and selected medical examiner offices throughout the country. An episode report is submitted for each drug-involved medical

emergency or drug-related death. Data for each episode report, abstracted from medical records, include demographic information about the patient or decedent, circumstances regarding the drug abuse episode, and specific substance information. Alcohol-related episodes are reported to DAWN only when alcohol is used in combination with another drug. At the time this report was prepared, the 1996 DAWN Annual Report had not yet been released. As a result, some cross-tabulations involving age and race/ethnicity were unavailable.

The number of ER drug abuse episodes and mentions of selected drugs in 1994 per 100,000, by sex and age, is presented in Table 33. Total ER cocaine episodes (62.0 per 100,000) exceed heroin/morphine episodes (27.8 per 100,000) and marijuana/hashish episodes (17.5 per 100,000) across the majority of age and sex groups. The rates of total ER episodes for drug abuse were highest among male patients ages 26–34 (456.0 per 100,000) and female patients ages 12–17 (400.0 per 100,000). Marijuana/hashish mentions are higher in the younger age groups (ages 18–25) for both men and women, and cocaine mentions are highest in the 26–34 age group for both sexes. Between 1994 and 1996, ER drug abuse episodes decreased for men and women and all age groups except 35 years and older (155.8 in 1994 compared with 157.7 in 1996) (SAMHSA 1997). Furthermore, while cocaine mentions decreased slightly for all persons (62.0 in 1994 compared with 61.3 in 1996), heroin/ morphine mentions (27.8 in 1994 compared with 29.9 in 1996) and marijuana/hashish mentions (17.5 in 1994 compared with 21.3 in 1996) increased.

The two drugs mentioned most frequently across all sex and racial/ethnic groups were alcohol-in-combination with another drug and cocaine (see Table 34). More than one-half (54.5 percent) of all ER drug episodes for African Americans involved cocaine compared with 14.6 percent for whites and 26.5 percent for Hispanics. A high percentage of all ER drug-related episodes for Hispanics and African Americans involved heroin/morphine (18.7 percent and 18.4 percent, respectively) compared with 8.4 percent for whites. A similar high prevalence of heroin/morphine use is seen with male patients (16.7 percent) compared to female patients (7.8 percent).

Trends in the estimated numbers of drug-related ER episodes by race/ethnicity and age from 1988 to 1994 are shown in Table 35. The total number of drug-related episodes was highest in 1994, increasing by 11 percent from 460,008 episodes in 1993 to 518,521 episodes in 1994. In 1996, this number decreased by 6 percent to 487,564 (SAMHSA 1997). Stratifying episodes by race/ethnicity indicated that the percentage increase in total number of drug-related episodes from 1993 to 1994 was greater for whites (12 percent) and African Americans (10 percent) than for Hispanics (5 percent). In 1996, these percentages decreased by 6 percent (263,319 in 1996), 8 percent (129,517 in 1996), and 8 percent (46,493 in 1996), respectively. Over the 6-year period, drug-related ER episodes have decreased for whites ages 18–25 (5 percent), compared with a 16-percent increase among Hispanics of the same age. Drug-related ER episodes have shown the biggest increases for those ages 35 and older across all racial/ethnic groups, with the highest increases occurring among Hispanic and African American adults. In 1996, the ER drug episodes decreased for all age groups except for age 35 and older, which increased by 6 percent (to 200,706).

In 1988 the total number of cocaine mentions in ER visits was 101,578 (see Table 36). Cocaine mentions decreased by 21 percent to 80,355 in 1990, but they have increased by 78 percent from 1990 to 142,878 mentions in 1994. The largest number of cocaine mentions in 1994 regardless of race was among persons ages 26–34. African Americans in this age group (26–34) had the highest number of mentions (36,237), followed by whites (19,520) and

Hispanics (5,740). Cocaine mentions for this age group have increased since 1988 among African Americans (64 percent), Hispanics (53 percent), and whites (34 percent). Increased cocaine mentions among individuals ages 35 and older have been highest among African Americans (168 percent), followed by Hispanics (122 percent) and whites (120 percent). In 1996, cocaine mentions increased to 144,180 (SAMHSA 1997). In 1996, the largest number of cocaine mentions was among persons ages 35 and older (65,517). In 1996, cocaine mentions increased for whites (42,803) and Hispanics (15,155) but decreased among African Americans (74,506).

As with cocaine mentions, total mentions for heroin/morphine have increased since 1988, from 38,063 in 1988 to 64,013 in 1994, an increase of 68 percent (see Table 37). In 1996, the increasing trend continued when heroin/morphine mentions reached 70,463 (an increase of 108 percent since 1990). Among racial/ethnic groups, the largest increase was among African Americans (93 percent), followed by Hispanics (86 percent) and whites (38 percent). Between 1990 and 1996, heroin/morphine mentions increased 6 percent for whites, 5 percent for African Americans, and 11 percent for Hispanics (SAMHSA 1997). The largest number of heroin/ morphine mentions was among persons ages 35 and older (39,982 in 1996). Increases in heroin/morphine mentions among individuals ages 35 and older were largest for Hispanics (179 percent), followed by African Americans (123 percent) and whites (77 percent).

Total mentions for methamphetamine/speed have increased since 1988, with large increases observed between 1993 and 1994 (see Table 38). Total methamphetamine/speed mentions increased from 8,992 in 1988 to 17,665 in 1994 (an increase of 96 percent). This increase is due primarily to the increase observed between 1993 and 1994 (78 percent). Among racial/ethnic groups the largest increase between 1988 and 1994 was among Hispanics (201 percent), followed by African Americans (117 percent) and whites (84 percent). In 1994, the largest number of methamphetamine/speed mentions were among persons ages 26–34. Increases in methamphetamine/speed mentions among individuals ages 26–34 were largest for Hispanics (375 percent) and whites (76 percent), while the largest increase in use for African Americans was in the 35 and older age group (499 percent).

In 1996 the total number of methamphetamine/speed mentions decreased dramatically to 10,787 (39 percent). In 1996 the decreases were 46 percent for whites (6,638), 38 percent for Hispanics (1,610), and 20 percent for African Americans (787).

As with methamphetamine/speed, total mentions for marijuana/hashish have increased since 1988, with large increases observed between 1993 and 1994 (see Table 39). Total marijuana/hashish mentions increased from 19,962 in 1988 to 40,183 in 1994 (an increase of 101 percent). This increase was due in large part to the increase observed between 1993 and 1994 (39 percent). Among racial/ethnic groups the largest increase was among African Americans (131 percent), followed by Hispanics (105 percent) and whites (94 percent). The largest number of marijuana/hashish mentions tended to be among persons ages 18–25 and 26–34. In 1996 the number of mentions for marijuana/hashish increased to 50,037 (SAMHSA 1997). In 1996 the number of marijuana/hashish mentions increased to 23,152 for whites, 17,887 for African Americans, and 4,945 for Hispanics. The number of marijuana/hashish mentions has increased most dramatically among persons ages 35 and older (2,160 in 1990 compared with 11,658 in 1996) followed by persons ages 12–17 (2,170 in 1990 compared with 8,720 in 1996). Marijuana/hashish mentions among individuals ages 18–25 were 45 percent of the total mentions for African Americans, 42 percent of the total mentions for whites, and 40 percent of the total mentions for Hispanics.

Table 40 presents the percentage of DAWN emergency drug episodes by drug concomitance and patient disposition. White patients presenting at ERs were slightly more likely to report use of more than one drug than were African American and Hispanic patients. In addition, males of each race were more likely than their female counterparts to report a multidrug episode. A larger proportion of whites of both sexes were admitted to the hospital following a drug-related emergency than were African American and Hispanic patients. Females regardless of race were more likely to be admitted to the hospital than were males. A possible explanation for these disposition differences is the fact that whites were more likely than African Americans or Hispanics to cite suicide as the motive for that incidence of drug use. Although this may be a function of the type of drug being used, disposition also may be related to socioeconomic factors such as health insurance coverage.

Table 41 compares the distribution among racial/ethnic groups of emergency department episodes reported by DAWN for heroin, methadone, PCP (phencyclidine), cocaine, marijuana/hashish, and methamphetamine/speed. Comparison of rates of ER episodes by race/ethnicity and share in total population reveals disproportionate distributions of drug-related episodes across many of the groupings. African Americans, although they comprised only 27.2 percent of all ER episodes, accounted for more than 40 percent of heroin/morphine mentions (40.6 percent), PCP and PCP combination mentions (45 percent), and cocaine mentions (53.9 percent). Hispanics, who comprised 9.7 percent of total ER episodes reported to DAWN, accounted for 19.8 percent of PCP and PCP combination mentions and 17.3 percent of methadone drug mentions. Whites, who comprised 53.9 percent of total ER episodes, accounted for 70 percent of the methamphetamine/speed mentions. In 1996, this same pattern of drug mentions was noted; among African Americans (26.6 percent of all episodes), cocaine mentions (51.7) and heron/morphine mentions (38.8); among Hispanics (9.5 percent of all mentions), heroin/morphine mentions (14.9); among whites (54.0 percent of all episodes), methamphetamine/speed mentions (61.5).

DRUG-RELATED DEATHS

Medical examiner data presented in DAWN reports are collected from a nonrandom sample and are not statistically representative of the Nation or of the respective metropolitan areas. DAWN defines a drug-related death as any death in which drug use is a contributory factor but not necessarily the sole cause; consequently, causation of death by the drug is not implied. Some medical examiners may include cases involving circumstantial evidence and other medical examiners may report drug-related deaths confirmed only through toxicologic analyses. In light of these limitations, caution should be used in interpreting these data.

The top three drugs (i.e., those medical examiners mention most frequently) reported for decedents by medical examiners across all sex and racial/ethnic groups were cocaine, heroin/morphine, and alcohol-in-combination with another drug (see Table 42). African American and Hispanic decedents were more likely than whites to have used cocaine prior to their deaths, whereas white decedents were more likely than African Americans and Hispanics to have used diazepam and were more likely than African Americans to have used methamphetamine/speed.

Figure 8 examines the manner of drug-related deaths by race/ethnicity. Hispanics have the highest percentage of accidental drug-related deaths (79.2 percent), followed by African Americans (62.1 percent) and whites (51.9 percent). The highest percentage of drug-related

suicides was among whites (24.6 percent) compared with the relatively low percentages of drug-related suicides among Hispanics (9.9 percent) and African Americans (8.3 percent).

SUMMARY

Data from the CDC on HIV/AIDS cases indicate that African Americans and Hispanics continue to represent increasing proportions of persons reported with AIDS, especially by AIDS transmission through injecting drug use. Most striking is the finding that although African Americans and Hispanics together comprise about 23 percent of the U.S. population, they account for about 52 percent of the reported cases of AIDS.

A large percentage of women with HIV/AIDS have contracted the disease through drug use. As of December 1996, whites (43 percent) had the largest proportion of AIDS cases among women who injected drugs, followed by African Americans (46 percent) and American Indian/Alaskan Natives (48 percent).

Data from DAWN were used to examine drug-related episodes reported by hospital emergency rooms and coroners' offices. The findings by race/ethnicity indicated that a high percentage of all ER drug- related episodes for Hispanics and African Americans involved heroin/morphine use. Drug-related ER episodes have shown the biggest increases for those ages 35 and older across all racial/ethnic groups, with the highest increases occurring among Hispanic and African American adults. In particular, cocaine and heroin/morphine mentions among individuals ages 35 and older have shown remarkable increases.

Differences in the outcomes of drug-related episodes were noted for individuals from various races/ethnicities. In particular, a larger proportion of whites of both sexes were admitted to the hospital following a drug-related emergency than were African Americans and Hispanics.

The top three drugs reported for decedents across all sex and racial/ethnic groups were cocaine, heroin/morphine, and alcohol-in-combination with another drug. Hispanics had the highest percentage of accidental drug-related deaths, followed by African Americans and whites. The percentage of drug-related suicides among whites was two to three times that for Hispanics or African Americans.

Table 31

Female adult/adolescent AIDS cases, by exposure category and race/ ethnicity, cumulative totals through December 1997

Exposure category	White, non-Hispanic		Black, non-Hispanic		Hispanic	
	Number	Percent	Number	Percent	Number	Percent
Injecting drug use	9,614	43	24,981	45	8,359	42
Hemophilia/coagulation disorder	91	0	74	0	36	0
Heterosexual contact	8,838	39	19,981	36	9,193	46
Receipt of blood transfusion, blood components, or tissue	1,739	8	1,146	2	517	3
Risk not reported or identified	2,181	10	9,009	16	1,789	9
Total	22,463	100	55,191	100	19,894	100

Exposure category	Asian/Pacific Islander		American Indian/ Alaska Native		Cumulative total	
	Number	Percent	Number	Percent	Number [1]	Percent
Injecting drug use	87	17	128	46	43,214	44
Hemophilia/coagulation disorder	4	1	1	0	206	0
Heterosexual contact	239	47	105	8	38,391	39
Receipt of blood transfusion, blood components, or tissue	91	18	13	5	3,509	4
Risk not reported or identified	87	17	32	11	13,148	13
Total	508	100	279	100	98,468	100

[1] Includes 133 women whose race/ethnicity is unknown.

SOURCE: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report (Volume 9, Number 2).

Table 32

Male adult/adolescent AIDS cases, by exposure category and race/ethnicity, cumulative totals through December 1997

Exposure category	White, non-Hispanic		Black, non-Hispanic		Hispanic	
	Number	Percent	Number	Percent	Number	Percent
Men who have sex with men	199,776	75	64,879	38	40,399	43
Injecting drug use	23,905	9	60,118	35	34,063	36
Men who have sex with men and inject drugs	21,066	8	12,842	8	6,230	7
Hemophilia/coagulation disorder	3,509	1	490	0	390	0
Heterosexual contact	4,178	2	11,464	7	4,674	5
Receipt of blood transfusion, blood components, or tissue	3,059	1	989	1	539	1
Risk not reported or identified	9,159	3	19,359	11	7,289	7
Total	264,652	100	170,141	100	93,584	100

Exposure category	Asian/Pacific Islander		American Indian/ Alaska Native		Cumulative total	
	Number	Percent	Number	Percent	Number [1]	Percent
Men who have sex with men	3,020	75	868	59	309,247	58
Injecting drug use	214	5	224	15	118,658	22
Men who have sex with men and inject drugs	138	3	242	16	40,534	8
Hemophilia/coagulation disorder	62	2	26	2	4,483	1
Heterosexual contact	119	3	37	2	20,493	4
Receipt of blood transfusion, blood components, or tissue	101	3	8	1	4,705	1
Risk not reported or identified	383	9	72	5	36,412	7
Total	4,037	100	1,477	100	534,532	100

[1]Includes 641 men whose race/ethnicity is unknown.

SOURCE: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report (Volume 9, Number 2).

Table 33

Number of emergency department drug abuse episodes and mentions of selected drugs per 100,000 population in the coterminous United States, by sex and age: 1994

Sex and age		Total episodes	Cocaine mentions	Heroin/ morphine mentions	Marijuana/ hashish mentions	Total population[1]
Total[2]	(6 years and over)	225.2	62.0	27.8	17.5	230,268,292
	6–11 years	4.5	*	*	*	22,286,635
	12–17 years	279.7	9.5	**	30.2	21,624,060
	18–25 years	402.0	90.9	30.0	49.6	27,925,648
	26–34 years	415.9	166.4	59.5	31.5	36,356,470
	35 years and older	155.8	44.4	27.3	6.8	122,075,479
Male	Total (6 years and over)	236.9	86.5	39.6	25.2	111,160,211
	6–11 years	3.6	*	*	*	11,408,985
	12–17 years	159.6	12.4	2.2	34.7	11,068,026
	18–25 years	415.1	119.9	39.4	74.6	13,564,645
	26–34 years	456.0	217.7	74.6	45.7	18,051,402
	35 years and older	184.4	68.0	43.5	10.2	57,067,152
Female	Total (6 years and over)	210.2	38.3	16.4	9.9	119,108,081
	6–11 years	5.4	*	*	*	10,877,650
	12–17 years	400.0	5.6	**	24.9	10,556,034
	18–25 years	383.0	62.7	20.9	25.1	14,361,002
	26–34 years	369.3	113.2	43.4	17.2	18,305,068
	35 years and older	128.0	23.2	12.7	3.6	65,008,327

[1]Average 1994 civilian noninstitutionalized population estimated by the Substance Abuse and Mental Health Services Administration based on a procedure using three Census Bureau data files.
[2]Total includes patients whose sex was unknown or not reported.

*Low precision, no estimate reported.
**Based on five or fewer respondents in numerator.

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

Table 34

Drugs mentioned most frequently by hospital emergency rooms by sex and race/ethnicity of patient: 1994

Rank	Drug name	Percentage of total episodes	Rank	Drug name	Percentage of total episodes
	Male patients			Female patients	
1	Alcohol-in-combination	37.0	1	Alcohol-in-combination	24.7
2	Cocaine	36.5	2	Cocaine	18.2
3	Heroin/morphine	16.7	3	Acetaminophen	11.4
4	Marijuana/hashish	10.6	4	Heroin/morphine	7.8
5	Methamphetamine/speed	4.3	5	Ibuprofen	5.5
6	Acetominaphen	3.8	6	Aspirin	5.4
7	Diazepam	2.3	7	Marijuana/hashish	4.7
8	Aspirin	2.2	8	Alprazolam	4.6
9	Amphetamine	2.2	9	Clonazepam	3.4
10	Alprazolam	2.1	10	Lorazepam	3.1
	White patients			Black patients	
1	Alcohol-in-combination	29.1	1	Cocaine	54.5
2	Cocaine	14.6	2	Alcohol-in-combination	36.9
3	Acetaminophen	8.5	3	Heroin/morphine	18.4
4	Heroin/morphine	8.4	4	Marijuana/hashish	10.7
5	Marijuana/hashish	6.8	5	Acetaminophen	4.9
6	Alprazolam	5.3	6	Ibuprofen	2.9
7	Aspirin	4.6	7	Aspirin	2.2
8	Methamphetamine/speed	4.4	8	PCP/PCP combinations	1.9
9	Ibuprofen	4.1	9	Diphenhydramine	1.1
10	Diazepam	3.9	10	Unspec benzodiazepine	1.0
	Hispanic patients				
1	Alcohol-in-combination	28.3	6	Methamphetamine/speed	5.2
2	Cocaine	26.5	7	Amphetamine	4.2
3	Heroin/morphine	18.7	8	Aspirin	3.5
4	Acetaminophen	8.4	9	Ibuprofen	2.6
5	Marijuana/hashish	6.2	10	PCP/PCP combinations	2.4

NOTES: These estimates are based on a representative sample of non-Federal hospitals with 24-hour emergency rooms in the coterminous United States.

Percentages are based on weighted emergency room episode estimates of 263,334 male patients; 250,333 female patients; 279,312 white patients; 141,171 black patients; and 50,438 Hispanic patients.

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

Table 35

Estimated number of DAWN hospital emergency room visits, by race/ethnicity and age: 1988–94

Race/ethnicity and age	1988	1989	1990	1991	1992	1993	1994
Total	403,578	425,904	371,208	393,968	433,493	460,008	518,521
6–34	295,301	301,872	254,297	261,873	277,887	287,737	324,933
12–17	54,206	55,299	49,109	47,494	46,822	49,971	60,472
18–25	114,753	111,707	92,236	92,410	96,307	98,108	112,262
26–34	125,657	133,510	111,980	121,354	133,506	153,650	167,250
35+	106,716	122,855	115,954	130,852	154,570	170,951	190,145
White	230,527	243,862	217,191	221,541	235,643	245,192	279,312
6–34	167,238	171,470	148,581	148,215	151,810	156,861	178,502
12–17	37,321	37,770	33,602	32,99	32,301	34,013	40,861
18–25	64,619	63,345	52,767	52,876	54,835	54,200	61,527
26–34	64,860	69,468	61,503	62,009	64,143	75,119	83,271
35+	62,691	71,863	68,247	72,810	83,519	87,668	100,044
Black	96,319	97,480	88,317	106,914	122,880	126,477	141,171
6–34	69,143	68,101	58,184	67,237	74,686	72,697	82,569
12–17	6,004	6,218	6,122	5,382	5,949	5,255	7,716
18–25	25,917	23,928	20,174	22,267	22,641	22,933	26,501
26–34	37,101	37,714	31,700	39,495	45,769	49,688	53,634
35+	26,809	29,041	29,726	39,227	47,762	53,544	58,332
Hispanic	33,983	38,743	29,834	33,082	42,174	47,836	50,438
6–34	26,352	29,062	22,074	23,546	29,604	32,387	34,273
12–17	4,296	5,162	3,856	4,059	4,455	5,740	6,426
18–25	10,812	11,597	9,432	8,886	10,812	11,553	12,927
26–34	11,202	12,234	8,752	10,511	14,044	16,321	16,420
35+	7,489	9,624	7,691	9,419	12,440	15,363	16,102

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

Table 36

Estimated number of DAWN hospital emergency room visits with mention of cocaine, by race/ethnicity and age: 1988–94

Race/ethnicity and age	1988	1989	1990	1991	1992	1993	1994
Total	101,578	110,013	80,355	101,188	119,843	123,143	142,878
6–34	79,715	83,973	57,131	70,113	78,188	76,192	87,960
12–17	2,755	2,544	1,859	2,138	1,534	1,567	2,054
18–25	32,322	31,600	19,614	21,766	23,883	22,096	25,392
26–34	44,632	49,818	35,639	46,137	52,760	57,970	66,404
35+	21,634	25,628	23,054	30,582	41,288	46,535	54,238
White	34,350	38,349	24,100	29,198	31,927	32,708	40,843
6–34	28,488	31,191	18,063	22,435	22,665	23,083	28,072
12–17	12,217	1,389	1,059	1,021	468	700	775
18–25	12,741	12,425	6,563	8,077	8,268	8,022	9,328
26–34	14,530	17,372	10,434	13,275	13,923	15,530	19,520
35+	5,798	7,008	6,013	6,660	9,2214	9,473	12,729
Black	48,761	51,052	43,010	56,106	69,123	68,532	76,984
6–34	36,321	36,805	29,179	35,994	42,134	38,654	43,709
12–17	686	613	413	447	341	345	374
18–25	13,525	12,453	9,016	9,710	10,596	9,355	10,638
26–34	22,105	23,735	19,741	25,829	31,190	32,307	36,237
35+	12,366	14,078	13,739	19,778	26,774	29,728	33,098
Hispanic	9,388	9,710	6,628	9,012	11,824	12,618	13,373
6–34	7,455	7,392	5,106	6,656	8,713	8,641	9,109
12–17	474	395	206	388	536	376	665
18–25	3,221	3,290	2,443	2,473	3,369	2,865	3,141
26–34	3,760	3,705	2,455	3,795	4,808	5,876	5,740
35+	1,914	2,303	1,499	2,337	3,075	3,946	4,245

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

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Table 37

Estimated number of DAWN hospital emergency room visits with mention of heroin/morphine, by race/ethnicity and age: 1988–94

Race/ethnicity and age	1988	1989	1990	1991	1992	1993	1994
Total	38,063	41,656	33,884	35,989	48,003	63,145	64,013
6–34	22,383	22,519	17,967	18,445	22,502	29,460	30,497
12–17	135	168	182	182	232	279	507
18–25	5,187	5,094	4,654	4,704	5,860	8,013	8,370
26–34	17,060	17,251	13,127	13,559	16,409	23,999	24,239
35+	15,533	18,949	15,850	17,310	25,376	33,571	33,359
White	16,977	17,644	13,667	13,367	17,926	23,026	23,383
6–34	10,797	10,225	7,610	7,763	8,580	11,900	12,566
12–17	39	*	*	*	*	168	379
18–25	2,430	2,078	1,892	2,075	2,454	3,637	3,599
26–34	8,327	8,046	5,628	5,583	6,026	9,137	9,551
35+	6,099	7,350	6,039	5,509	9,313	11,104	10,801
Black	13,475	13,338	12,313	15,175	18,600	23,303	25,989
6–34	6,559	5,618	5,503	6,495	7,733	8,849	10,582
12–17	34	40	54	29	29	32	37
18–25	1,191	1,031	1,092	1,407	1,878	2,269	2,994
26–34	5,334	4,546	4,357	4,951	5,826	7,735	8,611
35+	6,882	7,637	6,779	8,758	10,817	14,412	15,359
Hispanic	5,094	7,307	5,195	5,118	8,519	11,287	9,452
6–34	3,503	4,811	3,486	3,164	4,794	6,347	5,040
12–17	50	26	29	39	*	55	46
18–25	1,159	1,516	1,278	950	1,217	1,420	1,154
26–34	2,294	3,269	2,179	2,176	3,489	5,306	4,254
35+	1,581	2,491	1,704	1,949	3,714	4,926	4,406

*Low precision, no estimate reported.

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

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Table 38

Estimated number of DAWN hospital emergency room visits with mention of methamphetamine/speed, by race/ethnicity and age: 1988–94

Race/ethnicity and age	1988	1989	1990	1991	1992	1993	1994
Total	8,992	8,722	5,236	4,887	6,563	9,926	17,665
6–34	7,606	7,219	4,195	3,716	5,177	7,731	13,335
12–17	1,054	607	716	442	669	663	1,968
18–25	3,364	2,884	1,737	1,302	1,719	3,425	5,494
26–34	3,396	4,119	1,884	2,165	3,012	3,900	6,417
35+	1,378	1,502	975	1,168	1,378	2,182	4,318
White	6,737	6,955	3,890	3,485	4,607	7,070	12,374
6–34	5,612	5,728	3,161	2,654	3,556	5,503	9,446
12–17	682	422	561	176	343	291	1,617
18–25	2,662	2,388	1,311	973	1,269	2,427	3,799
26–34	2,454	3,258	1,407	1,609	2,132	2,933	4,329
35+	1,120	1,226	665	828	1,048	1,559	2,922
Black	452	488	484	370	263	347	982
6–34	361	360	353	252	154	220	443
12–17	7	0	1	8	9	13	15
18–25	58	118	204	57	53	44	79
26–34	305	260	158	201	103	179	423
35+	90	127	131	118	109	128	539
Hispanic	865	577	396	622	925	1,343	2,606
6–34	817	606	387	306	668	939	1,325
12–17	272	97	90	187	160	198	278
18–25	371	170	98	166	280	523	1,018
26–34	178	274	114	218	373	414	846
35+	121	97	78	105	97	223	374

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network. (1994 Annual Report).

Table 39

Estimated number of DAWN hospital emergency room visits with mention of marijuana/hashish, by race/ethnicity and age: 1988–94

Race/ethnicity and age	1988	1989	1990	1991	1992	1993	1994
Total	19,962	20,703	15,706	16,251	23,997	28,861	40,183
6–34	17,546	17,938	13,514	13,291	19,267	23,070	31,860
12–17	2,950	3,158	2,170	2,130	3,104	4,241	6,539
18–25	8,150	8,259	5,782	5,687	8,294	9,543	13,860
26–34	6,767	6,920	5,839	5,975	8,492	10,097	12,371
35+	2,350	2,700	2,160	2,882	4,689	5,624	8,277
White	9,717	10,077	7,835	8,030	10,484	13,483	18,882
6–34	8,750	8,923	7,050	6,895	8,697	11,180	15,391
12–17	1,800	1,861	1,429	1,189	1,821	2,590	3,991
18–25	4,292	4,137	3,200	3,163	3,498	4,678	6,445
26–34	2,737	3,059	2,525	2,732	3,626	4,326	5,338
35+	952	1,141	770	1,074	1,782	2,169	3,476
Black	6,527	6,338	5,207	5,621	8,934	10,098	15,053
6–34	5,468	5,246	4,108	4,307	6,569	7,364	11,288
12–17	397	575	257	419	524	576	1,147
18–25	2,550	2,102	1,655	1,669	2,880	2,884	5,102
26–34	2,740	2,702	2,321	2,431	3,491	4,201	5,461
35+	1,059	1,073	1,092	1,308	2,344	2,717	3,749
Hispanic	1,513	1,604	1,315	1,392	2,724	2,684	3,109
6–34	1,394	1,457	1,161	1,072	2,349	2,333	2,616
12–17	253	230	260	204	455	561	852
18–25	695	868	491	484	1,103	1,113	1,056
26–34	456	383	444	469	822	707	756
35+	113	148	154	316	371	349	491

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

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Table 40

Percentage of DAWN hospital emergency room drug abuse episodes, by selected episode characteristics, sex, and race/ethnicity: 1994

Episode characteristics	Males			Females		
	White	Black	Hispanic	White	Black	Hispanic
Drug concomitance						
Single-drug episodes	44.6	44.8	52.6	50.0	50.3	59.4
Multidrug episodes	55.4	55.2	47.4	50.0	49.7	40.6
Patient Disposition						
Treated and released	44.8	57.1	63.2	35.4	52.8	51.6
Admitted to hospital	51.2	40.0	32.5	62.2	44.3	44.4
Other	4.0	2.9	4.3	2.4	2.9	4.0

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

Table 41

Comparison of the race/ethnicity distribution for total DAWN hospital emergency room episodes with the race/ethnicity distribution for selected drug mentions: 1994

Selected drug mention	Race/Ethnicity		
	White	Black	Hispanic
Percentage of total DAWN ER episodes	53.9	27.2	9.7
Percentage of ER drug mentions for:			
Heroin/morphine	36.5	40.6	14.8
Methadone	46.7	24.1	17.3
PCP/PCP combinations	27.9	45.0	19.8
Cocaine	30.7	53.9	9.4
Marijuana/hashish	47.0	37.5	7.7
Methamphetamine/speed	70.0	5.6	14.8

NOTE: Percentages do not sum to 100 due to exclusion of data for patients of other and unknown race/ethnicity.

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (1994 Annual Report).

Table 42

Drugs mentioned most frequently by medical examiners, by sex and race/ethnicity of decedent: 1995

Rank	Drug name	Percentage of total episodes	Rank	Drug name	Percentage of total episodes
	Male decedents			Female decedents	
1	Heroin/morphine[1]	49.8	1	Cocaine	38.6
2	Cocaine	47.8	2	Heroin/morphine[1]	31.2
3	Alcohol-in-combination	42.2	3	Alcohol-in-combination	29.6
4	Codeine	13.0	4	Codeine	11.3
5	Marijuana/hashish	8.8	5	Amitriptyline	9.7
6	Diazepam	6.8	6	Diazepam	8.2
7	Methamphetamine/speed	5.6	7	Diphenhydramine	7.9
8	Methadone	4.8	8	Methadone	7.3
9	Diphenhydramine	4.1	9	Nortriptyline	6.9
10	Amitriptylene	3.6	10	Acetaminophen	6.8
	White decedents			Black decedents	
1	Heroin/morphine[1]	44.3	1	Cocaine	69.6
2	Alcohol-in-combination	38.4	2	Heroin/morphine[1]	43.8
3	Cocaine	32.8	3	Alcohol-in-combination	37.3
4	Codeine	13.9	4	Codeine	10.0
5	Diazepam	10.1	5	Marijuana/hashish	7.2
6	Marijuana/hashish	8.0	6	Quinine	5.6
7	Methamphetamine/speed	7.0	7	Methadone	5.4
8	Amitriptyline	6.3	8	Lidocaine	3.8
9	Diphenhydramine	6.1	9	Diphenhydramine	3.2
10	D-Propoxyphene	5.8	10	Diazepam	3.1
	Hispanic decedents				
1	Heroin/morphine[1]	55.9	6	Methadone	7.4
2	Cocaine	55.1	7	Methamphetamine/speed	6.9
3	Alcohol-in-combination	48.3	8	Amphetamine	4.4
4	Codeine	12.9	9	Amitriptyline	4.0
5	Marijuana/hashish	7.6	10	PCP/PCP combinations	3.8

[1]Includes opiates not specified as to type.

NOTES: Percentages are based on raw medical examiner drug abuse case counts of 7,005 male decedents and 2,166 female decedents.

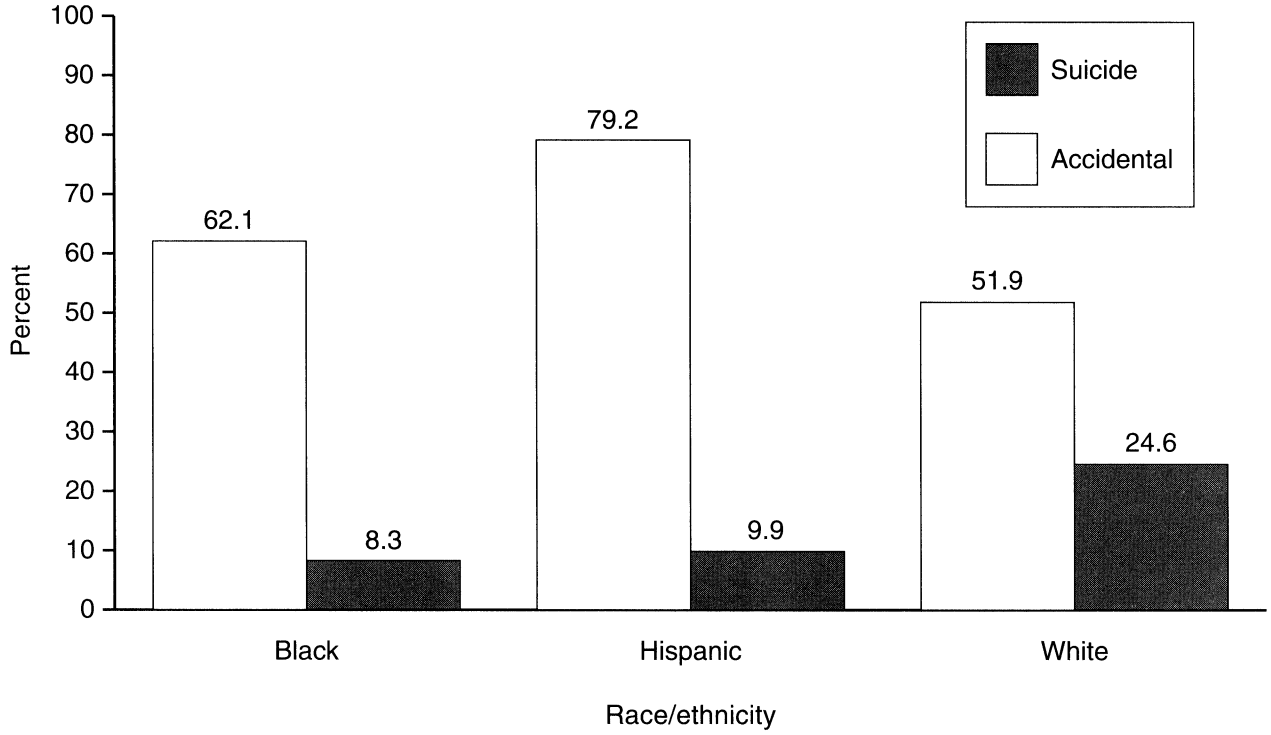
Percentages are based on total raw medical examiner drug abuse case counts of 5,376 white decedents, 2,559 black decedents, and 1,086 Hispanic decedents.

Drugs with fewer than 10 mentions are excluded.

SOURCE: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network.

Figure 8

Manner of drug-related death, by race/ethnicity, DAWN medical examiner data: 1995



SOURCE: Drug Abuse Warning Network, Substance Abuse and Mental Health Services Administration, October, 1996 file.

Chapter 7. DRUGS AND CRIME

Drug-related crime is considered one of the major problems facing the United States today. Concerns about crime relate to problems that include the high financial cost of law enforcement and the health and safety of citizens (Miller 1992). A wide range of psychological, social, and economic incentives can combine to produce serious drug use and crime patterns that become firmly established in some individuals. Some drugs, due to their power to induce compulsive use, are more likely to precipitate criminal activity than others. Cocaine and heroin are especially notable for their addictive power. Frequency of drug use also is a factor in criminal activity. A person who uses drugs several times a day is at higher risk of involvement in crime than is an irregular drug user (Bureau of Justice Statistics 1996).

The U.S. Department of Justice's National Institute of Justice (NIJ) has reported that in Fiscal Year 1996, more than one-half of all male arrestees in 14 major cities tested positive for drug use. In addition, Federal prison drug-related sentences increased by 290 percent between 1980 and 1995 (Bureau of Justice Statistics 1996). The Bureau of Justice Statistics reported that more than one-half of all Federal offenders sentenced to prison in 1996 were convicted of drug offenses. The link between drug use and criminal behavior has also been documented in several small-scale studies. In Baltimore, Maryland, addicts committed four to six times more crime during periods of heavy drug use than during periods when they were relatively drug free (Miller 1992). Police and other experts have determined that the rise in violent crime can partially be attributed to increased crack-cocaine sales.

In 1994 hospital emergency room (ER) records for individuals treated for violence-related injuries were reviewed; approximately 14 percent of the records indicated the victim or someone else involved in the incident had been drinking alcohol or using drugs (Bureau of Justice Statistics 1996). Furthermore, studies of the causes of homicide in three metropolitan areas indicated that approximately one-quarter to one-half of all homicides are drug related (Bureau of Justice Statistics 1996). Mortality data for 1993–95 found that homicide was the leading cause of death among African American persons ages 15–34, for whom the rate for this time period was 12 times that for whites (69.6 deaths per 100,000 versus 5.8 deaths per 100,000). The death rate for American Indian/Alaskan Natives (17.4 deaths per 100,000) and Asian Americans (8.7 deaths per 100,000) were 3 and 1.5 times that of whites, respectively. Hispanics, for whom the homicide rate was 5 times that for whites, had the second highest homicide rate (29 deaths per 100,000) (National Center for Health Statistics 1997).

Despite these associations, relatively little information is available on drugs and crime. This chapter presents data on drugs and crime from two sources: the Arrestee Drug Abuse Monitoring (ADAM) Program (formerly known as the Drug Use Forecasting [DUF] system), and the National Household Survey on Drug Abuse (NHSDA). The ADAM Program, co-funded by NIJ and the Bureau of Justice Assistance, measures recent drug use among booked arrestees at 23 sites in major metropolitan areas across the United States. The primary purpose of the ADAM Program is to monitor illegal drug use among booked arrestees in major American cities. It provides information about the effectiveness of local drug policies and practices and provides a solid basis for resource allocation decisions. By collecting urine samples and interviewing arrestees on a quarterly basis, the ADAM Program has become a consistent tool for tracking drug use trends among this difficult-to-study population of users.

Caution is urged when interpreting the ADAM data because of limitations regarding the sampling plan, completeness of the data, and focus of the interview instrument. Work is currently underway at NIJ to strenghten the sampling plan, instrument design, and data collection procedures.

DRUG USE AMONG BOOKED ARRESTEES

The following information is from a standardized data set of all ADAM Program urinalysis tests from 1987 to 1995 (see Table 43). The data show remarkable trends in drug use across races and through time. The percentage of arrestees who tested positive for marijuana peaked in 1988 for whites (40 percent), 1987 for African Americans (36 percent), and 1987 and 1988 for Hispanics (34 percent in both years). Between 1987 and 1993, white arrestees comprised the largest percentage of positive tests for marijuana use, followed by African Americans and Hispanics. However, in 1994 and 1995, African American arrestees passed whites as the racial group with the highest percentage of positive marijuana tests. In 1995 Asian arrestees showed the lowest percentages of positive tests for marijuana—approximately three times lower than those reported for whites, African Americans, and Hispanics.

Cocaine remained one of the most prominent drugs of abuse among arrestees between 1987 and 1995. Between 1987 and 1995, its use was detected most often in African American arrestees, followed by Hispanic and white arrestees. Positive tests for cocaine peaked at 63 percent for African American arrestees and 51 percent for Hispanic arrestees in 1988. Positive cocaine tests for white arrestees were highest in 1989 and 1992, at 32 percent. The number of positive cocaine results for African American arrestees was double that for whites between 1987 and 1988. In 1995 the percentage of positive test results for American Indian/Alaskan Native arrestees and Asian/Pacific Islanders arrestees was 30 percentage points lower than for African Americans.

Though it decreased between 1993 and 1995, the percentage of positive tests for opiate use was highest among Hispanics. During this period, opiate use among white and African American arrestees appears to have stabilized. Between 1987 and 1995, 9 to 13 percent of white arrestees tested positive for opiate use, 6 to 10 percent of African American arrestees tested positive, and 11 to 22 percent of Hispanic arrestees tested positive—the highest of all races/ethnicities. In 1995 5 percent of Asian arrestees tested positive for opiate use, and 7 percent of American Indian/Alaskan Native arrestees tested positive.

NIJ began testing arrestees for methamphetamine use in 1991. Large increases in the percentage of positive tests have been observed over time for all races. ADAM Program data from 1991 to 1995 show methamphetamine use by adult white arrestees far exceeds that of African American and Hispanic arrestees. Between 1991 and 1993, the percentage of arrestees testing positive for methamphetamine use more than doubled for whites, African Americans, and Hispanics. The percentages of white and African American arrestees testing positive for methamphetamine use decreased between 1994 and 1995 but increased slightly for Hispanics. It is notable that in 1995, the first year methamphetamine use was recorded for Asian arrestees, they represented the second highest percentage of positive tests for methamphetamine use.

DRIVING UNDER THE INFLUENCE OF ALCOHOL OR ILLEGAL DRUGS

NIDA has made a concerted effort to support research projects that help determine the role drug use plays in illegal activity. The NHSDA includes questions regarding activities in the past 12 months that might have been illegal. One question asked of respondents is whether they had ever driven any kind of vehicle while they were under the influence of alcohol or illegal drugs. Table 44 presents data for driving under the influence by age, sex, and race. Approximately 8.0 percent of all drivers reported operating a vehicle while under the influence of alcohol or illegal drugs during the previous 12 months. Whites report a consistently higher rate of driving under the influence compared with African Americans. Overall, nearly twice as many whites have driven under the influence (8.5 percent) compared with African Americans (4.2 percent). This disparity is even more pronounced among white youth, who are three to four times more likely to have driven under the influence.

Males are more likely to drive under the influence of alcohol or illegal drugs across all age and racial groupings, with the exception of white females ages 12–17. Driving a vehicle under the influence of alcohol or illegal drugs appears to peak for the 18–25 age group across all racial categories and to level off in subsequent years. One-quarter (25.3 percent) of white males ages 18–25 had driven a vehicle under the influence compared with 9.2 percent of African American males, 14.9 percent of white females, and 2.6 percent of African American females.

SUMMARY

Data from the ADAM Program were used to examine the potential for involvement in drugs among arrestees. In 1994 and 1995, African American arrestees passed whites as the racial group with the highest percentage of positive marijuana tests. In 1995 Asian arrestees showed the lowest percentages of positive tests for marijuana. Cocaine use is seen most often in test results for African American arrestees, followed by Hispanic and white arrestees. In 1995, the percentage of positive test results for American Indian/Alaskan Natives and Asian/Pacific Islanders was 30 percentage points lower than for African Americans.

ADAM Program data from 1991 to 1995 show that methamphetamine use by adult white arrestees far exceeds use by African American and Hispanic arrestees. It is notable that in 1995, the first year that methamphetamine use was recorded for Asian/Pacific Islander arrestees, they represented the second highest percentage of positive tests for methamphetamine use. The reader is cautioned regarding the interpretation of the ADAM data given its methodological limitations.

Data from the NHSDA were used to examine driving under the influence of alcohol or drugs. Overall, nearly twice as many whites have driven under the influence as have African Americans. This disparity is even more pronounced among white youth, who are three to four times more likely to have driven under the influence. Overall, one-quarter of white males ages 18–25 had driven a vehicle under the influence.

Table 43

Prevalence of positive urinalysis tests from the Arrestee Drug Abuse Monitoring Program (formerly the Drug Use Forecasting System): 1987–95

Race/ethnicity and year	Marijuana	Cocaine	Opiates	Methamphetamine
White				
1987	39	26	13	N/A
1988	40	31	13	N/A
1989	30	32	11	N/A
1990	25	26	10	N/A
1991	23	29	9	7
1992	27	32	9	7
1993	29	31	10	14
1994	27	30	9	17
1995	28	29	10	14
Black				
1987	36	56	10	N/A
1988	35	63	10	N/A
1989	21	61	8	N/A
1990	16	53	8	N/A
1991	15	56	6	0.3
1992	22	55	6	0.3
1993	26	54	7	0.6
1994	28	53	7	0.8
1995	30	50	7	0.8
Hispanic				
1987	34	43	22	N/A
1988	34	51	21	N/A
1989	25	43	18	N/A
1990	21	36	15	N/A
1991	20	38	13	2
1992	23	39	12	3
1993	25	37	13	5
1994	25	36	12	6
1995	25	33	11	7
American Indian/ Alaskan Native				
1995	37	19	7	4.4
Asian/Pacific Islander				
1995	9	20	5	7

N/A Not applicable.

SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring Program.

Table 44

Percentage of people having driven a vehicle under the influence of alcohol or illegal drugs in the past 12 months, by race, sex, and age: 1995

Race and sex	Age group				
	12 and older	12–17	18–25	26–34	35 and older
All races					
Both sexes	7.8	3.6	17.4	12.5	5.0
Male	10.8	3.3	22.5	17.6	7.5
Female	5.0	3.8	12.4	7.6	2.9
White					
Both sexes	8.5	4.0	20.1	14.0	5.3
Male	11.7	3.7	25.3	19.4	7.9
Female	5.6	4.4	14.9	8.7	3.1
Black					
Both sexes	4.2	1.4	5.7	5.6	4.0
Male	6.8	2.0	9.2	9.1	6.6
Female	2.1	0.8	2.6	2.8	2.0

SOURCE: National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1995.

Chapter 8. SUMMARY AND FUTURE DRUG ABUSE PROGRAM AND RESEARCH NEEDS

This report examines current data available on drug use among racial/ethnic minorities. The available information indicates that drug abuse affects these special populations in a manner disproportionate to reported use. The adverse consequences suffered by minority populations include increased rates of morbidity and mortality, alterations in educational achievement, and higher rates of injury and crime. African Americans and other minorities may be at greater risk than whites to fatal and nonfatal health consequences of drug abuse due to their preference for injecting drug use, their choice of more dangerous drugs such as crack cocaine, and their responses to intervention and drug treatment.

Data on drug use among racial/ethnic minorities uncovered several important differences in reported use. Among youth, Asian/Pacific Islanders generally report very low drug use compared with other groups, especially for alcohol. African American youth consistently report lower rates of drug use than do white youth. Hispanic youth commonly report more substance use than African American youth and only slightly less use than white youth. American Indian/Alaskan Native youth on reservations have very high rates of substance use, particularly alcohol; they generally report greater use of alcohol and other drugs than does any other racial/ethnic group. Presumably, these differential rates and patterns reflect differing causal factors that lead to the initiation of drug use behaviors and the continuation and intensification of use.

This report presents some interesting differences among racial/ethnic groups regarding the health consequences associated with drug abuse. Data from the Youth Risk Behavior Survey (YRBS) indicated risky sexual practices increased with drug use. A large percentage of African American youth who used marijuana reported multiple sex partners and other risky behaviors such as not using a condom. Data from the Centers for Disease Control and Prevention indicate that African Americans and Hispanics represent increasing proportions of persons reported with HIV (human immunodeficiency virus) or AIDS (acquired immune deficiency syndrome) through injecting drug use; and hospital episode data from the Drug Abuse Warning Network indicate that Hispanics had the highest percentage of accidental drug-related deaths, followed next by African Americans. Each of these findings has implications for designing and implementing prevention, referral, and treatment programs that can effectively address drug use among racial/ethnic groups.

An area of particular concern are the data on AIDS and race/ethnicity. The preponderance of African Americans and Hispanics among injecting drug users with AIDS is at least in part due to their preference for injecting drugs over other methods. Whether other factors such as differences in drug use practices and general health status also account for the high concentration of cases among racial/ethnic minorities is not clear. The fact remains that AIDS associated with injecting drug use affects African Americans and Hispanics more than whites. Higher HIV seroprevalence rates among African Americans and Hispanics indicate the need for intensifying AIDS education, prevention, and intervention programs targeting minority populations. Additional research is needed to determine the most effective intervention techniques to reach the racial/ethnic groups at highest risk. Additional health care

needs for minorities will result from the increased rate of HIV infection and other health-related consequences of drug abuse.

There are limitations to our understanding of drug abuse among minorities. For example, African American youth consistently report lower rates of drug use than do white youth, yet African American adult males are most likely to be current users of any illicit drug, particularly marijuana or cocaine. Distortions may occur when there is an over-reliance on biased drug-related arrest and treatment data. Inflated rates of drug use for African Americans and Hispanics may result when such data are collected from residents of lower socioeconomic neighborhoods or because minority populations, on average, are younger and therefore at greater risk for drug use and delinquent behavior. Drug use rates based on census data also may be inflated due to undercounting of African American and Hispanic youth.

Research on drug use among racial/ethnic minorities has not advanced to a stage that allows policymakers and program managers to effectively address the factors and consequences associated with drug abuse. Data collection efforts need to focus on prevention and intervention of drug abuse problems. Few studies evaluate how effective drug treatment programs are among Hispanics, African Americans, and other minority groups. Because of the prominent representation of African Americans and other minorities in drug treatment programs, racial, ethnic, and cultural factors must be taken into account in designing and conducting research to evaluate treatment. Ignorance of or inattention to these factors may result in data that are misleading or may, in some cases, preclude carrying out the research.

A further understanding of adolescent drug abuse is necessary for designing effective prevention strategies for minority youth. Research projects are needed to further explore the relationship of poor academic performance, school bonding, and drug use. Another area for research is acculturation-related stress and vulnerability to drug use among minority youth. Racial, ethnic, and cultural factors are likely to influence virtually every area of drug abuse, including the initiation of illicit drug use, the choice of drugs abused, the nature and extent of peer influence on drug use, the "style" of abuse (including frequency and pattern of use), perception of drug treatment (e.g., its availability, accessibility, and effectiveness), and relapse to drug use after treatment.

Few surveys of drug use among minorities have been conducted of high-risk groups such as school dropouts, runaways, or arrestees. Consequently, the current estimates of drug use in minority populations may misrepresent the true extent of the problem. One reason may be the fact that minorities are often underrepresented in studies of drug use because they are more likely to drop out of school. These data suggest that to effectively assess and meet minorities' needs, communitywide drug use education, prevention, and intervention programs are needed in addition to school-based programs. In addition, further research is needed to determine (1) if there are selective factors associated with students who graduate from high school, those who drop out, and those who remain in school longer; (2) if there are factors that protect students from drug abuse; and (3) the role the educational system plays in reducing, delaying, or eliminating drug use among all racial/ethnic groups.

Race and ethnicity are among the more difficult demographic factors to analyze because of a lack of consensus in classifying subpopulations. The categorizations of race and ethnicity are presently under review by the U.S. Government. Current definitions of race/ethnicity oversimplify a complex set of personal, social, and biological attributes. Generally, race is socially defined and is based on physical characteristics, and ethnicity involves culture and identity. Blacks and whites are defined as being part of a race, but Hispanics are considered

part of an ethnic group or nationality group reflecting the country of birth of a person or his or her family. Hispanics may identify with any of a number of racial groups; for example, a Mexican who has one Spanish parent and one American Indian parent may accurately label himself or herself white, Spanish, or American Indian. Cultural beliefs also affect how a person identifies himself or herself. Many immigrants bring certain cultural beliefs and ideas that influence their individual perceptions and their ethnic community. In addition, the rate and degree of acculturation varies from individual to individual and family to family. Consequently, there is tremendous diversity among individuals of the same racial or ethnic group.

Although interest exists in having data on race and ethnicity, the breakdowns are often restricted to “white” “black” and “other.” When information is collected on minority groups, the information rarely takes into account the heterogeneity of the population. We have data, for example, on drug abuse among American Indians in general, but there are more than 200 American Indian tribes for which we have almost no specific data. In addition, although some national-level data on drug use by race and ethnicity are stratified by age and gender, rarely are factors such as education or income status entered into the analysis. Data on Hispanic subgroups indicate there are some important distinctions in reported drug use among these populations. Further studies are needed to establish these differences and to understand the multitiude of factors that may contribute to the finding.

Additional in-depth epidemiological studies are needed to examine how racial, ethnic, and cultural factors are associated with the causes and consequences of drug abuse for all racial/ethnic groups. These studies should include case-control as well as longitudinal studies that control for the various sociodemographic characteristics. Future studies are required to examine the course of drug abuse in minority populations and the differential influences and consequences of this use over time. These studies would help to target the factors most predictive of initiation and continuation of drug use among racial/ethnic populations and identify the culturally relative factors associated with this use. Further examination of cultural factors also may help to shed light on the protective mechanisms among subpopulations and on risks of drug use. It is further recommended that drug and alcohol researchers collect data on minority drug use that is useful to policymakers and program managers so that appropriate funds and intervention can be provided to those most in need.

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