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STATISTICAL PERSPECTIVES ON DRUG ABUSE TREATMENT IN NEW JERSEY, 1986

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PREFACE

This is the fourth annual report on clients of New Jersey's drug abuse treatment system. It, as did its predecessors, attempts a statistical description of drug abusers in treatment; who they are demographically, what they use, what treatment they get, how long they stay in treatment, and whether or not they succeed in completing their treatment plans.

Before we go on to developing answers to these questions, perhaps we should pause to consider why we should be concerned, why drug abusers affect us.

I believe the answer to this question is because drug abuse affects all of us.

Families and friends of drug abusers worry over the self-destructive acts of abusers--their loss of employment, trouble with the police, "hanging out" with undesirable associates, and now over the possibility that they may get AIDS through sharing needles. Friends and family members often are also the victims of drug abusers: their lies, deceptions, "scams," con games, irresponsible behavior, failure to offer emotional and financial support, theft of money and property from the home, and now their importation of AIDS into the family.

Peers of young drug abusers may become enmeshed in the negative lifestyles of their friends, being influenced to ignore classwork and drop out of school.

Employers pay for drug abuse in impaired workmanship, excess absenteeism, as well as supervisors and coworkers who enable or cover up their colleague's abuse.

In some inner cities, whole neighborhoods are lost to drug dealers and associated criminals.

All of us, even if we are not affected directly, pay extra taxes to cover the costs of drug abuse treatment and prevention programs, law enforcement, judicial and corrections and parole system costs, and costs of health care for the estimated 459 (out of 688 new cases) New Jersey citizens who got AIDS last year because of drug abuse.

Drug abuse treatment and prevention, as part of a broad social policy, provides the means to reduce the human and social costs of this major burden.

Please feel free to send us your comments on this report.

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Assistant Commissioner
Alcohol, Narcotic and Drug Abuse

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INTRODUCTION

In New Jersey, no less than in the rest of the nation, drug abuse is a serious and changing problem. It has grave social, psychological and economic consequences for abusers, their families and friends, and for many institutions in society. It imposes immense burdens on our health care, education, law enforcement, judicial, and correctional systems.

A large variety of drugs and chemicals are and have been abused. Abuse may involve either improper use of legally prescribed drugs or any use of illegal drugs and chemicals. Currently, the substances which account for the largest numbers of treatment admissions are heroin and other opiates, cocaine, amphetamines, marijuana, barbiturates, hallucinogens, tranquilizers, and PCP.

Individuals who abuse drugs risk their mental and physical health and even their lives. Heroin and barbiturates have long been known to have the potential to cause lethal overdoses. Recently cocaine has been found to cause death from cardiac arrest even in low doses. Unsterile and shared hypodermic needles are the mode of transmission for a variety of diseases, includes AIDS, AIDS-Related Complex, and hepatitis Type B. Amphetamine and PCP psychoses are now known to be related to drug induced changes in brain chemistry, which can produce bizarre and often violent behavior.

Although causes are unknown, drug abuse is associated with several psychological, social and geographic factors. In the late 1970's, psychologists found that over 70 percent of drug treatment clients were depressed. Earlier, sociologists noted that particular drugs tended to be abused by individuals with similar demographic characteristics. For example, benzodiazepines are most commonly abused by middle and lower middle class women. Males in their late teens and early twenties are the likeliest abusers of marijuana. Heroin tends to be abused by lower class males, particularly those from minority groups. Opiates tend to be abused more in the northern part of New Jersey, whereas, stimulants are much more prevalent in the southern part. Cocaine use is epidemic throughout the State.

Five new developments are attracting the attention of those involved in drug abuse prevention, treatment and research. There are:

1. Scientists now understand that drugs affect the basic reward system in the brain.

2. Drugs are now being examined for their ability to be abused or self-administered, not just for their ability to cause addiction.

3. There has been an explosion in the number of people seeking treatment for cocaine. This has led to a better understanding of the health threat it poses.

4. Much more is now known about opioid drugs that occur naturally in the body and how they relate to the synthetic ones which are abused.

5. Researchers can now predict, (but not perfectly), who is at risk for drug abuse by examining individual behavior and circumstances.

Reward systems and self-administration

The first and second of these points are closely related. Until recently it was thought that only those drugs which cause physiological addiction, that is, produced tolerance and a withdrawal syndrome, were the most serious threats to individual and public health. Heroin was known to cause addiction and a large-scale treatment system was set up to treat addicts. It is now known that many other psychoactive drugs, those that affect the central nervous system, also affect the brain's reward system directly and are likely to be self-administered. Animals whose response to drugs is the same as humans' are now being used to test the abuse potential of existing and new drugs. Measures of abuse potential of various drugs can be developed by observing how long test animals are willing to continue pressing levers for them.

The discovery of endorphins (naturally occurring opioids) in 1975 led to greatly increased interest in brain research. Early investigators thought that they had found the cause of addiction. Later researchers showed that there was no relationship between the number of endorphins or their receptors in the brain and individual likelihood of becoming addicted. Attention turned to determining how naturally occurring chemicals interacted with externally administered ones in the brain. This led to a great proliferation of studies by neuroscientists from many fields. Brain research is currently very complex, rapidly changing, and impossible to summarize with finality.

Most investigators currently believe that the brain's reward system consists of a complex set of neural pathways stimulated and inhibited by a group of naturally occurring neurotransmitters (chemicals such as dopamine, norepinephrine, serotonin, acetylcholine, and perhaps others). They agree that the system is poorly understood. Yet most seem also to agree that dopamine is probably the most directly involved of all neurotransmitters in the brain's reward system. Researchers have produced a large body of evidence on the interactions of various abused drugs with these neurotransmitters.

Perhaps stimulant drugs' effects on brain chemistry are best understood. Receptors for these drugs have recently been identified in the brain. These stimulants have been found to be associated with neurochemical changes in the brain during, immediately after, and as a long term consequence of use. During acute use, dopamine and norepinephrine are released and their reuptake is blocked. The stimulant user only experiences rewarding effects when his serotonin-producing system is intact. If it is not, tolerance occurs and self-administration increases. Several drugs have been found to block this effect. In the long term, stimulant use leads to prolonged profound lowering of brain serotonin levels, possibly because of the destruction of dopamine neurons, although the nervous system seems to be able to adapt to this depletion by activating other systems to increase neurotransmitter levels. When stimulant administration stops following prolonged use, the overabundance of neurotransmitters can result in hyperactivity that can contribute to a withdrawal syndrome and depression. The acute psychosis that can occur after brief exposure to stimulants may be due to temporary overactivity of dopamine in specific areas of the brain.

Cocaine shares many of the stimulants' effects on neurotransmitters but also demonstrates some important differences. Like the stimulants, it affects dopamine, norepinephrine and serotonin. But its effect is probably greatest on dopamine. Cocaine may release more dopamine from storage but neurotransmitter pools do not remain depressed long after cocaine use stops. The cocaine high is thought to arise from its prolonged effect of dopamine. The effect on dopamine has been interpreted by some to mean that cocaine's effect on the reward system is more direct than that of other drugs. This might help to explain the recent explosion of cocaine use.

Most investigators currently believe that heroin and the narcotics, although obviously reinforcing drugs, seem to have little direct effect on the neurotransmitter reward system. As far as is known now, they primarily effect the endorphins and thus modify reward rather than produce it.

There is no evidence that the sedatives and anti-anxiety agents affect the neurotransmitter reward system. These drugs have some rewarding properties, but apparantly much less than others. The reward system they affect is not understood.

The hallucinogens are a very complex group of five classes of substances which behave differently with respect to the reward system. Apparently only one class affects the neurotransmitter reward system. This class contains LSD, DMT, DOM, and mescalin. These drugs act on serotonin, which in turn acts on several specialized neuronal receptor sites.

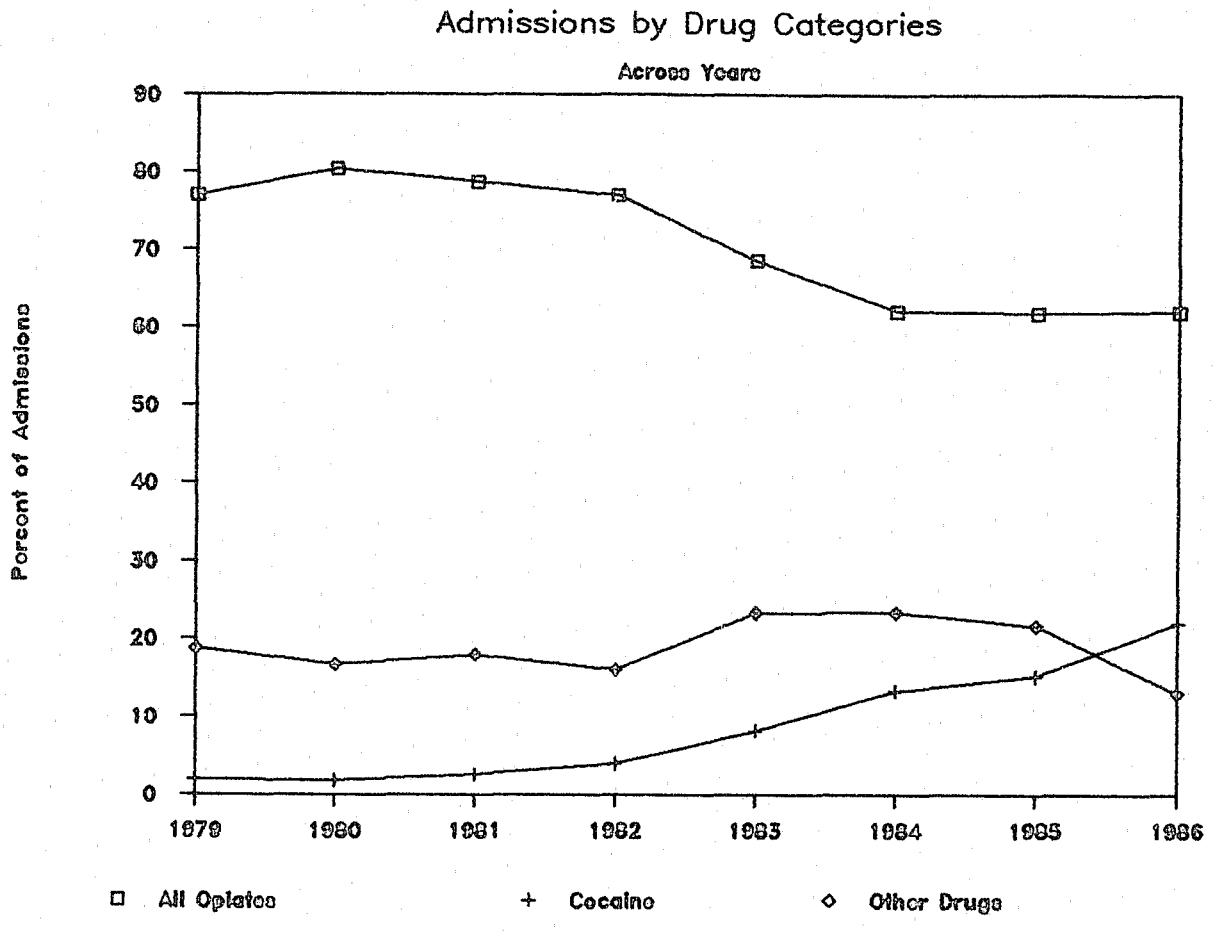
Inhalants are also a complex group of drugs. There are four classes of these. Their rewarding effects appear to involve the reduction of oxygen to the brain. This state is interpreted by the user as euphoric. It may involve the reflex release of an adrenaline-like substance, possibly norepinephrine, which is also called noradrenaline.

The cocaine epidemic

The third major recent development in the field of drug abuse is the explosion in the number of people seeking treatment for cocaine and the subsequent understanding of the health threat it poses. Studies of the abuse potential of cocaine show it is the most reinforcing of all drugs. Rhesus monkeys allowed unlimited access to it prefer it to eating. Animals given free access to it will increase the amounts they take very rapidly. They become debilitated and many die within 5 days. This is earlier than deaths resulting from unlimited access to amphetamine. After 30 days of unlimited access to cocaine, 90 percent of experimental animals are dead. This is a much higher percentage than that for heroin, which is 36 percent.

There are no systematic studies of complication rates in cocaine users but anecdotal reports indicate that use may affect the heart and metabolism. There have been reports of heart attack, irregular heart rhythms, stroke, brain hemorrhage, high blood pressure, malnutrition, anorexia, endocrine abnormalities, and colitis so severe as to require surgical intervention. There are other effects related to the specific route of administration of the drug. For those who snort,

sinus irritation may result. Sometimes this can be so severe as to lead to perforations of the nasal septum which must be surgically corrected. Smokers of cocaine may impair the ability of their lungs to exchange oxygen and carbon dioxide. Intravenous users run the additional risks of hepatitis and AIDS.



Opioid drugs

The fourth of the recent developments to have affected drug treatment is the greater understanding of opioid drugs that occur naturally in the body and how they relate to the synthetic ones which are abused. The natural opioids are now known to be a complex set of at least four major groups, each of which contains two to five members. They occur in the brain and in testes and ovaries. There is some evidence that they may be produced in the reproductive system.

The natural opioids found in the brain play complex roles in a number of metabolic functions. They do not make up just one system of regulation of pain. Instead, they form a complex series of brain systems involved in the regulation of pain, mood, and psychosis, endocrine function, the cardiovascular system, the circulatory system, and just possibly kidney and bladder functions, central glucose regulation, and elements of immune system function. The natural opioids are

affected by chronic stress and change with brain development. Natural opioids in the brain appear to be about 20 times more potent than synthetic ones of the same structure.

Knowledge of the structure and function of the brain's opioid receptor has produced an understanding of changes that occur during heroin addiction. There are a large number of mechanisms involved.

There have also been clinical results of the better understanding of the opioid receptor. Among these are better understanding of the action of buprenorphine, discovery of the effectiveness of naloxone in preventing heroin overdose death from respiratory depression and in preventing sudden infant death syndrome. Other clinical benefits may arise in the future as drugs are developed to achieve the desirable effects of morphine, such as controllable appetite suppression and pain relief, without its addictive potential.

Predictions

The fifth of the recent developments in the field of drug abuse is the emergence of the ability of researchers to predict, even if imperfectly, who is at risk for drug abuse by examining individual behavior and circumstances. They have found that there are family, peer, and individual factors involved.

Family factors which are statistically associated with drug abuse are a family history of alcoholism, criminality or anti-social behavior, parental drug use or approval of drug use, and problems with parental direction or discipline. Specific problems with parental discipline are unusual laxity, severity or inconsistency, constant criticism, and absence of praise.

Peer factors which are predictive are drug use by peers or siblings.

Individual factors indicative of increased risk of drug abuse are age less than 15 years at first use of any drug, and achievement, school commitment, and social alienation. Children who fail in mid to late elementary school, have been antisocial or misbehaved at school, have no interest in school, or generally feel alienated, act rebellious, have a low sense of responsibility or have been aggressive are statistically more likely to abuse drugs than are others.

The Division of Narcotic and Drug Abuse Control (DNDAC) of the New Jersey State Department of Health was established to help New Jersey citizens cope with the problem of drug abuse in the State. DNDAC's main mission is:

> to promote the behavioral health of the residents of New Jersey by addressing the problem of drug abuse/addiction through the development and coordination of activities that provide education, prevention, training, intervention, treatment and the development and dissemination of knowledge; and by regulating the manufacture, distribution and sale of controlled dangerous substances and other drugs.

DNDAC monitors federally and State funded drug programs. Currently there are 79 identifiable drug abuse treatment units serving New Jersey. Seventy-two units report to DNDAC. Included in those reporting units are 66 which are State funded.

The five new developments in drug abuse have affected the system of drug treatment in the State by altering both the types of clients in treatment and the types of treatment programs available. This change has come about largely because of the dramatic increase in admissions for cocaine use. In 1986, nearly one quarter of all admissions were for primary cocaine abuse. This change occurred very rapidly. In 1980 primary cocaine users were only 1.8% of all admissions. In 1986, cocaine admissions for the first time surpassed admissions for all other drugs combined except heroin. No other drug of abuse has seen an increase in admissions like this in recent times. All other rates have remained fairly stable, except for heroin admissions, which have declined over the same time period from 80.4 percent to 58.0 percent of admissions. This means that among admissions, the ratio of cocaine users to heroin users has changed from 1:44.4 to 1:2.6 in the same time period.

Because of this increase in cocaine users seeking treatment, there are now a number of experimental outpatient programs for cocaine abusers in the State. These employ drugs such as desipramine and l-tryptophan which block the effects of cocaine on neurotransmitters, along with traditional counseling approaches. They are being implemented under guidance from research physicians.

The extent of drug abuse is one question which interests many people but is difficult to answer with certainty. This is because drug abuse is an illegal activity and people do not engage in it openly. They are often reluctant to answer questions about it unless these are part of carefully designed and expensive studies.

In 1983, Alcoholics Anonymous conducted a simple survey of its members. It found that many were addicted to drugs in addition to alcohol. Drug addiction rates varied by sex and age. Forty percent of women reported addiction, while only 27 percent of men did. About 80 percent of 18 year old members were addicted, while only 10 percent of 60 year olds were. For all those aged 30 and under, the reported adiction rate was just under 50 percent.

A random survey of households, conducted in New York, has been used to estimate prevalence of drug use in the general population aged 12 years or older in New Jersey since the populations of the two states are demographically comparable. Some of the highlights of these results follow:

Almost 900,000 New Jersey residents (12% of all residents) have illicitly used one or more drugs in the last six months.

Of these, 150,000 (2% of all residents) are categorized as substantial or extensive users and should be considered in need of drug abuse treatment.

The drugs most frequently used during the last six months are:

Marijuana	10%
Stimulants	3%
Cocaine	3%

Over half a million people, or almost one-tenth of the population, have used marijuana in the last 30 days.

More than 100,000 people have used cocaine in the last 30 days.

130,000 have used stimulants in the last 30 days.

For the most frequently treated drug of abuse, heroin, however, household surveys are perhaps less reliable. Estimates seem to indicate that there are about 40,000 heroin addicts in the State.

In 1986, a carefully designed random sample of high school students yielded valuable information on drug use in this population. The study was carried out by the New Jersey Department of Law and Public Safety in cooperation with the Departments of Health and Education. Some of its key findings were that at some time in their lives:

- 89% of students have used alcohol
- 56% of students have used drugs other than alcohol
- 49% have used marijuana
- 19% have used cocaine
- 17% have used amphetamines
- 17% have used inhalants as intoxicants
- 13% have used hallucinogens
- 13% have sniffed glue
- 11% have used tranquilizers
- 8% have used barbiturates
- 2% have used heroin

These students also reported on their current use of drugs. (Current use was defined as use within the past month.) Students indicated that they had used the following drugs:

- 62% used alcohol in their last month
- 21% used marijuana in the last month
- 7% used cocaine in the last month
- 6% used amphetamines
- fewer than 4% each used hallucinogens, tranquilizers, barbiturates, inhalants, or glue in the last month.

These results represent changes over the last comparable survey, carried out by the same agencies in 1983. Most recent results indicate a statistically significantly lower percentage of students in 1986 than in 1983 have ever used alcohol, marijuana, and barbiturates. More students, 1.4 percent more, reported having ever used cocaine in 1986, but this result was not statistically significant.

In addition to the studies that tell us how many people use drugs, in 1986 we have information on what drugs people have been concerned about. This information is not from a random sample so it is not representative of what the average person might say if asked, but it does describe what people knowledgeable about and motivated enough to call the New Jersey Drug Abuse Hotline were concerned about in 1986. This hotline is a 24-hour, 7 day a week tollfree number for New Jersey residents operated by the treatment facility, Together, Inc. in Gloucester County. The Hotline has been operating since March, 1983. During this time, over 28,000 calls have been received. The total number of calls in 1986 was 14,535 or an average of 1,211 per month. Services are provided for families, friends and professionals who deal with substance abusers, as well as substance users themselves. The Hotline provides information and education regarding drugs and issues surrounding drug use. Crisis counseling is provided, as well as referrals for treatment and ancillary services. The Drug Hotline is staffed by trained, professional telephone counselors. The calls, counted by drug and topic, were:

Drug	Calls	Drug	Calls
Cocaine	3,543	Drug Testing	329
Marijuana/Hash	1,394	Narcotics	268
Heroin	1,009	Methadone	207
Family & Drugs	890	Hallucinogens	190
Parents/Adults Users	873	Other Drugs	160
General Drugs	870	Drug Withdrawal	140
Alcohol	808	Drug Emergency	133
Crack	750	Over-the-Counter	127
Amphetamines	597	Hynotics/Sedatives	123
Parents/Youth Users	577	PCP	107
Drugs and Crime	459	Other Depressants	105
Drug Unknown	424	Barbiturates	94
Tranquilizer	358		

This report, which provides information about New Jersey drug treatment programs and the clients they serve, was prepared by the New Jersey State Department of Health, DNDAC, Office of Data Analysis and Epidemiology. The information in it is based on 1986 data from CODAP, the data collection system through which programs report client activity to the State. The report attempts to provide answers to the following commonly asked questions about drug abuse, drug abusers, and drug abuse treatment:

- What types and patterns of drug abuse are treated?
- Where does drug abuse occur?
- What are the characteristics of drug abusers entering treatment?
- How many enter treatment?
- Are there more drug abusers entering treatment today than in the past?
- What types of treatment are available?
- Do drug abusers volunteer for treatment?
- How long do people use drugs before they enter treatment?
- How many people complete their treatment programs?
- How long do they stay in treatment?

WHAT ARE THE PATTERNS OF DRUG ABUSE?

Drug abuse patterns are determined by the specific type of drug and its availability, as well as by the users needs. Five patterns of use, defined by the National Commission on Marihuana and Drug Abuse[1] are discussed below:

Experimental use. Experimental use is defined as short-term, non-patterned trials of drugs with varying intensity and with a maximum frequency of 100 times. These users are primarily motivated by curiosity about the drugs and a desire to experience the anticipated effects. Experimental use is generally in social settings and among close friends.

Social-recreational use. Social-recreational drug use generally occurs in social settings among friends or acquaintances who wish to share an experience perceived by them as acceptable and pleasurable. Such use is primarily motivated by social factors and does not tend to escalate to more individually oriented patterns of use. Unlike experimental use, which is limited to a few episodes, social use tends to be repeated in weekly or bi-weekly episodes.

Circumstantial-situational use. This pattern of drug use is defined as a task-specific, self-limited use which is variably patterned, differing in frequency, intensity and duration. It is motivated by a perceived need or desire to achieve a known and anticipated drug effect deemed desirable to cope with a specific condition or situation. Such use may occur in four or five episodes per week.

Intensified use. This is defined as long-term patterned drug use at least once a day. Such use is motivated chiefly by a perceived need to achieve relief from a persistent problem or stressful situation or a desire to maintain a certain self-prescribed level of performance.

Compulsive use. This pattern is characterized by high frequency and intensity of drug use of relatively long duration, producing some degree of dependence. The compulsive patterns are usually associated with a preoccupation with drug-seeking and drug-taking behavior to the relative exclusion of other types of behavior. The motivation to continue compulsive drug use is primarily related to a need to elicit the acute drug effects in the face of increasing tolerance and incipient withdrawal effects.

A form of compulsive alcohol use that has emerged in the 1980's as a problem with other drugs, called "binges" or "runs," refers to continuous periods of repeated drug-taking, during which users consume substantial dosages of drugs. During binges, which can interrupt any pattern of drug use, users may assume some of the behavioral characteristics of compulsive users, but they may also adopt other patterns of use when they are not binging. This form of drug use appears to be motivated by a desire to maximize pleasurable drug effects and is usually associated with some degree of toxicity.

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1. National Commission on Marihuana and Drug Abuse, Drug Use in America: Problem in Perspective, Second Report (Washington, D.C., Government Printing Office, 1983).

Individuals engaged in these different patterns of use of drugs have different needs for treatment. Those whose use never progresses beyond the social-recreational type are not candidates for treatment, while those who engage in compulsive use clearly could benefit from it. Between these extremes, circumstantial/situational, and intensified users might benefit from drug treatment along or in combination with other forms of treatment designed to help them solve their underlying problems. Binge users may also benefit from treatment if their drug use seriously disturbs family or work life.

WHAT TYPES OF DRUG ABUSE ARE TREATED?

Clients admitted to drug abuse treatment clinics in New Jersey have problems with a wide range of drugs and chemicals, including improperly used prescribed drugs, as well as illegal substances. The CODAP reporting system classifies drugs into 14 categories:

- Heroin
- Other opiates (non-prescription methadone, opium, morphine, codeine, Demerol, Dilaudid, etc.)
- Marijuana/hashish (includes THC, "hash oil," other cannabis preparations)
- Barbiturates (phenobarbital, Seconal, Nembutal, etc.)
- Amphetamines (Benzedrine, Dexedrine, methamphetamine, "speed," and related compounds such as Preludin, Ritalin, etc.)
- Alcohol
- Cocaine (includes crack)
- PCP
- Hallucinogens (LSD, mescaline, psilocybin, MCA, DMT, mushrooms, peyote, etc.)
- Tranquilizers (Librium, Valium, Miltown, etc.)
- Other sedatives or hypnotics (methaqualone, chloral hydrate, Placidyl, Doriden, etc.)
- Inhalants (glue, nitrous oxide, organic solvents, etc.)
- Over-the-counter (legally obtained, non-prescription drugs)
- Other (any psychoactive drug not falling into one of the above categories)

The number of clients who are polydrug users, e.g. use more than one major drug at the time of admission has been steadily increasing in recent years. Currently, polydrug users represent two-thirds of all admissions and this is an increase over 1985.

Heroin, along with other opiates such as codeine and morphine, continues to be a very serious drug problem in New Jersey. Clients treated for abuse of and, more often, addiction to these opiates account for three-fifths (58%) of Statewide admissions or 7,969. While the number of clients admitted in 1986 for heroin use has grown over the previous year, heroin abusers constitute a smaller proportion of treatment admissions.

Users of other opiates admitted in 1986 numbered 493 and constituted 4 percent of treatment admissions. This includes non-prescription methadone, which involved 286 admissions, or 3 percent.

Cocaine, though, is the fastest growing abused drug in New Jersey. Cocaine admissions have increased dramatically over the years, both in absolute numbers and in the proportion of treatment admissions. In 1986, 3,024 clients were admitted for primary cocaine use. This is 23 percent of the year's admisions. By comparison, in previous years the proportions were:

1980	1.8%
1981	2.6%
1982	4.0%
1983	8.2%
1984	13.3%
1985	15.2%

An additional 4,040 clients entered treatment with cocaine as a secondary drug problem--making cocaine the most popular secondary drug used by admitted clients. When primary, secondary, and tertiary cocaine users are combined, 54 percent of admissions are involved with this drug.

One of every three primary cocaine users entering treatment smoked cocaine as "Crack." This is a change. Previously almost all cocaine users snorted the drug.

There were 731 admissions for marijuana/hashish and all tetrahydrocannabinol (THC) drugs. These users constituted 5 percent of all admissions.

Barbiturate admissions numbered 187 and accounted for a little over 1 percent of clients.

Six hundred sixty six admissions of users of amphetamines occurred in 1986. These constituted nearly 5 percent of all treatment admissions.

There were 112 or 1 percent of treatment admissions for alcohol in 1986.

There were 127 admissions for PCP; these made up 1 percent of treatment admissions in 1986.

Hallucinogen users numbered 165 admissions and accounted for 1 percent of all admissions.

Tranquilizer admissions made up nearly 1 percent of 1986 admissions. There were 108 of these.

Other sedatives accounted for 44 or less than a half percent of admissions.

Only 14 admissions, a negligible percentage, were for use of inhalents.

Over-the-counter drug users contributed to 18 admissions, or less than a tenth of 1 percent of all 1986 admissions.

There were 13 admissions of users of drugs other than the above listed ones in 1986. This also constituted less than one tenth of 1 percent.

Frequency of Admissions by Primary Drug, 1986

Drug	N	%
Heroin	7,986	58
Cocaine	3,092	23
Marijuana	731	5
Amphetamines	666	5
Other Opiates	365	3
Barbiturates	187	1
Hallucinogens	165	1
Non-Prescription Methadone	132	1
PCP	127	1
Alcohol	112	1
Tranquilizers	108	1
Other Sedatives	44	-
Over-The-Counter	18	-
Inhalents	14	-
Other	13	-
TOTAL	13,760	100

WHAT TYPES OF THERAPY ARE PROVIDED AT THE CLINICS?

The three major types, or modalities, of therapy provided are:

1. Drug-free
2. Detoxification
3. Maintenance

1. Drug-free - Drug-free treatment is so named because its goal for its clients is abstinance from all mind altering chemicals. Drug free treatment does not include the use of any chemical agent or medication as an integral part of the treatment regimen. However, drugs may be used as an adjunct to treatment or to treat any medical problems the client may have. Drug-free programs consist of two types: outpatient and residential.

In 1986, 47 percent, or 6,477 admissions Statewide received treatment in a drug free program, 1,205 residentially and 5,271 in an outpatient setting. The gender ratio in drug-free modalities was 3 males to every 1 female.

2. Detoxification - Persons treated in the detoxification ("detox") modality are primarily opiate abusers and represent 39 percent of all admissions, or 5,355 clients. In the planned withdrawal of a client from a drug, prescribed medication or decreasing doses of the problem drug are used as the primary element. The detoxification period does not exceed 21 days when methadone is prescribed for opiate addicts. Detoxification from non-opiate substances, such as barbiturates, other sedative-hypnotics or tranquilizers, may take longer. Clients are often referred to other treatment modalities at the end of their prescribed detoxification treatment plan.

In 1986, the male to female ratio in detoxification programs was 2.7 to 1. The average age of the detox client in 1986 was 31.

3. Maintenance - In maintenance programs, persons are regularly medicated with drugs (methadone, L-alpha-acetylmethadol (LAAM)) to achieve stabilization. The long-term goal is to have all maintenance patients detoxified from the maintenance drug until complete abstinence is achieved, although in many cases this goal may never be achieved. Clients treated in a maintenance modality are mostly users of heroin and are generally treated with methadone.

In 1986, 1,830 clients were admitted to a maintenance modality. The sex ratio was 1.8 males to every 1 female. Maintenance clients are generally older than those in other modalities, with an average age in 1986 of 33 years. At any given time slightly over 40 percent of all active clients in treatment are treated in a maintenance modality.

On very few occasions the primary treatment modality assigned to a client is other than those specified above. It may be with or without medication and includes acupuncture, chemotherapy, and transcendental meditation. In 1986, 99 clients were treated in this 'other' modality. Two thirds were cocaine users.

Modality	Number	Percent
Drug Free	6,477	47
Detox	5,355	39
Maintenance	1,830	13
Other	100	1
	13,762	100

HOW MANY PEOPLE RECEIVE TREATMENT FOR DRUG ABUSE?

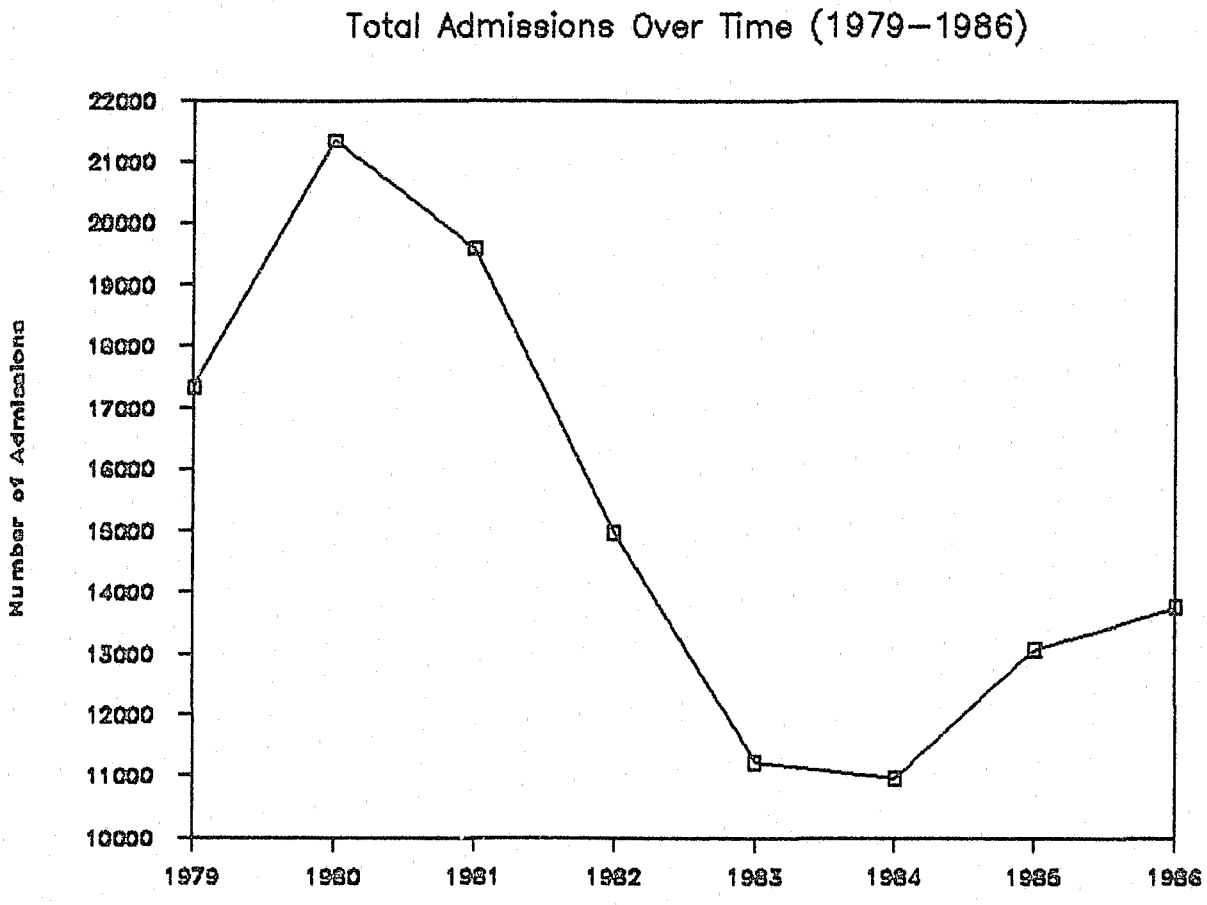
During 1986, 13,760 persons were admitted to treatment in clinics which participate in the CODAP reporting system, while a comparable number (12,861) were discharged during the year. In recent years, New Jersey has continued a trend in admitting the third highest number of clients into treatment in the country--behind New York and California. At any point in time, over 8,000 clients are receiving treatment.

HOW HAVE ADMISSIONS CHANGED OVER TIME?

While the number of State funded treatment clinics has declined from 82 in 1984 to 66 in 1986, the number of drug abusers admitted to treatment has increased by 25 percent. The number of active clients (clients in treatment at any given point in time) has increased by 15 percent since 1984.

This is in response to a number of factors. Perhaps the chief among these is the number of heroin admissions, since these account for the largest percentage (58%) of admissions among all drug types. Heroin admissions are influenced by the

prevalence of heroin use, which is influenced in turn by several factors. Of major importance among these factors is the availability of heroin.



Factors other than heroin admissions which influence overall treatment admissions are levels of funding, the opening and closing of treatment facilities, and the increase in cocaine use. Specific peaks and valleys on the graph on page 11 can be accounted for as follows:

- In 1980, there was an increase in heroin use, thus driving admissions up.
- Starting in 1981, federal funding was dramatically decreased for drug treatment, and admissions fell.
- In the same year, initial attempts to make up for reduced federal funding resulted in establishing client fees in a few clinics. By 1982 all State funded clinics were required to include cost sharing through client fees in their budgets and as a result, admissions continued to drop sharply.
- In 1985, admissions began to increase again, due partially to the increase in incidence and prevalence of cocaine usage, and entry into treatment of those whose use of the drug had become unmanageable.

- In 1986, both heroin and cocaine admissions rose. Heroin admission increases may be partially attributed to IV users' concern over AIDS, since the great majority of heroin admissions use the drug intravenously. Fifty-three percent of New Jersey AIDS cases are IV users.

- 1986 also witnessed a large influx of crack users entering treatment after initiating use the prior year. Most of these users were seeking treatment for the first time.

WHAT TYPES OF PEOPLE ARE TREATED FOR DRUG ABUSE IN NEW JERSEY?

Persons admitted to New Jersey clinics in 1986 were from all backgrounds, including different social, educational, and economic levels.

Marital status

Married persons accounted for 17 percent of all clients admitted to treatment. An additional one-fifth of the clients were either divorced or separated at the time of admission. About three-fifths were single (never married).

Educational attainment

Educationally, 57 percent of admissions had achieved a high school level of education or higher. Three percent of admissions possessed undergraduate or postgraduate degrees.

Employment status

More than half (56%) were unemployed at the time of admission. Included in the total rate of unemployed admissions were 11 percent who were seeking work--unlike the remaining 45 percent, who were unemployed and not seeking work.

Insurance coverage

One out of every four clients had private insurance coverage, while 9 percent were covered by public insurance and an additional 57 percent reported no insurance coverage.

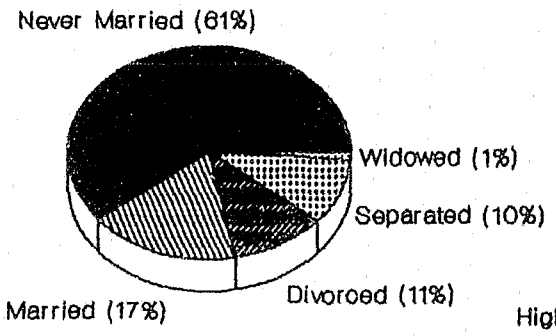
DO MALE AND FEMALE DRUG ABUSERS DIFFER?

In 1986, the New Jersey drug treatment system admitted a total of 9,668 males and 4,092 females. Thus, 70 percent of admissions were male and 30 percent female. The proportion of treatment admissions who are female began to increase in 1976 from a rate of 25 percent. Since then, it has fluctuated between 27 percent and 32 percent. Last year, 1985, it was at its peak of 32 percent.

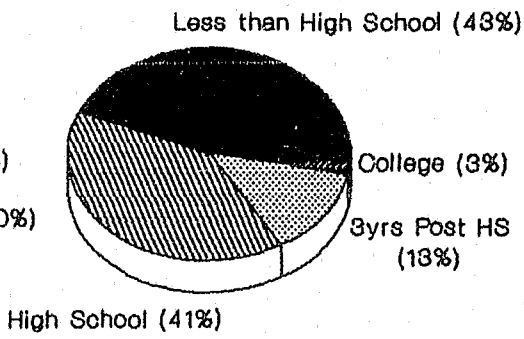
SOCIAL CHARACTERISTICS OF CLIENTS

(1986 Admissions)

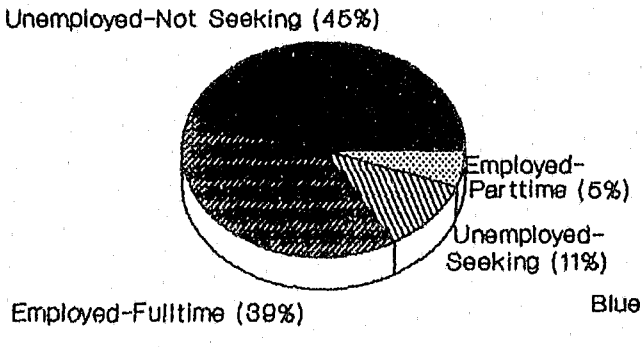
MARITAL



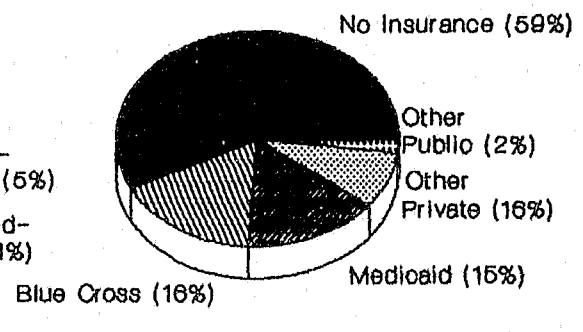
EDUCATIONAL



EMPLOYMENT

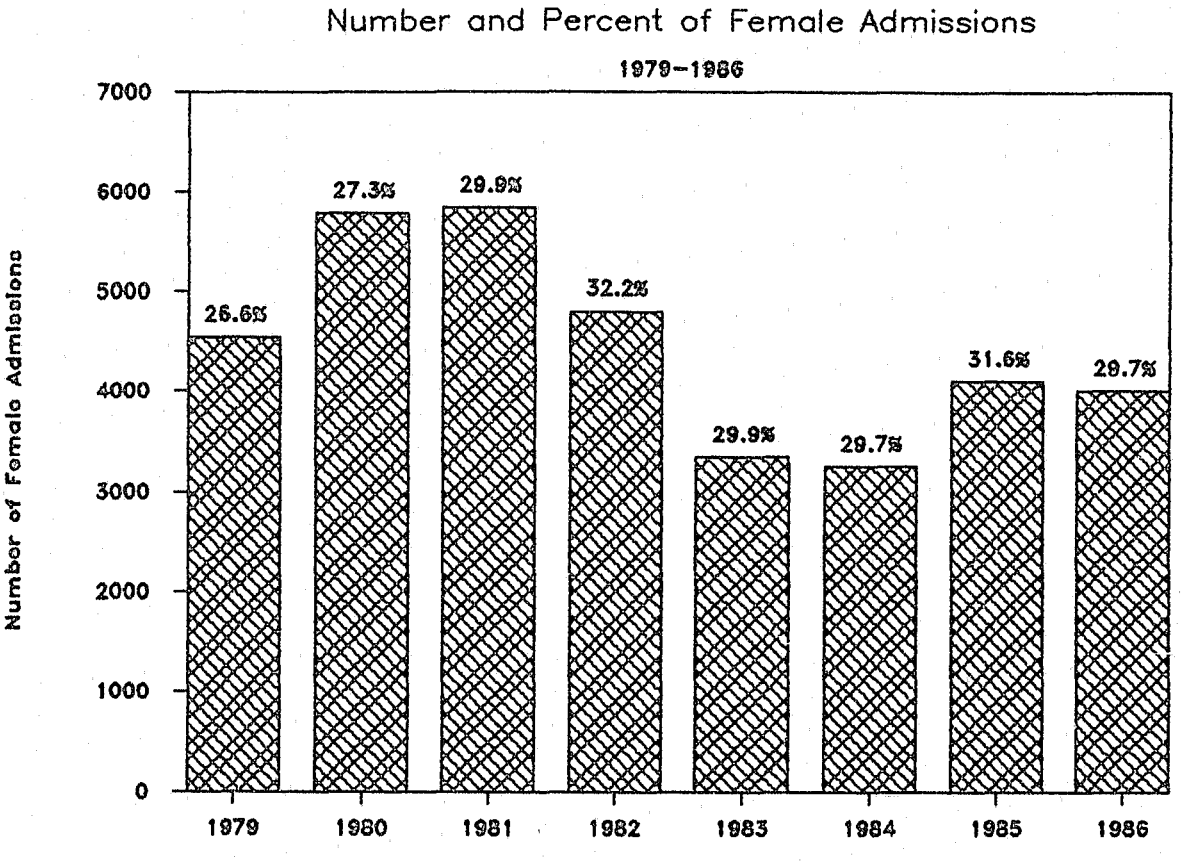


HEALTH COVERAGE



For both men and women, heroin was by far the most frequently mentioned primary drug of abuse at admission. But women entering treatment were more likely than men to be heroin users: 62 percent of female admissions reported heroin use, as compared to 56 percent of males. Cocaine was the second most frequently used drug for both sexes, but males, 24 percent, were more likely to be cocaine users than were females, 19 percent. After these two drugs there was little correspondence in order of drug preference between male and female drug abusers.

An examination of the proportion of each group by specific drug shows that males tend to be more likely than females to be users of cocaine, marijuana, and hallucinogens, while women are more likely than men to be users of heroin and other opiates, and tranquilizers. Both groups are about equally likely to use amphetamines, barbiturates/sedatives, PCP, alcohol, and other drugs.



As far as other indicators of drug abuse are concerned, female admissions appear to be more likely to be hard core members of the culture of heroin addiction and its treatment system than are male admissions. Women are more likely to be using needles, to be using very frequently (more than 3 times per day), and to be admitted to detox or maintenance. They have had more prior treatments than men and have been discharged from an earlier treatment episode more recently than men. However, females have had less involvement with the criminal justice system than have male admissions. Thus, females are more likely than males to have been admitted voluntarily and as self-referrals. Incongruously, women are less likely to have started drug abuse before age 15 and are more likely

than men to have been using drugs less than two years prior to admission. By contrast with women, men are more likely to be light users or polydrug users with no or fewer prior treatments who are admitted to drug-free modalities with more criminal justice system involvement.

By demographic and socioeconomic background characteristics, women admitted to treatment were more likely to be black or Hispanic and to be on Medicaid than men. They are slightly more likely to have completed high school but less likely to have any college education. Males admitted are more likely to be either under 18 or over 45 but are older than females. Males are also more likely to be employed, married and white.

Indicators of change and status at discharge uniformly favor males over females, but only slightly. Men are a bit more likely to be discharged with treatment complete and drug-free, to have completed a skill development program and to have gained a job after having been unemployed. They stay in treatment slightly longer. Buy they also are more likely than females to have been arrested during treatment.

Total Admissions, Number and Percent, By Sex

	Number	Percent
Male	9,668	70
Female	4,092	30

Primary Drug of Abuse, By Sex

Drug	Males		Females	
	N	%	N	%
Heroin	5,444	56	2,542	62
Cocaine	2,309	24	783	19
Marijuana	592	6	139	3
Amphetamines	458	5	208	5
Other Opiates	319	3	178	4
Barbiturates/Sedatives	150	2	81	2
Hallucinogens	148	2	17	-
PCP	101	1	26	1
Alcohol	79	1	33	1
Tranquilizers	41	-	67	2
Other	27	-	18	-
	9,668	100	4,092	100

Drug Abuse Indicators,

Percent (except where average is indicated)	Male	Female
using needles	56	60
using less than daily	46	39
using 3+ times/day	18	19
with secondary drug use	70	65
using before age 15	15	12
with no prior treatment	44	38
first time admissions using less than 2 years	33	40
admitted voluntarily	69	84
self-referred	48	56
admitted to detox	37	44
admitted to maintenance	12	16
admitted to drug-free, outpatient	41	32
admitted to residential drug-freee	9	7
admitted to other modality	1	1
no arrests 24 months prior to admission	52	65
average number prior treatments	1.6	1.9
average number prior arrests	.9	.6
average number months since last discharge	53.0	44.0

Demographic and Socioeconomic Indicators

Demographic (percent except where average is indicated)

under age 18	7	4
over age 45	2	1
white	55	53
black	30	39
Hispanic	15	18
average age	29	28

Socioeconomic (percent except where average is indicated)

employed	52	26
health insurance	35	55
married	19	14
completed 12 grades	40	41
average grade completed	11	11

Discharge and Change Indicators

Percent (except where average is indicated)

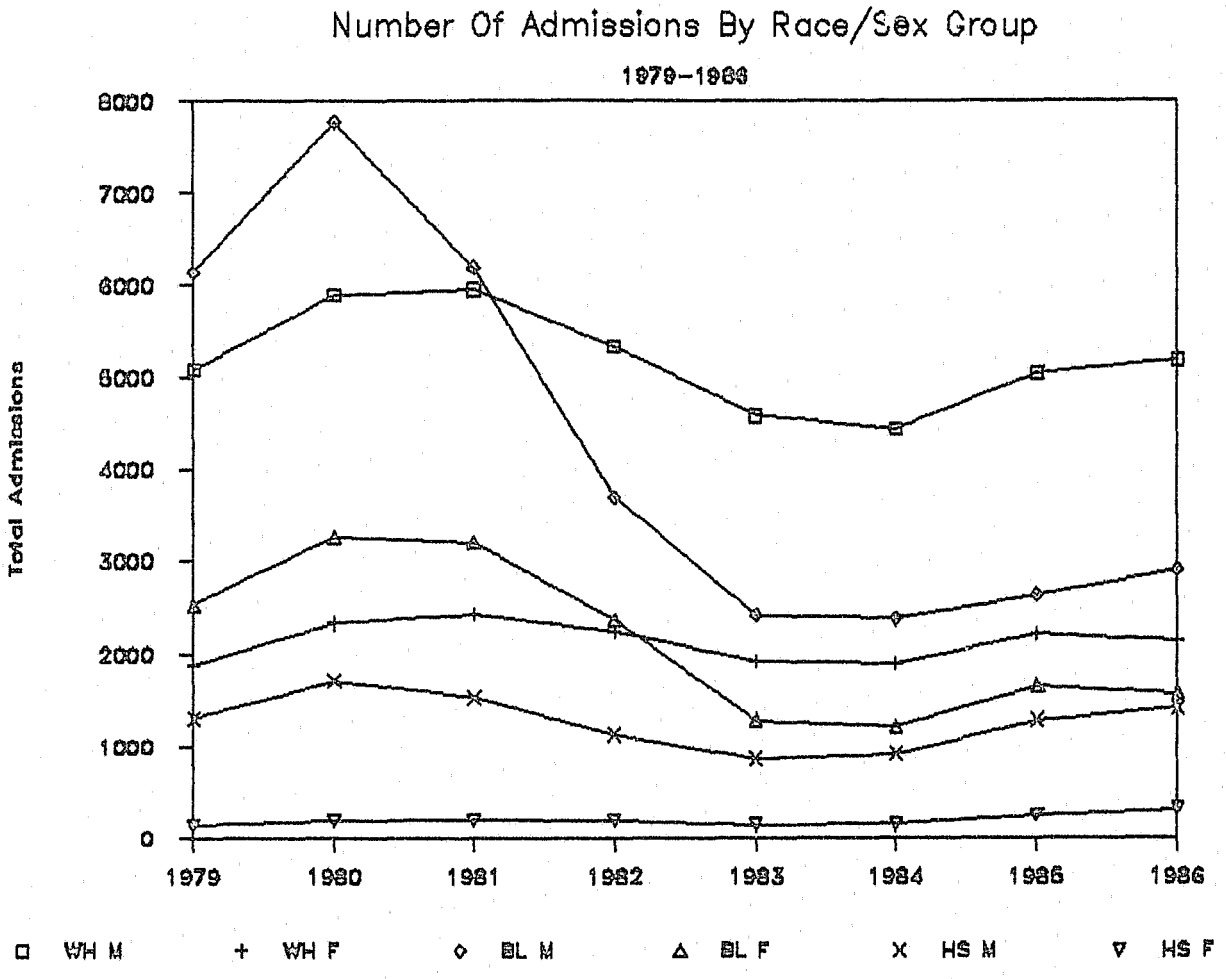
arrested during treatment	8	6
discharge treatment complete, no drug use	22	18
completed skill development program	3	2
unemployed at admission, employed at discharge	7	6
average time in treatment, days	189	180

DO WHITE, BLACK, AND HISPANIC DRUG ABUSERS DIFFER?

In 1986, 7,458 white, 4,510 black, and 1,748 Hispanic drug abusers were admitted to treatment. These groups represented 54, 33, and 13 percent of admissions, respectively.

Heroin was the most frequently reported primary drug of abuse for all racial/ethnic groups. The proportion of Hispanics choosing heroin was the highest among the three groups, at 63 percent. Black heroin users were 62 percent of black admissions, and white heroin users constituted 54 percent of white admissions.

Cocaine was the second most frequent primary drug of abuse mentioned by all three groups, but the highest proportion of cocaine users among the three were blacks. Black cocaine users made up 27 percent of black admissions, whereas among Hispanic admissions 24 percent reported cocaine as their primary drug of abuse, and white cocaine admissions comprised only 19 percent of white admissions.



After cocaine, third and subsequent choices of drugs are not the same across racial/ethnic groups. Whites' third most frequently reported drug is amphetamines, 9 percent, followed by marijuana and other opiates, each about 5 percent of white admissions. Barbiturates and hallucinogens rank next at about 2 percent each for whites. They are followed by PCP, alcohol and tranquilizers, each, for whites,

representing approximately 1 percent of admissions. Use of drugs other than these for whites is under one half of one percent.

Blacks rank marijuana third. Five percent of black admissions reported this drug as their primary drug of abuse. Opiates other than heroin are fourth for blacks, at 2 percent of black admissions. One percent of blacks used barbiturates. All other drugs were chosen by black admissions in less than one half of one percent of the cases.

Hispanics' third choice of drug is also marijauna, 5 percent, but their fourth and fifth choices are barbiturates and PCP at 2 percent for each drug. Amphetamines, opiates other than heroin, hallucinogens, and alcohol each constitute only about 1 percent of Hispanic admissions. All other drugs are negligible for this group, constituting less than one half of one percent of admissions.

To generalize about use of particular drugs by drug abuse treatment admission clients by race and ethnicity in New Jersey, it can be said that the two biggest drugs of abuse constitute the large majority of black and Hispanic admissions, 89 percent and 87 percent respectively for these two groups. When marijuana is added, another 5 percent of each group is accounted for. But for whites, the two major drugs constitute only 73 percent. To account for over 90 percent of white admissions, amphetamines, and opiates other than heroin must be added to the two leading drugs and marijuana. Only 1 drug is mentioned by the same proportion of admissions across all racial/ethnic groups: marijuana is 5 percent of each group's admissions. There is virtually no agreement among all three groups on the rank ordering of drug preference after the two major drugs of abuse.

Other indicators of drug abuse show few dramatic differences among racial and ethnic groups. All have about 57-59 percent using needles, 37-46 percent using less than daily, 67-70 percent with secondary drug use, 13-16 percent beginning use before age 15, 67-76 percent admitted voluntarily, 45-52 percent self-referred, and 55-58 percent reporting no arrests in the 24 months prior to admission. Similar proportions of each group's members are admitted to each modality: 39 percent detox, 10-14 percent methadone maintenance, 35-42 percent drug free outpatient, 7-12 percent drug free residential, 1 percent or less to another. Arrests before treatment average .7 to .9 per client.

Where differences do occur they are confined to very heavy or long term drug use, and prior treatment admissions. Whites had the lowest proportion using 3 or more times per day: 15 percent of white admissions compared to 21 percent for blacks and 29 percent of Hispanics. Whites also had the lowest proportion of first time admissions using for more than 10 years: 15 percent, compared to 21 percent for Hispanics and 28 percent for blacks. But whites had had the most prior treatments, averaging 1.9 compared to 1.2 for Hispanics and 1.5 for blacks. They also had the highest proportion of repeat admissions, 62 percent, versus 54 percent for blacks, and 44 percent for Hispanics. Whites, not surprisingly, had been in treatment more recently than the other groups; they averaged only 45 months since their last discharge, while blacks averaged 53 and Hispanics averaged 60.

In contast to the relative lack of variation among racial/ethnic groups on indicators of drug abuse other than primary drug choice, some indicators of demographic and all indicators of socioeconomic status vary widely. Blacks have a more than 50 percent higher proportion of admissions over age 45 than do the two other groups. Hispanics and whites each only had 14 percent of admissions in this age group while blacks had 22 percent. This is not surprising in view of their relatively higher proportion of long-term drug users. The proportion of females also varied greatly. Hispanics were only 18 percent female, while whites were 29 percent and blacks 35 percent. However, average age varied little. Blacks averaged 30 while Hispanics and whites averaged 28 years.

Whites had the highest employment rate, 54 percent, and highest proportion of admissions who had completed 12 grades, 46 percent. Hispanics had the highest proportion of married clients, 21 percent. Blacks had the highest proportion admitted with health insurance, 45 percent, but most of the difference was due to Medicaid.

There was also a great deal of variation in discharge indicators. Hispanics have the lowest rates of arrest during treatment, 6 percent; the highest proportion discharged with treatment complete and no drug use, 28 percent; and the highest rate of completion of a skill development program, 8 percent, (but this is 4 times that of the other two groups). However, whites stay in treatment longer, 203 days on average, compared to 144 days, and 172 days for Hispanics and blacks respectively.

Total Admissions, Number and Percent, By Race/Ethnicity

	Number	Percent
White	7,458	54
Black	4,510	33
Hispanic	1,748	13

Primary Drug of Abuse, by Race/Ethnicity

	White		Black		Hispanic	
	N	%	N	%	N	%
Heroin	4,063	54	2,801	62	1,100	63
Cocaine	1,437	19	1,227	27	417	24
Marijuana	404	5	243	5	79	5
Amphetamines	634	9	18	-	12	1
Other Opiates	383	5	92	2	21	1
Barbiturates/sedatives	127	2	62	1	41	2
Hallucinogens	127	2	17	-	18	1
PCP	81	1	16	-	30	2
Alcohol	74	1	19	-	19	1
Tranquilizers	93	1	8	-	7	-
Other	34	-	7	-	3	-
	7,457		4,510		1,747	

Drug Abuse Indicators

Percent (except where average is specified)	White	Black	Hispanic
using needles	57	59	58
using less than daily	46	44	37
using 3+ times/day	13	21	29
with secondary drug use	67	70	70
using before age 15	14	13	16
with no prior treatment	38	44	54
first time admissions using more than 10 years	15	28	21
admitted voluntarily	76	71	67
self-referred	52	50	45
admitted to detox	39	39	39
admitted to maintenance	14	14	10
admitted to drug-free, outpatient	40	35	42
admitted to residential drug-freee	7	12	9
admitted to other modality	1	1	-
no arrests 24 months prior to admission	55	58	55
average number prior treatments	1.9	1.5	1.2
average number arrests in 24 mos prior to treatment	.9	.7	.8
average number months since last discharge	45	53	60

Demographic and Socioeconomic Indicators

Demographic (percent except where average is specified)

under age 18	6	5	7
over age 45	14	22	14
male	71	65	82
female	29	35	18
average age	28	30	28

Socioeconomic (percent except where average is specified)

employed	54	32	35
health insurance	42	45	31
married	18	14	21
completed 12 grades	46	38	22
average grade completed	12	11	10

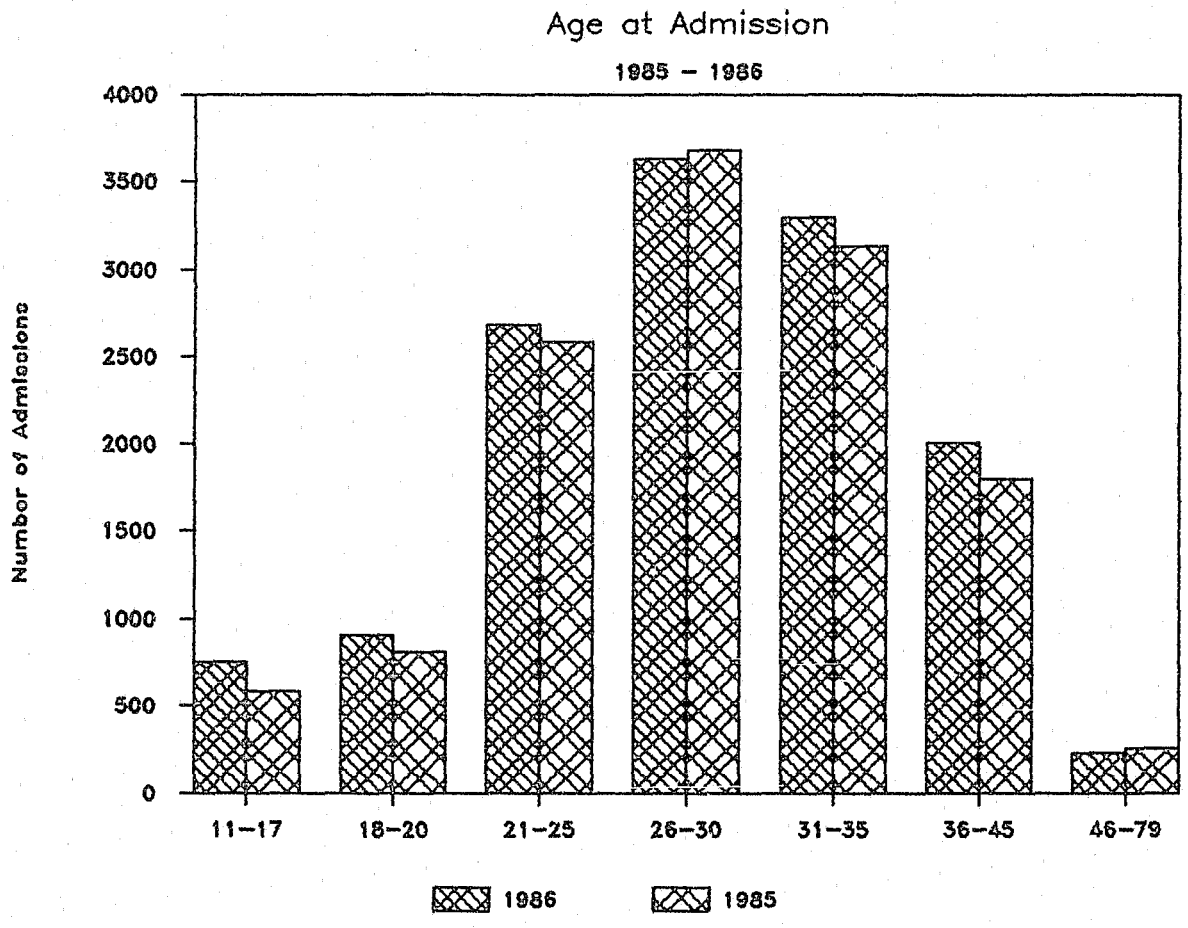
Discharge and Change Indicators

Percent (except where average is specified)

arrested during treatment	7	9	6
discharge treatment complete, no drug use	23	14	28
completed skill development program	2	2	8
unemployed at admission, employed at discharge	7	6	6
average time in treatment, days	203	172	144

WHAT ARE THE AGES OF PEOPLE TREATED FOR DRUG ABUSE?

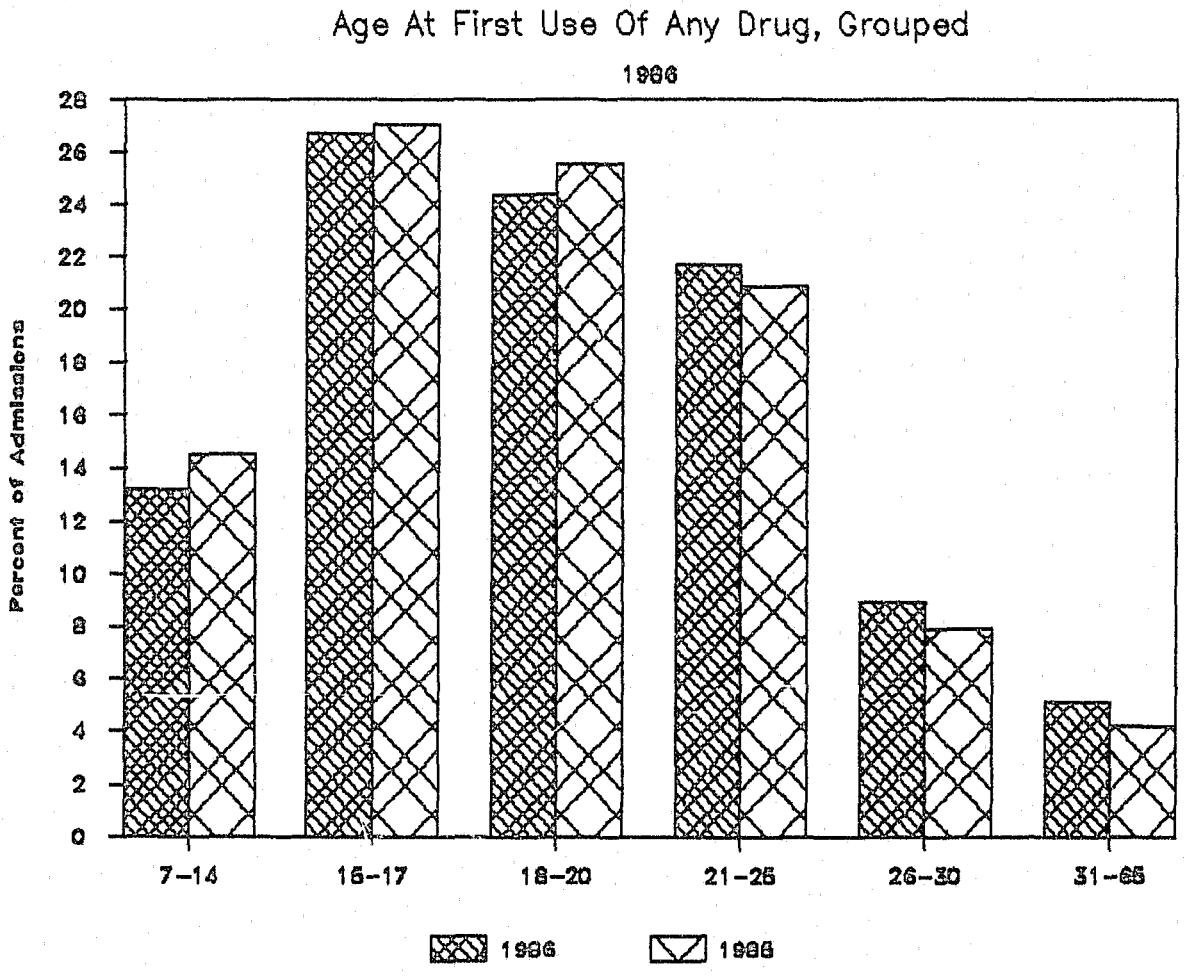
Forty-seven percent of 1986 admissions were between 21 and 30 when they entered treatment. Clients older than 30 accounted for 41 percent of all 1986 admissions; included are 230 clients who were between 46 and 79. At the time of admission, only 12 percent of 1986 clients were under 21 years of age.



In recent years drug use among young people in New Jersey has steadily increased. The percentage of clients who initiate drug use after the age of 25 traditionally has been very low when compared to other age groups represented in New Jersey's treatment system. In the past few years, though, the number of clients who initiated drug use after age 25 has been about 14 percent of New Jersey's treatment admissions. As for young people, many first begin experimenting with drugs before reaching the age of 18. Two out of every five of our clients began using their primary drug of abuse before the age of 18. Due to external social pressures, a lack of recognition of their drug problem, or lack of treatment availability, many young people who should be in treatment are not. Treatment data indicate that most early teenage drug users continue to use drugs until early adulthood before treatment is seriously considered.

Considering age groups in different drug categories, primary marijuana and hallucinogen clients had the highest rate of adolescent users, (between ages 11 and

17) entering treatment. Adolescent users comprised 43 percent of each drug group's admissions in 1986. Of those entering treatment for heroin and other opiates, about 22 percent were age 36 and older. However, tranquilizer admissions recorded the highest rate of clients entering treatment age 36 and older--those clients represented 25 percent of primary tranquilizer admissions in 1986.



IN WHAT AREAS OF THE STATE ARE DRUGS USED MOST?

The four northeast counties, Bergen, Essex, Hudson, and Union, contributed one-half of drug treatment program admissions in 1986. Part of the reason for this is the fact that these counties have a large proportion (37%) of the State's population. But this is not the only reason, since these counties contribute more than a proportionate share of drug treatment admissions. A possible additional reason is that these areas also have the highest concentrations of those segments of the population who are known to abuse specific drugs, such as middle and upper-middle class males in high-stress work situations, who abuse cocaine, and lower-class males, particularly minority males, who abuse heroin and/or cocaine. An additional factor is very likely the availability of large volumes of drugs at wholesale prices in the known distribution areas in and around New York City.

The southwestern counties of Burlington, Camden, Gloucester and Mercer, which comprise 19 percent of New Jersey residents, are also within a less than 30-minute car ride to another large drug market, Philadelphia. Admissions from these counties represented 17 percent of New Jersey's admissions in 1986 and accounted for 57 percent of all primary amphetamine clients.

WHAT ARE THE SOURCES OF REFERRALS INTO THE TREATMENT SYSTEM?

Voluntary

Approximately 74.0 percent (9,933 admissions) of New Jersey clients entered treatment on their own in 1986. Nearly 70 percent of these voluntary admissions were self referred. Concerned family members and friends referred another 13 percent or 1,300 of the clients who entered treatment for drug abuse problems. Oftentimes, it is those individuals who are close to drug users who first recognize the need for the user to seek professional help for their problem and urge them into a treatment facility. Community service and mental health agencies can quickly and correctly diagnose a social and/or mental health problem of an individual as having origins in illicit drug use. For example, a cocaine user having problems in meeting his legal financial obligations or a PCP user experiencing acute psychosis is more likely to have these problems as a consequence of drug use. In 1986, 11 percent of voluntary admissions, or over 1,000 clients, had accepted recommendations from professionals in community service and mental health agencies to enter New Jersey's treatment programs. Medical hospitals, where many drug users may during or after a traumatic drug experience, referred another 4 percent of volunteer admissions, or over 350 clients, to treatment in 1986.

While current concerns regarding drug use in the school and work place are of high priority to parents and employers, those users who were referred to treatment by either school or employer accounted for only 1 percent of voluntary admissions or 119 drug users who entered treatment programs in 1986.

Involuntary

In 1981, the rate of involuntary admissions was 15 percent. The next few years showed a steady increase in the rate of clients being lawfully compelled to enter a program for treatment. In 1986, 27 percent of all admissions (3,620 clients) were ordered to receive treatment in New Jersey's clinics through federal, State, and local criminal justice agencies. A primary reason that many of these individuals came into contact with the law was the illegal use or possession of drugs. Parole and probation agencies throughout the State compelled over 2,845 users, or 21 percent of all admissions, to enter treatment for help with their drug problem. New Jersey's Treatment Alternatives to Street Crime programs (TASC) referred over 283 clients to treatment. These accounted for 2.1 percent of all Statewide admissions.

CLIENT'S PRIMARY DRUG USE BY COUNTY OF RESIDENCE -- 1986
(Including Out-of-State Clients)

COUNTY OF RESIDENCE	HEROIN		OTH. OPIATE		COCAINE		CRACK		AMPHET.		MARIJUANA		PCP		BARBS.		TRANQ.		HALLUCIN.		COUNTY TOTAL	
Atlantic	419	77.4%	12	2.2%	56	10.4%	10	1.8%	25	4.6%	16	3.0%	0	0.0%	0	0.0%	2	0.4%	1	0.2%	541	4.0%
Bergen	1036	64.3%	73	4.5%	207	12.8%	231	14.3%	4	0.2%	23	1.4%	13	0.8%	5	0.3%	13	0.8%	7	0.4%	1612	11.9%
Burlington	179	65.8%	8	2.9%	23	8.5%	12	4.4%	42	15.4%	7	2.6%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	272	2.0%
Camden	313	44.3%	31	4.4%	99	14.0%	46	6.5%	152	21.5%	40	5.7%	0	0.0%	19	2.7%	5	0.7%	1	0.1%	706	5.2%
Cape May	49	46.7%	4	3.8%	26	24.8%	4	3.8%	20	19.0%	0	0.0%	0	0.0%	1	1.0%	0	0.0%	1	1.0%	105	0.8%
Cumberland	47	62.7%	3	4.0%	12	16.0%	1	1.3%	9	12.0%	1	1.3%	0	0.0%	2	2.7%	0	0.0%	0	0.0%	75	0.6%
Essex	1393	58.9%	175	7.4%	353	14.9%	172	7.3%	15	0.6%	107	4.5%	2	0.1%	119	5.0%	13	0.5%	16	0.7%	2365	17.4%
Gloucester	99	27.1%	14	3.8%	37	10.1%	18	4.9%	151	41.4%	17	4.7%	2	0.5%	8	2.2%	15	4.1%	4	1.1%	365	2.7%
Hudson	1448	67.5%	53	2.5%	212	9.9%	117	5.5%	5	0.2%	205	9.6%	69	3.2%	12	0.6%	14	0.7%	9	0.4%	2144	15.8%
Hunterdon	9	10.0%	4	4.4%	17	18.9%	1	1.1%	22	24.4%	32	35.6%	1	1.1%	1	1.1%	0	0.0%	3	3.3%	90	0.7%
Mercer	633	63.9%	5	0.5%	53	5.3%	181	18.3%	31	3.1%	57	5.8%	13	1.3%	6	0.6%	4	0.4%	8	0.8%	991	7.3%
Middlesex	252	36.5%	23	3.3%	230	33.3%	20	2.9%	63	9.1%	45	6.5%	7	1.0%	12	1.7%	11	1.6%	27	3.9%	690	5.1%
Monmouth	490	60.1%	17	2.1%	159	19.5%	21	2.6%	27	3.3%	29	3.6%	1	0.1%	7	0.9%	13	1.6%	51	6.3%	815	6.0%
Morris	107	61.5%	7	4.0%	29	16.7%	10	5.7%	0	0.0%	16	9.2%	0	0.0%	1	0.6%	0	0.0%	4	2.3%	174	1.3%
Ocean	136	49.8%	14	5.1%	77	28.2%	7	2.6%	22	8.1%	12	4.4%	0	0.0%	2	0.7%	1	0.4%	2	0.7%	273	2.0%
Passaic	815	66.2%	13	1.1%	194	15.8%	101	8.2%	4	0.3%	52	4.2%	19	1.5%	11	0.9%	5	0.4%	17	1.4%	1231	9.1%
Salem	25	55.6%	1	2.2%	3	6.7%	5	11.1%	9	20.0%	0	0.0%	0	0.0%	0	0.0%	2	4.4%	0	0.0%	45	0.3%
Somerset	82	25.3%	5	1.5%	156	48.1%	4	1.2%	40	12.3%	25	7.7%	0	0.0%	3	0.9%	4	1.2%	5	1.5%	324	2.4%
Sussex	8	47.1%	0	0.0%	5	29.4%	1	5.9%	0	0.0%	2	11.8%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	17	0.1%
Union	290	59.9%	22	4.5%	95	19.6%	35	7.2%	3	0.6%	9	1.9%	0	0.0%	21	4.3%	2	0.4%	7	1.4%	484	3.6%
Warren	6	10.2%	2	3.4%	18	30.5%	1	1.7%	14	23.7%	15	25.4%	0	0.0%	1	1.7%	1	1.7%	1	1.7%	59	0.4%
Other States	141	71.6%	11	5.6%	14	7.1%	11	5.6%	6	3.0%	12	6.1%	0	0.0%	0	0.0%	1	0.5%	1	0.5%	197	1.5%
DRUG TOTAL	7977	58.8%	497	3.7%	2075	15.3%	1009	7.4%	664	4.9%	722	5.3%	127	0.9%	231	1.7%	108	0.8%	165	1.2%	13575	100.0%

NOTE: Crack is separated from cocaine for identification purposes.

HOW LONG DO PEOPLE USE DRUGS BEFORE ENTERING TREATMENT?

Admission data indicate that 43 percent of the 13,760 persons admitted to treatment were never in a treatment program previously. Of those new clients almost 22 percent sought treatment within 12 months of their first use of their primary drug. Nearly three out of every ten new clients used drugs for 2 to 4 years before seeking treatment. Thus slightly over one-half of all new drug clients had entered a New Jersey treatment program within 4 years of their first "try." Eighteen percent of New Jersey's drug treatment clients continued use of their primary drug between 5 and 7 years before entering a treatment program. The highest rate of new users was recorded for clients who did not enter treatment until after 8 years of use. Over 1,730 clients (30 percent of new admissions) did not enter treatment at all during a period of 8 years of drug use:

Time Lag Between First Use and Entry into Treatment

1 year	22%
2-4 years	30%
5-7 years	18%
8+ years	30%
	100%

HOW LONG DO PEOPLE STAY IN TREATMENT?

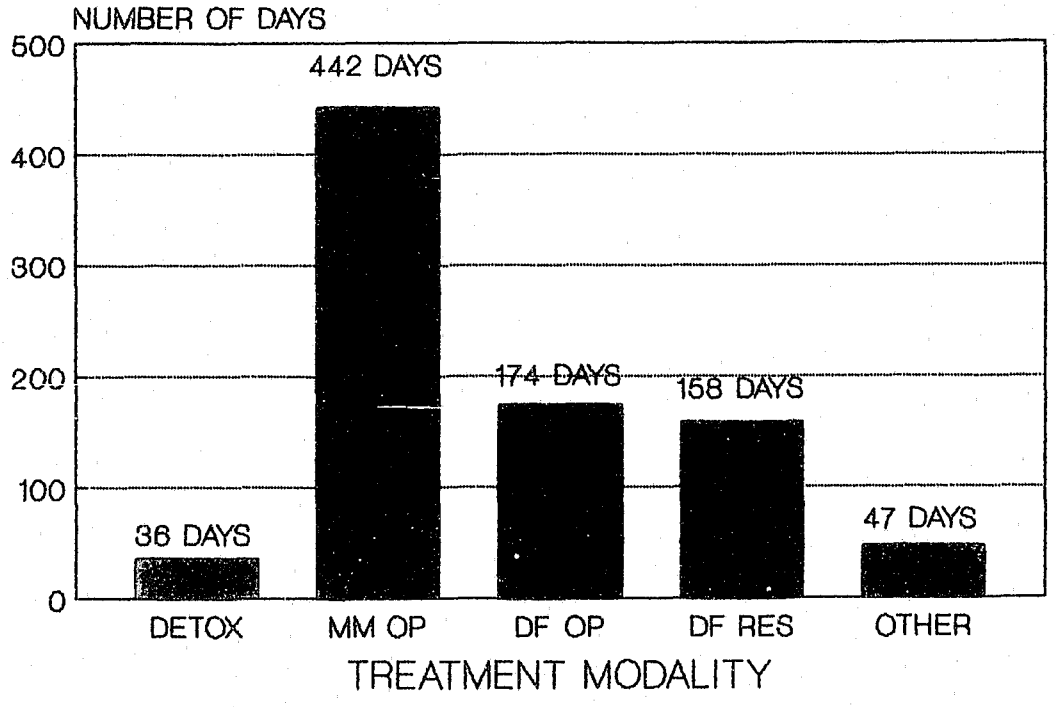
Length of stay in treatment varies by modality. In 1986, the average time spent in treatment by patients admitted to a detox program was 36 days. For those admitted to outpatient methadone maintenance it was 442 days, while outpatient and residential aftercare admissions remained 174 and 168 days respectively. Those admitted to the "other" modality remained, on average, 47 days.

Clients leaving one modality, however, may not necessarily end their treatment episode. Frequently clients entering one treatment modality may require referral to different treatment settings after completing their initial programs. The particular drug abused and severity of abuse determine the need for subsequent referral. For example, heroin may require treatment first in a methadone maintenance modality. However, once discharged from methadone maintenance the client may elect to receive followup treatment as an outpatient in drug-free care. At other times a client may enter treatment with more than one drug problem in need of treatment. While a detox program is suitable for a primary opiate abuse problem and would probably initiate a treatment sequence for a client whose polydrug use included opiate addiction, another treatment modality would be more suitable to treat non-opiate secondary or tertiary drug problems.

DO MANY PEOPLE COMPLETE THEIR TREATMENT PROGRAMS?

In 1986, 12,861 clients were discharged from New Jersey's drug treatment programs. Of those who were discharged over the year, 2,773 users, or 22 percent of all discharges, had completed their recommended treatment plan.

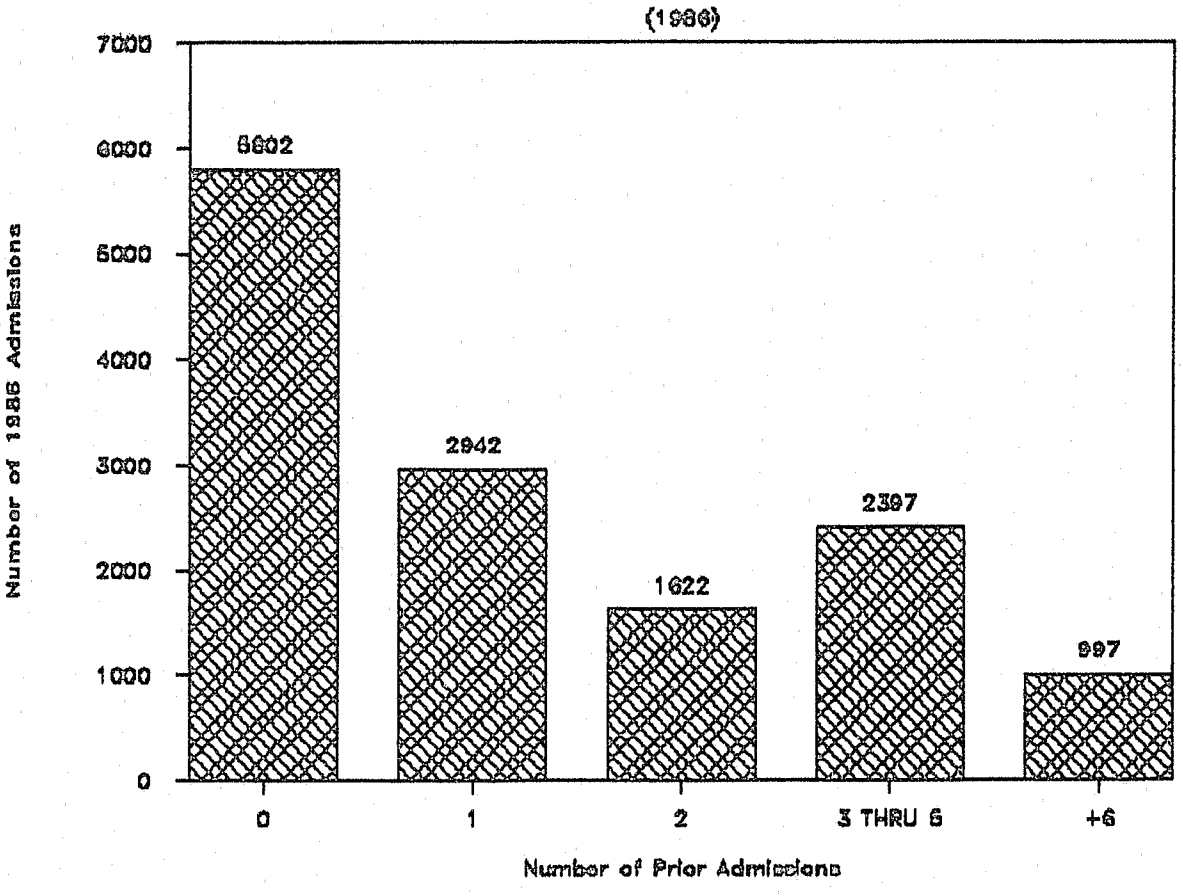
AVERAGE TIME IN TREATMENT AT DISCHARGE (1986)



The percentage of persons completing treatment programs is not impressively large--dependence on drugs is not easy to overcome. It should be kept in mind, though, 57 percent of all persons admitted have participated previously in treatment. While many clients may not complete their first treatment program, they may be more successful in subsequent treatment experiences. Furthermore, followup studies have shown that even clients who did not complete treatment showed signs of improvement over their pretreatment drug abuse activity.

DO MANY PEOPLE RETURN TO DRUG ABUSE TREATMENT PROGRAMS?

Oftentimes, because of users' immediate living environments, pressure from their peers, or just their desire to continue use after a period of 'rest,' abstention from drug use, even after completion of a treatment plan, is not successful the first time. For example, heroin clients have very high rates of prior admissions. Due to the highly reinforcing properties of opiates (including heroin) many heroin and other opiate clients are readmitted many times. Other drugs, for example, cocaine and tranquilizers, may produce lesser physiological addiction, but show evidence of producing greater psychological compulsion for continued abuse. These drugs exhibit the same consequences of relapse following treatment.



Repeat admissions occur among all drug categories but are most common among the opiate (including heroin) users. Over three-fourths of heroin admissions had been in treatment before. Sixty-nine percent of those who used other opiates were treated for drug abuse prior to their index admission in 1986. One-half of primary heroin readmissions had three or more previous treatment episodes. Repeat admissions were least common for persons with marijuana problems. Seventy-seven percent of marijuana users had no previous treatment. However, one-quarter of marijuana's readmission population had received treatment at least two times prior. Seventy-one percent of cocaine admissions had no previous treatment. This may be because it is only fairly recently that cocaine has been perceived as a dangerous drug.

Percent of Admissions Who Had Received Previous Treatment, By Primary Drug at Admission

Heroin	75
Other Opiates	69
Tranquilizers	53
Barbiturates	43
Hallucinogens	40
Other	35
Amphetamines	33
PCP	32
Cocaine	29
Alcohol	26
Marijuana	23

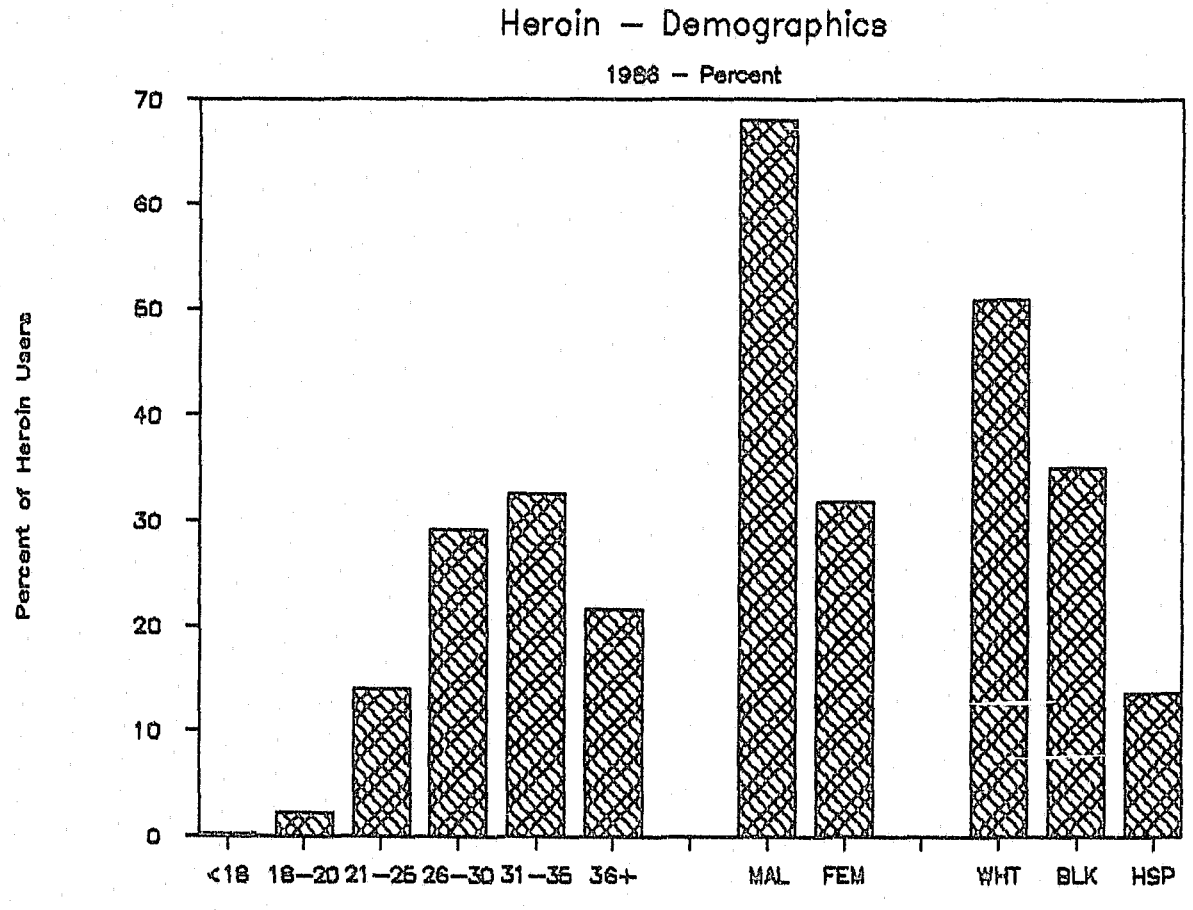
HEROIN AND OTHER OPIATES

Heroin

New Jersey clinics experienced a slight decrease in admissions among heroin users in 1986. The 7,986 heroin admissions in 1986 were 104 fewer than the previous year. However, the proportion of heroin users entering treatment for the first time increased to represent 25 percent of all primary heroin admissions. One-half of heroin admissions who had received treatment previously had been in treatment three times or more.

The total number and percent of heroin users going into a detox treatment modality increased by 4 percent to represent 61 percent of admissions. On the other hand, there was a 4 percent decline in admissions to methadone maintenance to 22 percent of primary heroin users entering treatment.

Sixty-two percent of heroin admissions were between the ages of 26 and 35. The average age of the heroin user entering treatment was 31.3 years. Juvenile admissions (between ages 11 and 17) accounted for 22 users or only three-tenths of a percent of admissions. Adults aged between 46 and 79 years accounted for 163 (2%) of the heroin admissions.



The majority (54%) of heroin users began use between 15 and 20 years of age. Heroin users who began using the drug between the ages of 7 and 15 accounted for 12 percent of heroin admissions. Initial use of the drug began for 27 percent of the heroin admissions while they were in the age group 15 through 17. Another 27 percent began between the ages of 18 and 20. An additional 23 percent initiated heroin use between the ages of 21 and 26.

Treatment data over the years indicate that more heroin users are entering treatment earlier in their drug careers. Of the total new heroin admissions, one-half used the drug for 8 years or more before entering a treatment program in 1986. Thirteen percent of the new clients sought treatment within their first year of use.

Heroin users who administered the drug through inhalation (snorting) accounted for 9 percent, or 727 users. Snorting heroin increased by 3 percent (or 252 users) over the previous year. Intravenous heroin use has declined from 95 percent of heroin admissions in 1984 to 90 percent in 1986.

Ninety percent of heroin admissions reported using the drug at least once a day. Forty-seven percent used 2-3 times per day and 29 percent used more than 3 times a day.

Sixty-three percent of admissions indicated use of a secondary drug at the time of admission. Of those heroin clients who indicated poly-drug use, 73 percent cited cocaine as their secondary problem. (The most frequent of all 1986 polydrug use patterns was that of heroin primary and cocaine secondary.)

Of all drug categories, heroin users indicated the highest rate of voluntary entry into treatment (89%). Sixty-eight percent of primary heroin admissions entered treatment on their own, as self referrals. Referrals from voluntary agencies and groups such as hospitals, community service and mental health facilities, family, friends, employers and schools comprised 21 percent of admissions.

Probation, parole and other criminal justice agencies referred 11 percent of heroin admissions.

While 22 percent of the heroin admissions reported one arrest in the 2 years prior to admission, 64 percent entered treatment without any prior arrest in the same time period. These low arrest rates and high voluntary admission rates are explained more by the criminal justice system's rate of referral of arrested heroin users to treatment than by the criminal behavior and self-motivation of addicts.

Half of all heroin admissions were white.

Male heroin admissions outnumbered female admissions 2 to 1.

Heroin users with less than a high school education comprised 41 percent of all heroin admissions in 1986. A slightly greater percentage, or 42 percent, completed high school, while an additional 3 percent had completed a college level of education.

At the time of admissions, 42 percent were employed full or part-time.

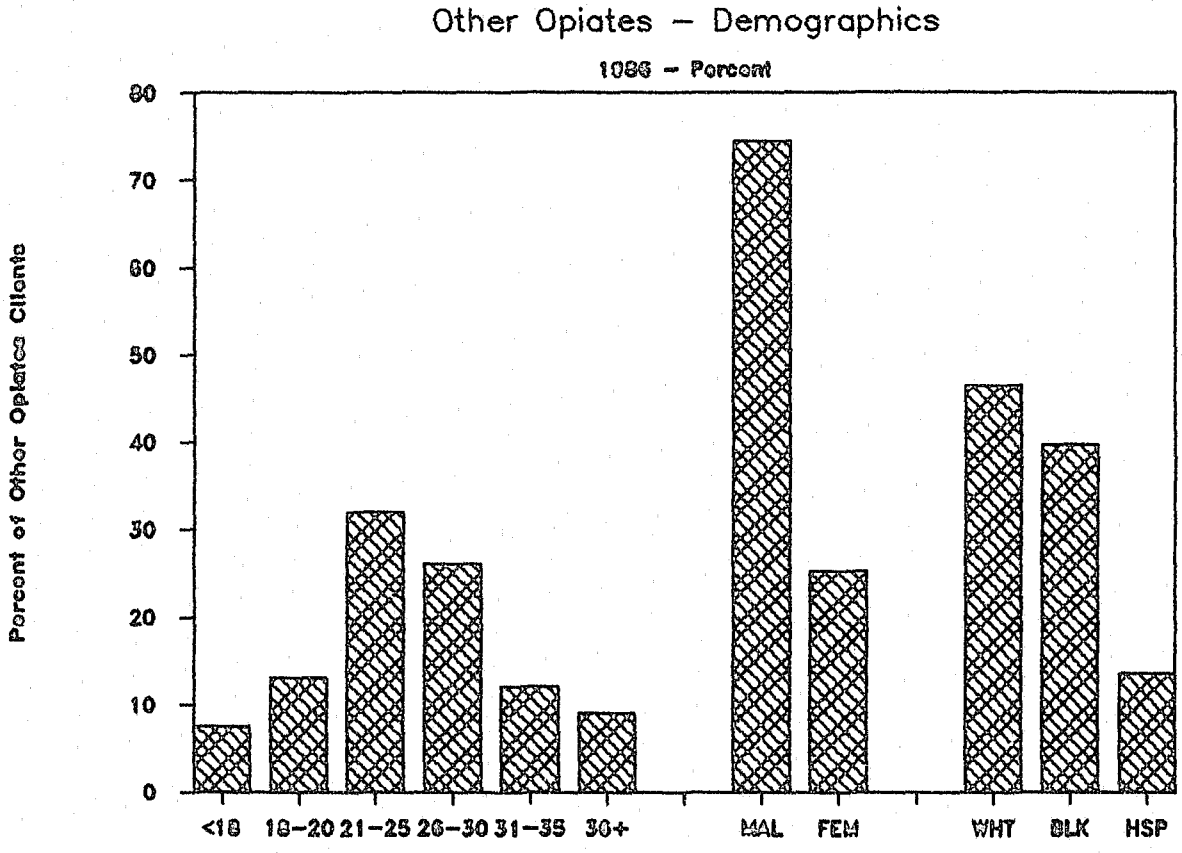
While one-fourth of the users were divorced or separated at the time of admissions, 54 percent were never married. Married heroin clients represented 20 percent of primary heroin admissions.

Other Opiates

Users of opiates other than heroin comprised 4 percent of drug treatment admissions in 1986. The 497 opiate users who entered treatment were admitted to all four major treatment modalities. The drug-free outpatient modality admitted 182 users, or 37 percent of primary opiate admissions. Opiate clients who required detoxification comprised 37 percent of admissions while the maintenance modality admitted 21 percent. The remaining 5 percent of admissions entered drug-free residential care.

Whites comprised 77 percent of all primary opiate admissions.

Sixty-four percent of opiates admissions were male.



The average age of admissions for opiate admissions in 1986 was 30. Admission rates among juveniles (ages 11 through 17) and young adults (aged 18 through 20) accounted for 2 percent and 4 percent of opiate admissions respectively. Only 2 percent of opiate admissions were over 45. Ninety-six percent of opiate admissions were between the ages of 21 and 45.

Sixty-nine percent (or 341) of primary opiate admissions had received drug treatment previously. One-third of prior admissions had been in treatment only one other time, one-fourth had had two prior treatment experiences, another 37 percent had been treated for drug abuse 3 to 5 times previously.

Of the opiate users who were entering treatment for the first time, 17 percent sought treatment within the first year of use. Forty-four percent of the first-time opiate admissions used their primary drug of abuse 2 to 4 years before seeking professional treatment. Twenty-eight percent of new admissions entered treatment after 5 to 10 years of opiate use, while another 10 percent continued to use drugs for more than 10 years before receiving treatment for the first time.

Among all drug categories, opiate users continue to show the lowest number of users initiating use of their primary drug between the ages 7 and 15. Those who first used the drug before they were 15 accounted for 4 percent of primary opiate admissions.

Because of their high potential for physiological dependence and relatively short duration of action, opiates tend to be used frequently. Two out of every three admissions used opiates daily before entering treatment. The various types of opiates were taken orally by 87 percent of the clients, while 11 percent took the drugs intravenously. Ten of the opiate admissions entered treatment for inhaling the drug.

Seven out of every ten opiate users were admitted to treatment with polydrug problems. The use of various secondary drugs scaled a wide range for opiate users. Heroin use among primary opiate users accounted for 16 percent of the clients with polydrug problems. Barbiturates and cocaine each comprised 14 percent, while other sedatives accounted for another 21 percent. Alcohol and tranquilizers represented 14 percent and 11 percent respectively.

Seventy-eight percent of opiate admissions entered treatment voluntarily. Of the 379 primary opiate clients who entered voluntarily, 68 percent sought treatment directly on their own. Family and friends of opiate users referred 9 percent (or 45 users) to treatment. Involuntary admissions accounted for 116 users or 23 percent of all primary opiate admissions.

After tranquilizer and heroin users, opiate users at the time of entering treatment, had the lowest arrest rate among all drug categories. Of those opiate users entering treatment in 1986, 60 percent stated they had not been arrested in the prior 24 months.

Considering educational status in 1986, opiate admissions had the highest rate among the drug categories of users entering treatment with high school and higher levels of education. Forty-three percent had completed high school and an

additional 23 percent had received various levels of college training. Other socioeconomic characteristics indicate that 47 percent of the opiate admissions were employed. Those opiate clients who were married at the time of admission represented 26 percent--the highest rate of married clients among the drug categories. One-fifth of opiate admissions were either divorced or separated at the time of admission.

COCAINE AND CRACK

Cocaine

New Jersey's treatment system admitted 3,092 drug users in 1986 whose primary problem was cocaine use. This is twice as many as were admitted for primary cocaine abuse in 1984. Cocaine users, as a proportion of all drug users admitted to treatment are now 1.6 times their 1984 proportion.

White males comprised 36 percent of primary cocaine admissions while white females represented 10 percent. Black males and females comprised 28 percent and 13 percent respectively. Hispanic males and females comprised 12 percent and 2 percent respectively, of primary cocaine admissions in 1986.

Drug-free outpatient treatment programs admitted 73 percent of the 3,092 cocaine users. Eighteen percent were treated in drug-free residential care while another 7 percent (208 users) required detox treatment.

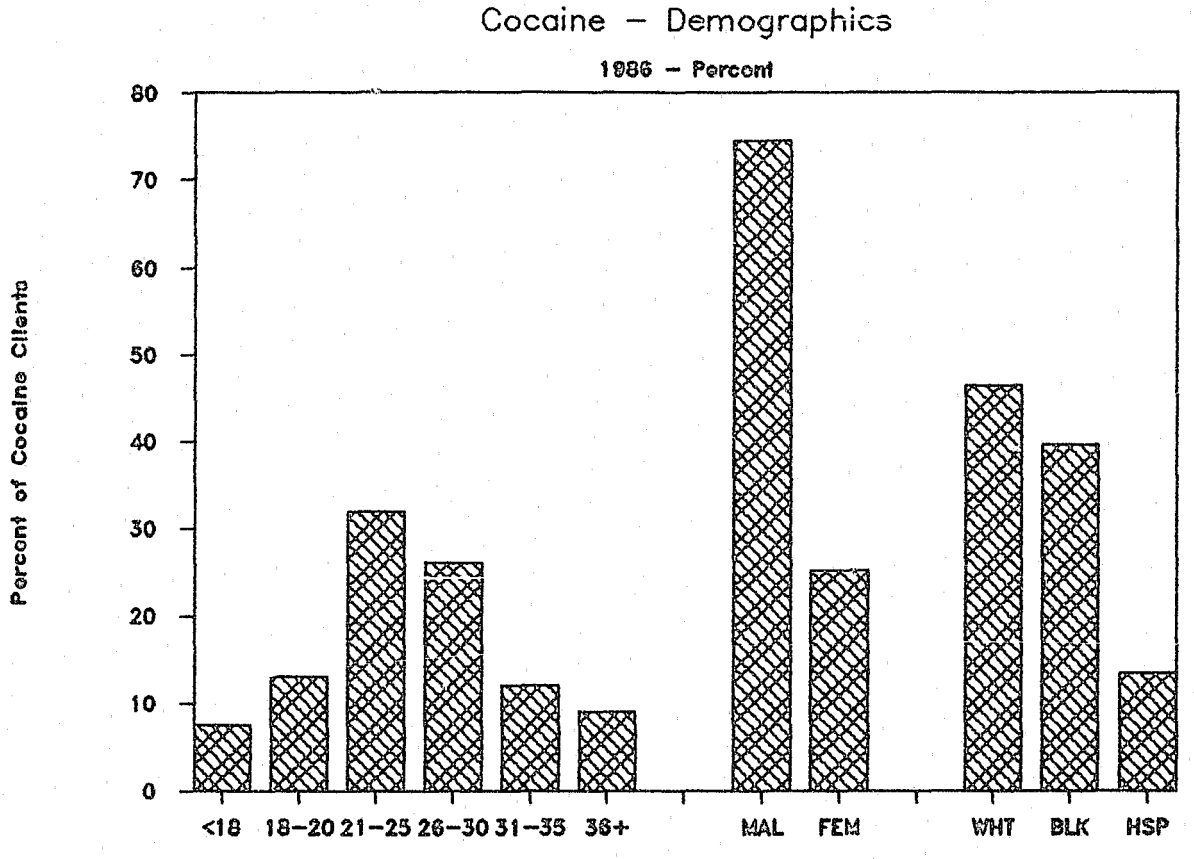
Of the 1986 cocaine admissions, 29 percent were returning for repeated treatment. Of the 2,187 who had no prior treatment history, 30 percent had used the drug for one year or less before seeking treatment. An additional 35 percent used the drug for 2 to 4 years before seeking treatment for cocaine abuse. Cocaine users tend to enter treatment earlier in their drug abuse careers than do users of other drugs.

Nearly 30 percent of primary cocaine admissions began use of the drug between the ages of 7 and 17; this includes 8 percent who had used the drug before age 15. One-half of all primary cocaine admissions indicated that they began use of the drug between the ages of 18 and 25. The years after age 25 showed a declining rate of initiation of cocaine use. Twelve percent began cocaine use during the ages between 26 and 30, while 9 percent initated use after age 30. The average age at first use was 21.3.

Juvenile admissions accounted for 246 users, or 8 percent of primary cocaine admissions. Admissions of clients over the age of 45 comprised 33 users, or 2 percent of primary cocaine admissions. The average age of primary cocaine admissions was 26.

Of the three most popular forms for administering cocaine, the most popular continues to be snorting. Snorting, or nasal inhalation of the powdered substance, accounted for 54 percent of cocaine admissions. This is a 10 percent decline from the previous year. For the first time, smoking cocaine has replaced intravenous use as the second most popular method of using the drug. Smoking cocaine or

"crack" has been steadily increasing over the years. In 1983, 3 percent of cocaine admissions were in treatment for smoking the drug. In 1986, one out of every three primary cocaine admissions or 1,016 users entered treatment for smoking cocaine. (A more detailed description of crack users is presented in the next section.) Injecting cocaine as a primary route of administration has declined across years among treatment admissions. Last year's notable and new observation concerning an oral route of administration for cocaine was found to continue this year, but at a lower rate. Taking cocaine by swallowing the drug in its hydrochloride (powder) form accounted for 18 treatment admissions in 1986.



Nearly three out of every four cocaine users were admitted with multiple drug problems requiring treatment. Forty-eight percent of polydrug users in treatment for primary cocaine abuse used marijuana as a perferred secondary drug. Another 22 percent entered treatment with alcohol as the secondary drug or abuse. Heroin and amphetamine use among primary cocaine users with poly-addictions accounted for 12 percent and 6 percent respectively, totaling 427 clients. The use of PCP and tranquilizers among cocaine users represented 71 and 39 clients respectively.

In 1986, 872 users, or 54 percent of cocaine admissions sought treatment voluntarily. Overall voluntary admissions increased from the previous by a total of 6 percent. Involuntary admissions, which include referrals from the judicial system, accounted for 46 percent of admissions.

Forty-seven percent of cocaine admissions reported no arrests in the 2 years prior to admission. Fifty-three percent (a decline of 10% from the previous year) of cocaine admissions reported at least one arrest in the past 2 years. And 19 percent of admissions were arrested two or more times in the past 2 years.

The educational status of cocaine users entering treatment has not changed much for the past four years. Cocaine users with a high school or a higher level of education represented 59 percent of cocaine admissions. There were 100 users who had achieved post-graduate levels of education and an additional 428 users had obtained up to 3 years of post high school education before entering treatment. Cocaine users showed a slight decline in employment levels. Although they have traditionally been the most highly employed of drug users, in 1986, the proportion of cocaine users who were employed at the time of admission declined 4 percent over last year. Users married at admission comprised of 14 percent of cocaine users. Cocaine users whose marital status was single represented 71 percent.

Crack

In recent years the smoking of cocaine, as crack, has become a very popular method of administering the drug. The surge in the number of clients entering treatment for this type of cocaine abuse in 1986 and the attention and publicity of the drug occasions a separate section for crack.

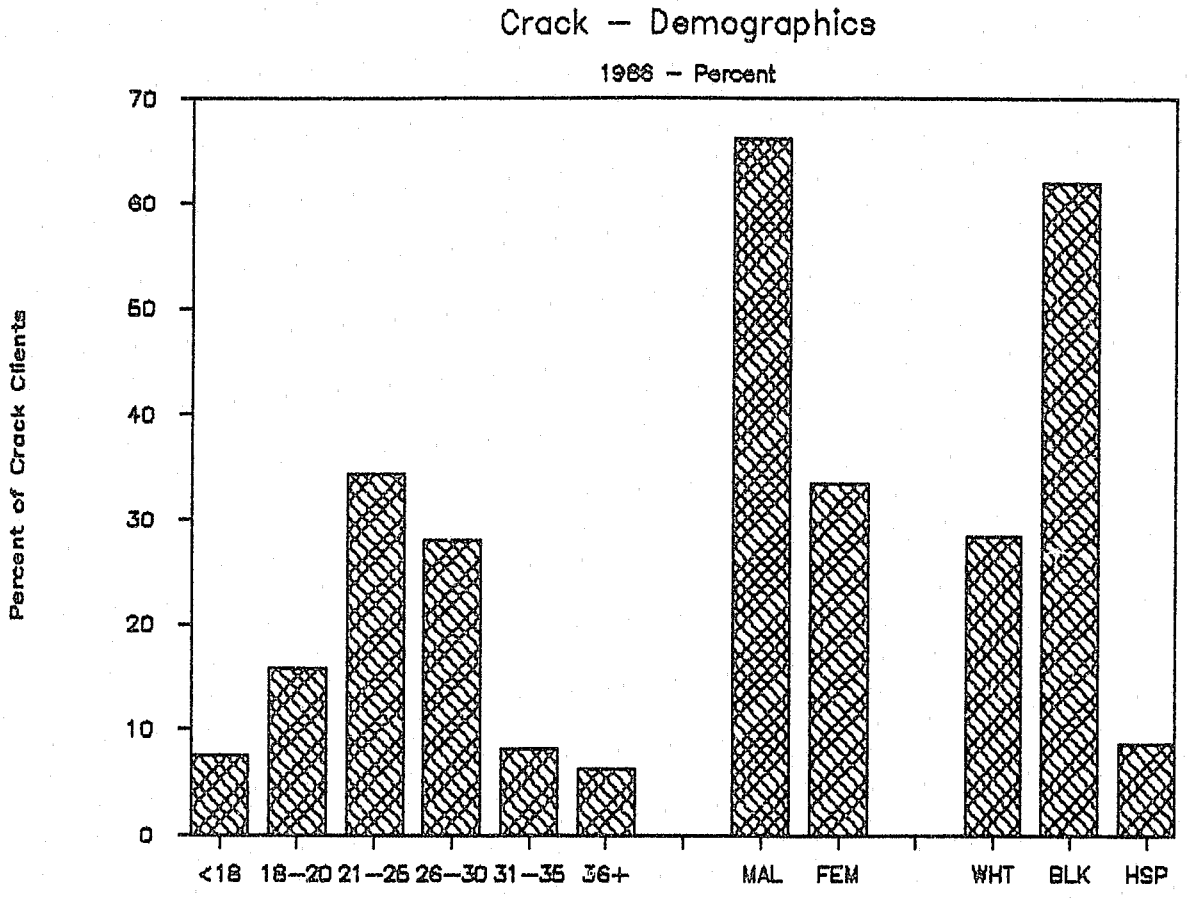
In 1986, 1,019 cocaine users were admitted to treatment for smoking crack. Crack users, as a proportion of cocaine admissions, increased 20 percent from 1985 to represent one-third of all cocaine admissions in 1986. The rate of growth in the proportion of cocaine users smoking crack has been extremely high over the past 3 years. From 1983 to 1984 it more than doubled. Between 1984 and 1985 it nearly doubled again. But in 1986 the rate was 2½ times that of 1985. If considered a separate drug category, crack admissions would show the greatest increase of all drugs in 1986.

Fifty-seven percent of crack users were admitted to a drug-free outpatient facility. Another 24 percent required drug-free residential care, while 15 percent of crack admissions were admitted to a detoxification program.

Seven out of every ten crack users who entered treatment in 1986 were doing so for the first time. Of those clients who were entering treatment for the first time, 43 percent had used crack for less than a year. Compared to other drug categories a higher rate of crack users entered treatment within their initial year of use. In the case of crack, this can be interpreted as indicative of the drug's debilitating effects as well as negative monetary and social consequences. Within three to four years after the first usuage of the drug, nearly three-quarters of 1986's primary crack admissions (73.4%) have sought treatment.

Considering the racial composition of crack clients, blacks comprised 62 percent while whites comprised 29 percent and Hispanics 9 percent.

Eight percent of crack admissions were under the age of 18. Eighty-six percent were between 18 and 36. Only 6 percent were over 36. The average age of the crack admission was 25.



Female admissions displayed a higher frequency of use of crack prior to admission than males. Fifty-five percent of the female crack admissions used the drug on a daily basis. Males using the drug daily accounted for 41 percent of male crack admissions.

Of the primary crack users who entered treatment in 1986, 65 percent indicated use of a second drug at the time of admission. Secondary marijuana use accounted for 53 percent of the 658 poly-drug crack users. The use of alcohol by primary crack users accounted for an additional 20 percent. Twenty-seven users or 4 percent, administered their secondary drug intravenously.

Voluntary admissions accounted for 73 percent of primary crack admissions. The rate of crack users who voluntarily entered into treatment was relatively high when compared to the other major drug categories. Only users entering treatment for opiate use had a higher rate of self referral. Forty-three percent of crack admissions sought treatment directly on their own. Family and friends of crack users helped refer 113 clients (11%). Hospital referrals, particularly among black females, were higher among crack users than other drug users. Twenty-seven percent of crack admissions involuntarily admitted to treatment

Forty-five percent of all crack admissions reported having been arrested at least once within the two year period prior to admission.

Considering other socio-economic factors of the crack abusers entering treatment, three-fourths were single, 12 percent were married and an additional 12 percent were divorced or separated. Educationally, 57 percent of primary crack admissions had finished high school. Fifty-six percent of admissions had no health insurance coverage.

Of the 1986 crack admissions, 766 were discharged from treatment within the year. Of those discharged, 13 percent completed treatment with no drug use at the time of discharge. On the other hand, crack users had the highest rate of clients voluntarily leaving treatment before completion. Fifty-three percent left treatment against advice while an additional 14 percent of crack admission were discharged because of noncompliance.

MARIJUANA

New Jersey clinics in 1986 experienced increases in drug users seeking treatment for marijuana use. In 1984, 362 or 3 percent of all drug admissions entered treatment for marijuana abuse. The following year (1985) the number of primary marijuana users admitted to treatment almost doubled to 617, representing 5 percent of all drug admissions. In 1986, 731 drug users entered treatment for marijuana abuse.

The increase in marijuana users is reflective in the admissions level of users from the age group 11 through 17. In 1985, this group comprised 30 percent (or 183 users) of marijuana admissions. Admissions data from 1986 showed that this group of juveniles increased 17 percent to comprise 43 percent or 312 users. The average age of marijuana admissions declined from 22 in 1985 to 21 in 1986.

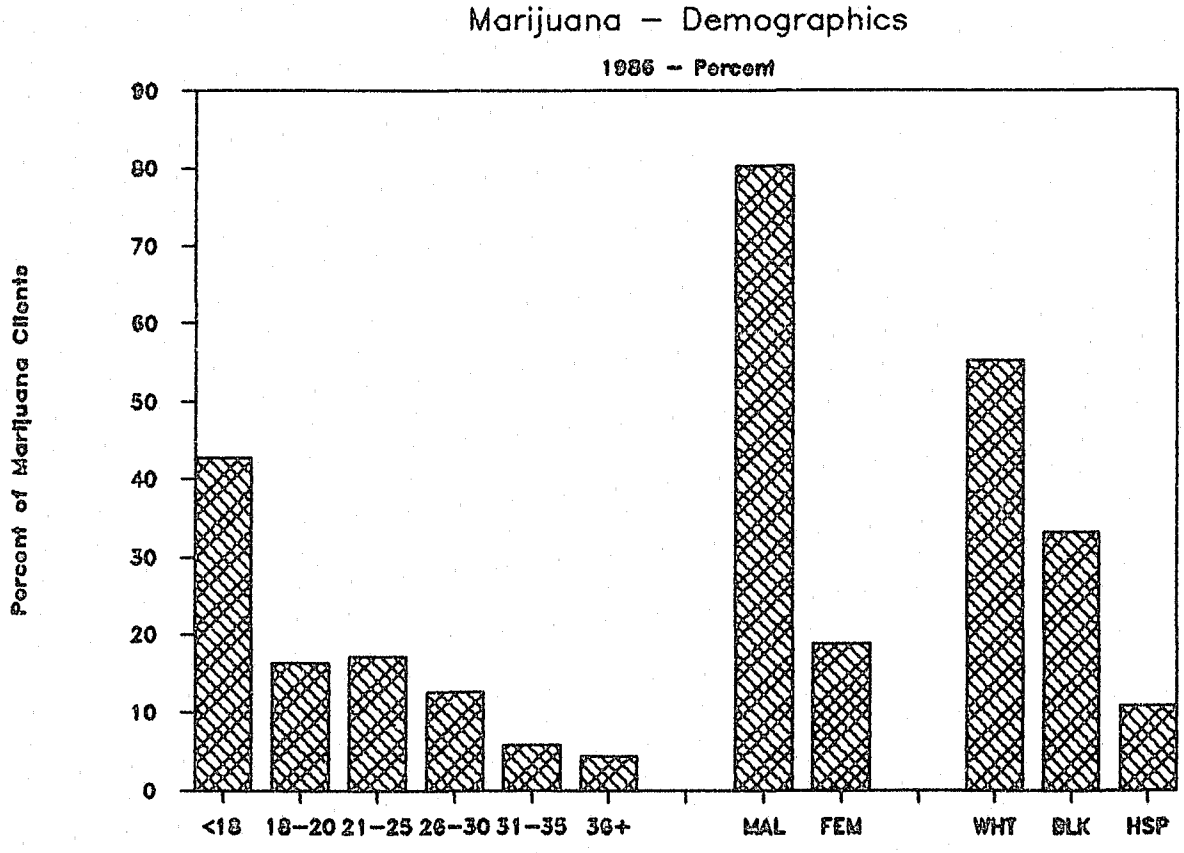
Ninety-nine percent of primary marijuana users were treated in a drug-free modality; ninety-seven percent of these, as outpatients.

Repeat marijuana admissions reflected a decline of 4 percent from 1985 to 23 percent in 1986. Of the 731 marijuana users who were admitted, 565 or 77 percent were entering treatment for the first time.

In 1984, the proportion of admissions who initiated marijuana use between the ages 7 and 14 was slightly over one-half. The following year (1985) the rate for this same age bracket had declined to 46 percent and then increased by 2 percent in 1986. Eighty-six percent of the 1986 marijuana admissions had begun marijuana use by the age of 17.

In 1986, there was an increase in users seeking treatment relatively soon after initial drug use. Of those who reported no prior admissions, 40 percent entered treatment within the first two years of use. The year prior (1985) this category represented 25 percent of primary marijuana users.

Over years there has been a drop from 40 percent of admissions who used marijuana on a daily basis in 1984 to one-third (33%) in 1985 and 1986. Those who use marijuana on a weekly basis represented 52 percent of admissions.



At the time of admission, two out of every three marijuana clients indicated use of a secondary drug. Fifty-eight percent of the primary admissions with polydrug problems indicated alcohol as their secondary drug problem. An additional 21 percent of the marijuana clients entered treatment with cocaine abuse as a secondary problem. Of the polydrug users among primary marijuana admissions four percent used each of the following: PCP, amphetamines and hallucinogens.

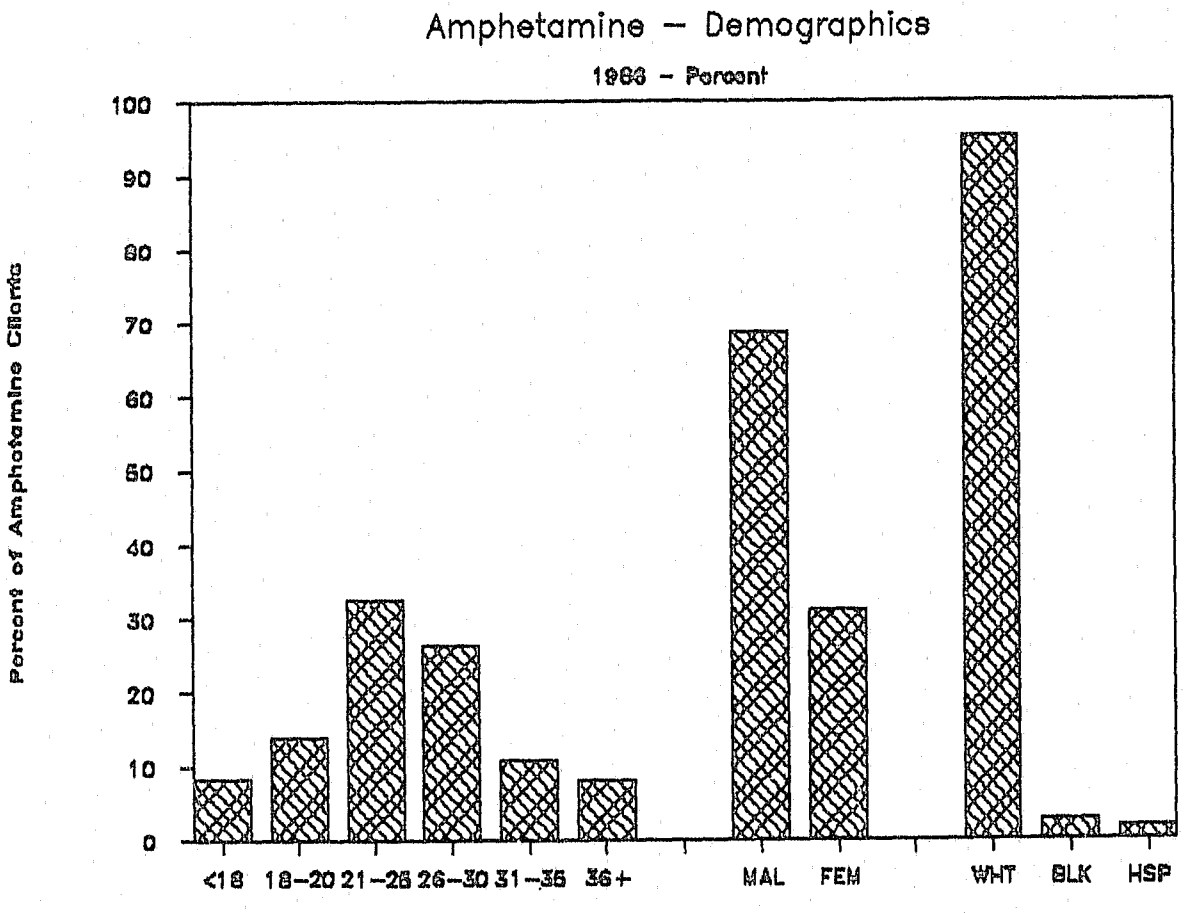
Voluntary admissions comprised 38 percent of marijuana clients. The rate of self referral (10%) among marijuana admissions represented the lowest among all drug categories. Users urged to treatment by family or friends accounted for 12 percent of these clients and represented the highest rate of family/friend referral among all drug categories. Community service and local mental health agencies accounted for a total of 9 percent of referrals. Sixty-two percent of admissions were involuntary. Four out of every 10 users were involuntarily referred to treatment by probation offices throughout the State. Six percent of the marijuana admissions were referred to treatment after being released from a correctional institution by the State parole system.

Thirty-seven percent of marijuana admissions reported no arrests in the 24 months prior to admission. Sixty-three percent of marijuana admissions report having been arrested at least once in this time period. Those arrested between two and four times within a two year period comprised 19 percent of primary marijuana admissions.

Since 43 percent or 313 marijuana admissions were less than 18 years old, other socioeconomic indicators for total marijuana admissions are greatly skewed. However, considering socioeconomic indicators for the 418 adult (18 and over) marijuana smokers, one sees that 67 percent were employed at the time of admission and 76 percent were never married. While 55 percent of the adult marijuana users used alcohol in conjunction with marijuana, one out of every four (25%) marijuana smokers used cocaine as a secondary drug.

AMPHETAMINES

Amphetamine admissions have been declining since 1983 when they totalled 1,216. In 1986, amphetamine accounted for 5 percent or 666 admissions. While 96 percent of amphetamine users were admitted into drug free programs, 26, or 4 percent required detoxification treatment. Continuing past years' trends, whites comprised 96 percent of amphetamine admissions; 65 percent were white males.



Of the 666 users who entered treatment, 449, or 2 out of every 3 admissions, were entering treatment for the first time. Those with one prior admission accounted for two-thirds of previously admitted clients. Clients with 2 or more treatment experiences totaled 11 percent.

Amphetamine use began very early in life for many amphetamine users. Seventeen percent had their first experience with the drug between the ages 7 and 14. The high risk age group appears to be between 15 and 17, when one-third, or 221 users, initiated their first use of the drug. Thirty-five clients, or 5 percent of admissions first tried the drug after age 30.

The number of school age amphetamine users entering treatment declined by 5 percent from the previous year. Amphetamine users between 11 and 17 accounted for 8 percent of amphetamine admissions in 1986. The average age at admission for amphetamine users was 26.

After one year of using amphetamines, 15 percent of new admissions entered a program for treatment. The second year of use is when the fewest new amphetamine users enter treatment. The 5th and 7th years of use showed the highest frequency of new users entering treatment. However, 30 percent of new admissions used the drug for 8 years or more before seeking treatment.

Snorting, or inhalation, was the most popular form of administration of amphetamines. Forty-six percent of the users snorted amphetamines and 34 percent injected the drug intravenously. Another 19 percent took the drug orally.

Of the amphetamine users who entered treatment with polydrug problems, one-half used marijuana. Nineteen percent of the polydrug users reported the use of alcohol as their secondary problem while 20 percent reported cocaine use.

Although 21 percent of amphetamine users used the drug less than once a week the modal frequency of use was several times per week. The percentage of admissions in this group has increased over the years from 19 percent in 1984 to 45 percent in 1986, while the proportion using daily declined 9 percent in a year.

In 1986 voluntary admissions accounted for 45 percent of amphetamine admissions. This was a decline of 9 percent from the previous year. The number of voluntary admissions who entered directly on their own (self-referral) accounted for 21 percent. Another 11 percent were referred to treatment by family members or friends. Fifty-five percent were involuntary referrals. Most of these admissions were sent to treatment programs by probation officers throughout the State.

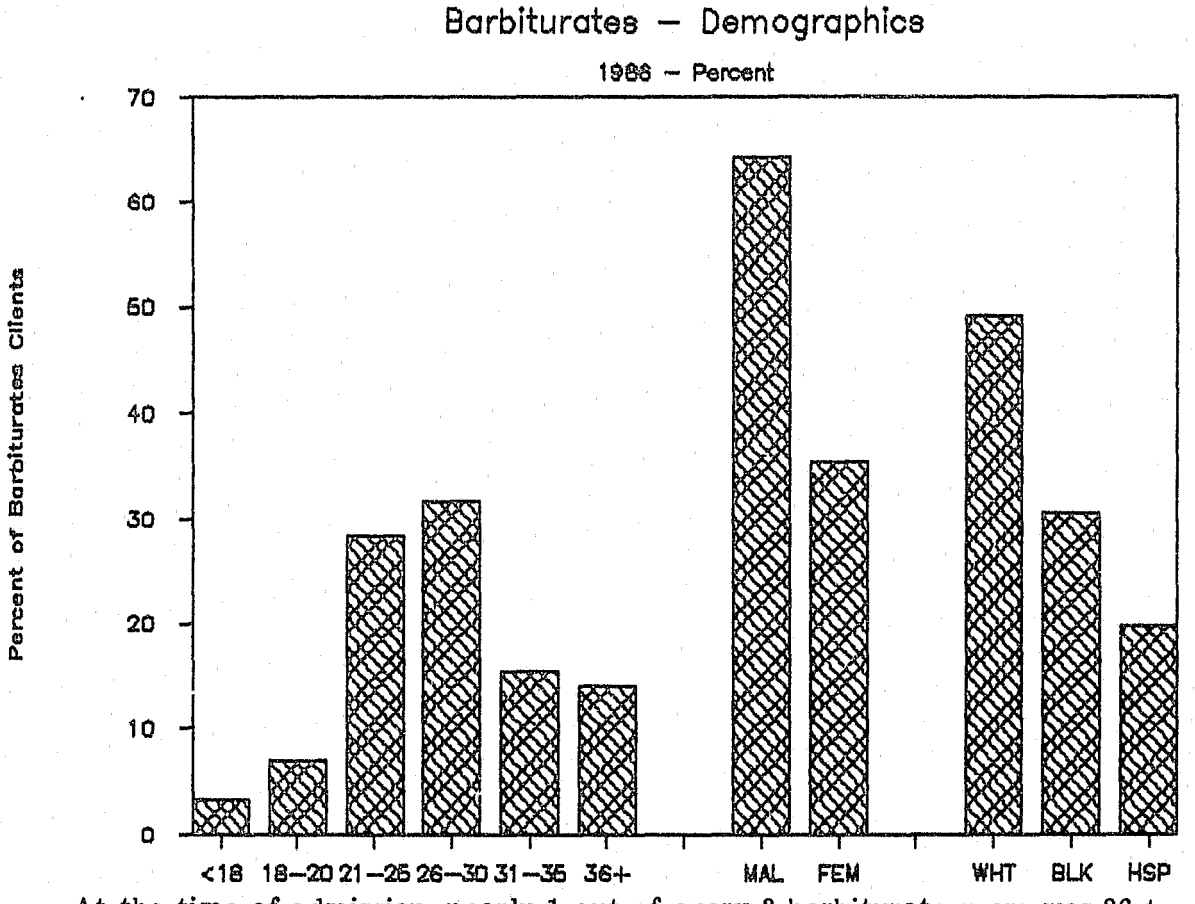
In 1986, 35 percent of amphetamine admissions reported no arrest in the prior 24 month period.

Educationally, 40 percent of amphetamine admissions had completed high school. The employment rate of amphetamine admissions is the highest among drug categories. In 1986, 59 percent of all primary amphetamine users entered treatment employed. Married users comprised 14 percent of amphetamine admissions while those divorced or separated accounted for 21 percent--an increase of 4 percent over the past two years.

BARBITURATES

In 1986, New Jersey's drug treatment clinics admitted 187 persons, 1 percent of all admissions, for barbiturate abuse. Over four years the barbiturate admission rate has declined from 3 percent in 1983. Drug-free outpatient programs admitted 69 percent of barbiturate users while 28 percent entered drug-free residential care.

The rate of barbiturate users entering treatment with prior treatment experiences increased by 7 percent to account for 43 percent of primary barbiturate admissions. Of those users who were entering treatment for the first time, 69 percent had used barbiturates for 5 years or more before seeking treatment, but 26 percent had used for 10 years or more.



At the time of admission, nearly 1 out of every 3 barbiturate users was 26 to 30 years old. The age group 46 through 79 represented the highest rate of admissions in this age group among drug categories. Juvenile admissions, ages 11 through 17, accounted for 3 percent of barbiturate admissions. The average age for primary barbiturate admissions was 29.

Eighteen percent of the barbiturate users entering treatment began use of the drug by the age of 14. By the age of 20, 65 percent had begun use.

Barbiturates were administered orally, in pill form, by 98 percent of the users. Most users used the drug at least once a day, but an almost equal number used it only several times per week.

Eighty-five percent of primary barbiturate admissions entered treatment with a secondary drug problem. The previous year (1985) 91 percent of barbiturate admissions had secondary drug problems. Of those clients with secondary drug problems, alcohol, marijuana and cocaine were most frequently mentioned.

Over half of barbiturate admissions entered treatment voluntarily. Most of these were self referred, but a number were referred by social service agencies or a friend or family member. Involuntary admissions among barbiturate clients have increased 5 percent in the past two years. Involuntary admissions imposed by the various criminal justice agencies accounted for 49 percent of barbiturate admissions in 1986; most of these were from probation.

One-half of barbiturate admissions indicated no arrest in the previous 2 year period. Considering educational status, one-third of the admissions had completed high school while 56 percent had not. Barbiturate users who entered treatment while employed represented 32 percent of these admissions. Two out of every three barbiturate users was not married at the time of admission. Continuing an upward trend, the rate of users divorced or separated at the time of admission represented 18 percent of admissions--a 7 percent increase over the past two years.

HALLUCINOGENS

Hallucinogen admissions accounted for 163 users or 1 percent of all primary admissions in 1986. Nearly all hallucinogen users entered drug-free programs for treatment.

Whites comprised 78 percent of the hallucinogen users entering treatment while blacks and Hispanics represented 10 percent and 12 percent respectively. Nearly 7 out of every 10 admissions were white males.

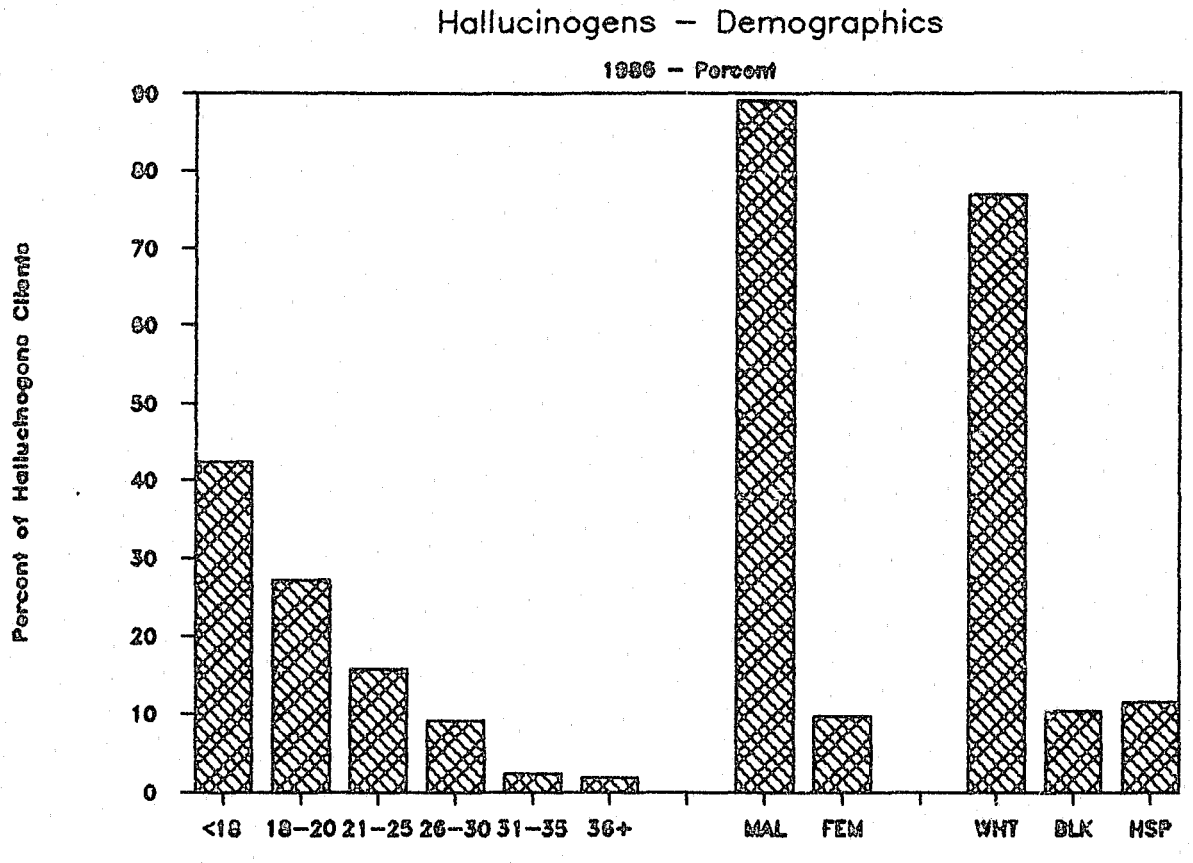
Next to marijuana users hallucinogen admissions had the highest rate of juvenile admissions. Hallucinogen users between the ages of 11 and 17 represented 43 percent of admissions. The average age of the hallucinogen admission was 20. This is the youngest average age across the drug categories.

Sixty percent of all hallucinogen users entering treatment in 1986 were repeated admissions. Among drug categories, hallucinogens had the highest number of users entering treatment within the first year of abuse, but many also entered between 2 and 4 years after initiation of use.

After marijuana, hallucinogen users had the highest rate of users who first used the drug between the ages 7 and 14, 39 percent. Age at first use data indicate that after a person reaches 17 years of age the chances drop significantly that he will initiate hallucinogen abuse.

Nearly 80 percent of hallucinogen admissions took their drug orally in a pill form, while 17 percent smoked it.

While 27 percent used the drug less frequently than once per week, 57 percent used hallucinogens several times per week.



Fifty-four percent of admissions indicated a secondary drug of abuse at the time of admission, mostly marijuana, cocaine, alcohol, and amphetamines.

Voluntary admissions among hallucinogen users accounted for 53 percent of all admissions. Hallucinogen users had the lowest rate of self-referrals to treatment of all drug categories. Eleven percent of admissions entered treatment directly on their own. Forty-seven percent entered treatment under compulsion. Nearly one-third (32%) of all hallucinogen admissions were ordered to treatment by the various probation offices throughout the State.

Next to PCP users, hallucinogen users had the highest arrest rate at the time of admission. Two-thirds of hallucinogen admissions had been arrested at least one time in the 24 months prior to admission. Thirty-eight percent of those who had been arrested reported two or more arrests.

The high rate of juvenile admissions (43%), influenced socioeconomic indicators. For example, the rate of users not completing high school was 73 percent, while the unemployment rate was 63 percent. Marital status indicated that 13 users or 8 percent of hallucinogen admissions were currently or once married.

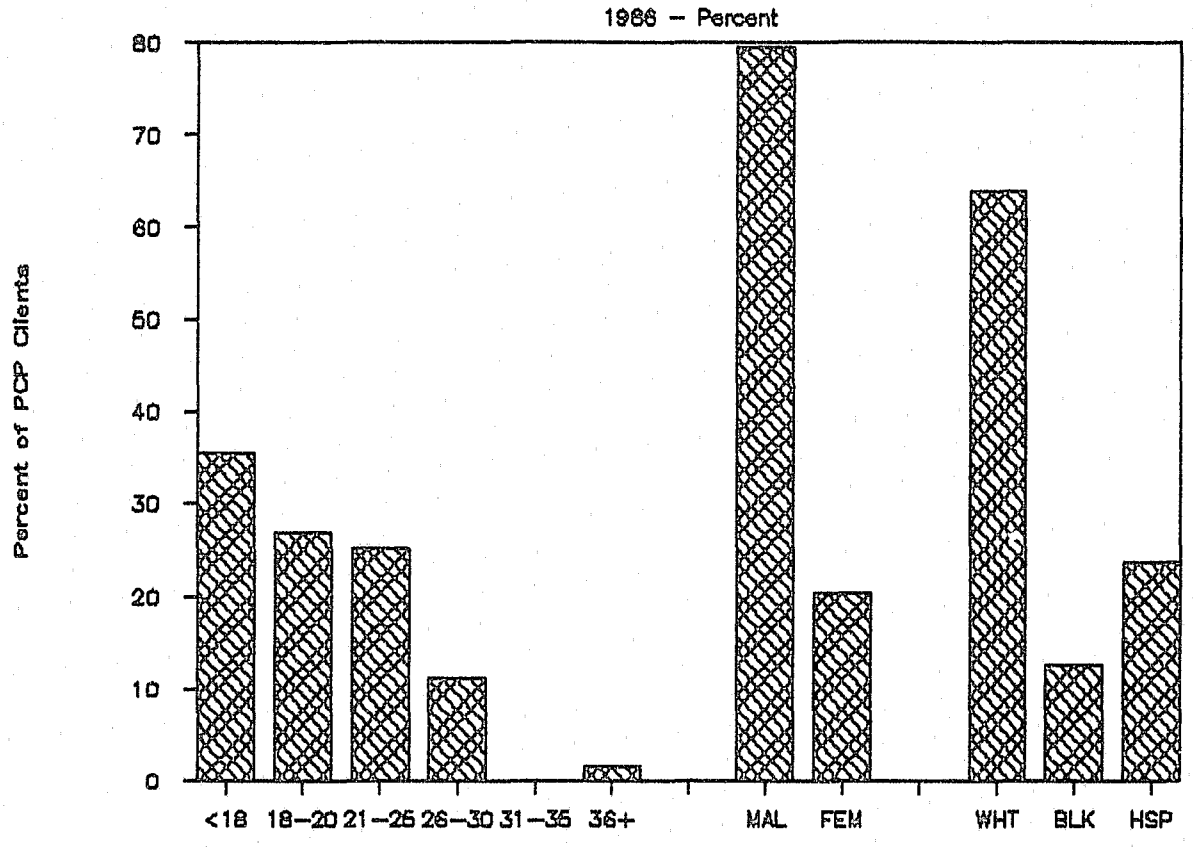
PCP

In 1986, 127 primary PCP users were admitted to New Jersey's clinics for drug treatment. Almost all PCP users were admitted to drug free programs. Nine out of every ten admissions entered outpatient care while 9 percent entered residential care.

Dropping from the second highest in 1985, PCP users had the third highest rate, 35 percent, of adolescent admissions in 1986, after marijuana and hallucinogen admissions. The average age of the PCP user at the time of admission was 20.

Compared to other drug categories a higher rate of first time PCP users entered treatment within their initial year of PCP use. Of the 86 PCP admissions who had no prior treatment history, 42 percent sought treatment within a year of their first use of the drug.

PCP – Demographics



Three out of every ten PCP admissions had received prior drug treatment. Twenty-four percent of PCP users admitted had two or more prior drug treatment episodes.

Nine of every ten PCP admissions smoked PCP.

Most users took the drug on a weekly basis.

The most popular method of administering PCP is lacing the drug on marijuana and smoking it. This is reflected in the high rate of polydrug clients who reported marijuana use as the secondary drug of abuse.

Of the nine major drug categories for which users sought treatment, PCP users had the third lowest rate of self-referrals. The combined rate of voluntary admissions among PCP users entering treatment was 29 percent. Seventy-one percent of these users were compelled to entered treatment, most of these by probation agencies across the State.

PCP users recorded the highest arrest rates among all drug categories. PCP users who had been arrested one or more times within the 24 months prior to entering treatment accounted for 81 percent of the total primary PCP admissions.

PCP clients had the highest unemployment rate among all drug admissions, or 62 percent. Primary PCP users who had received a high school level of education represented 20 percent of admissions. Ninety-five percent of PCP admissions were never married.

TRANQUILIZERS

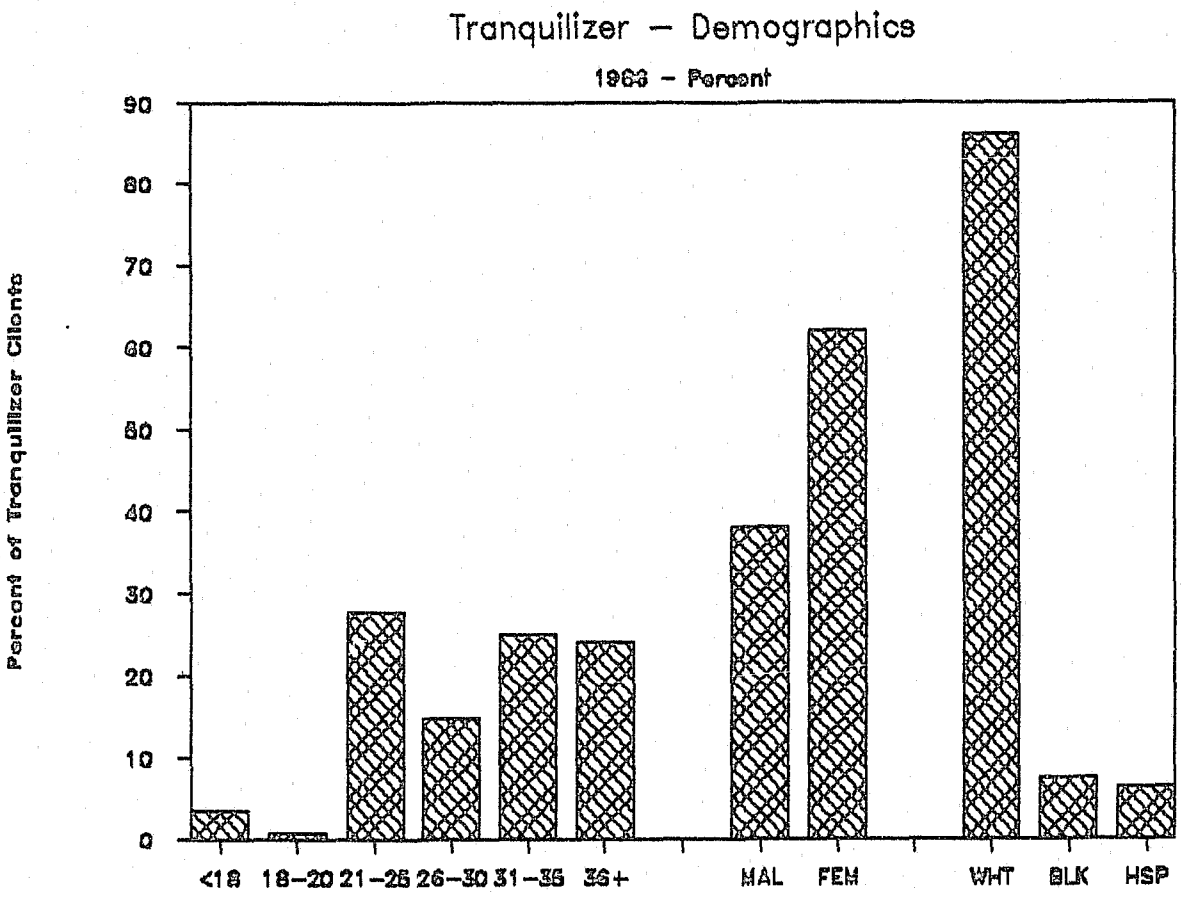
In 1986, 108 persons entered New Jersey's clinics for the treatment of tranquilizer abuse. While 78 percent of tranquilizer users were admitted into drug-free programs, 19 percent required inpatient detoxification. Tranquilizer users had the third highest rate (after heroin and other opiate users) of detox admissions among drug users.

Unlike the other drug categories, tranquilizer admissions consisted mainly of female users, who accounted for 62 percent of all of these admissions. White females accounted for one-half of the total tranquilizer admissions.

Tranquilizer users are generally older at the time of first use. However in 1986, admitted clients who began use of tranquilizers between the ages of 7 and 17 accounted for one-quarter of admissions. This group has increased by 8 percent over the previous year. Indicative of a younger drug user is the fact that the age group 21 through 25 accounted for 1 out of every 4 admissions, but one of every five admissions was between 36 and 45. This was the highest rate of admissions across drug categories for clients in this age bracket. Tranquilizer users also had one of the highest rate of admissions for clients older than 46. The average age of tranquilizer admissions dropped from 33 in 1985 to 32 in 1986.

In 1986 there was an increase in tranquilizer users seeking repeated treatment. Tranquilizer users who had been in treatment previously accounted for slightly over one-half of tranquilizer admissions; most of these had received treatment one or two times.

Tranquilizer users entering treatment for the first time represented 47 percent of all primary tranquilizer admissions. One out of every four new tranquilizer admissions entered treatment within a year of their first abuse, but an equal number had used tranquilizers for 10 years or more before entering treatment.



Tranquilizers were taken orally by all users. Most users, 55 percent, took the drug one or more times per day, but nearly one-third of tranquilizer clients used on a weekly basis.

Seven out of every ten tranquilizer users entered treatment voluntarily. Users who sought treatment directly, on their own (self-referral), accounted for 30 percent of all tranquilizer admissions. Tranquilizer users represented the highest rate of community mental health and service referrals among all the drug categories. Next to PCP, tranquilizer users had the lowest rate of referrals to treatment by family or friends. Involuntary referrals to treatment comprised 30 percent of admissions, but the largest number of these were from non-criminal justice agencies.

Compared to most other drug categories, tranquilizer admissions were well educated; 44 percent had completed high school. Fifty-two percent of tranquilizer admissions were unemployed at the time of admission.

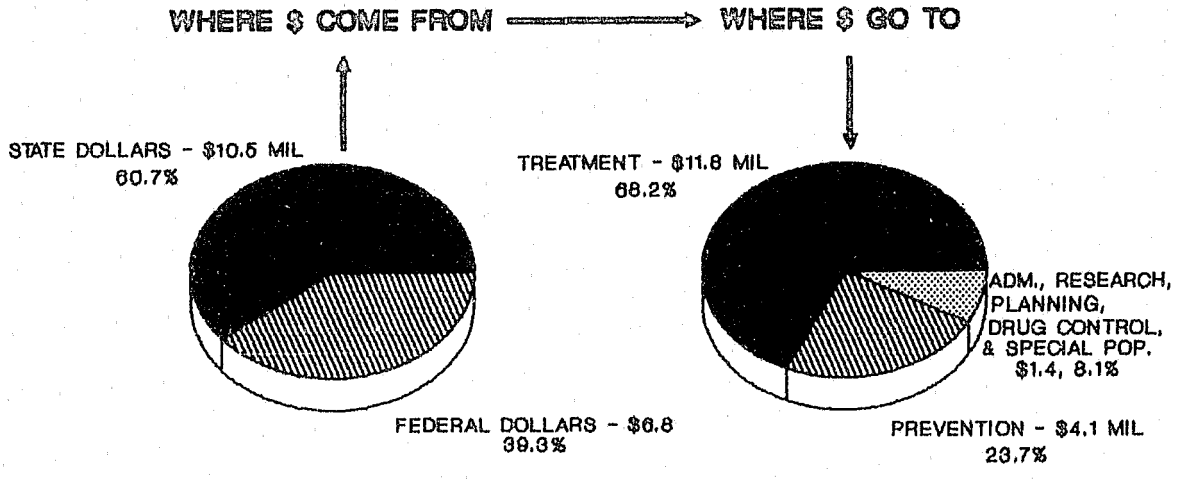
In comparison with other drug categories, marital status at admission of tranquilizer users showed high rates of marriage, divorce and separation.

WHO PAYS FOR DRUG ABUSE TREATMENT?

The funding for New Jersey's contracted drug abuse treatment units comes from a large number of sources, including federal agencies, State and local governments, churches and charitable organizations, clients fees, and public or private health insurance.

The federal government provides $6.8 million and the State government provides a total of $10.5 million for treatment costs. Client fees, health insurance coverage, charitable donations and other program income generated by New Jersey's contracted programs accounts for approximately $4.3 million. While most of the $4.3 million from other program income is spent on treatment costs by contracted programs, part of this income goes to prevention efforts.

GOVERNMENT REVENUE SOURCES FOR PUBLICLY FUNDED TREATMENT PROGRAMS IN NEW JERSEY



Of the toal $17.3 million federal and State funds allocated, $11.8 million goes to the clinics for drug abuse treatment, $4.1 million for prevention, and $1.4 million for support services.

A total of 5,965 treatment "slots" were funded in 1986. A treatment slot is a space in a treatment program sufficient to serve one client for one year. Due to great demand for treatment, there were about 7,500 individuals in treatment in State funded programs at any given time in 1986. This means that the programs collectively operated at 26 percent over funded capacity.

WHERE CAN MORE INFORMATION ABOUT DRUG ABUSE TREATMENT BE OBTAINED?

For further information about drug abuse treatment in New Jersey contact:

New Jersey State Department of Health
Division of Narcotic and Drug Abuse Control
Office of Treatment and Rehabilitation
129 East Hanover Street
CN 362
Trenton, NJ 08625-0362
(609) 292-7232.

You may also contact any of the clinics on the treatment facility listing below.

ALPHABETICAL LISTING OF TREATMENT FACILITIES

NAME OF FACILITY	TELEPHONE	COUNTY
Adolescent Substance Abuse Program	201-285-4220	Morris
Alcove at West Jersey Health System	609-342-4505	Burlington
Alpha House (Straight and Narrow)	201-345-6000	Passaic
Bayshore Youth Services Bureau	201-290-9040	Monmouth
Beacon Hall	609-767-3000	Camden
Bergen County Narcotic Clinic	201-967-4217	Bergen
Bridge, The	201-228-3000	Essex
Burlington Comprehensive Counseling, Inc.	609-267-9553	Burlington
Cape May County (Operation Junction)	609-729-1404	Cape May
Cedar Outpatient (Straight and Narrow)	201-345-6000	Passaic
Center for Addictive Diseases (Turning Point, Lakeland)	609-228-4200 X 10	Camden
Center for Addictive Diseases (Turning Point, Collingswood)	609-854-1222	Camden
Center for Mental Health	201-383-1533	Sussex
City of East Orange Alcohol and Drug Abuse Control Program	201-266-5200	Essex
City of Orange	201-266-4173	Essex
Community Guidance Center of Mercer County	609-587-7044	Mercer
Community Psychotherapy Associates	201-339-0142	Hudson
Corner House	609-924-8018	Mercer
Counseling & Referral Service of the Brick Area	201-458-7511	Ocean
C.U.R.A., Inc.	201-622-3570	Essex

NAME OF FACILITY	TELEPHONE	COUNTY
Damon House, Inc. (New Brunswick, Admin Ofc)	201-828-3988	Middlesex
Damon House, Inc. (New Brunswick)	201-828-6002	Middlesex
Damon House, Inc. (Paterson)	201-279-5563	Passaic
Discovery Institute for Addictive Diseases	201-946-9444	Monmouth
Dismas House (Straight and Narrow)	201-345-6000	Passaic
ESCAPE Center/Youth Co-Op	201-442-3700 X 2170	Middlesex
Essex Substance Abuse Treatment Center, Inc.	201-623-6100	Essex
Faith Farm	609-455-6145	Salem
Family Guidance Center of Warren County	201-689-4470	Warren
Family Service and Child Guidance Center	201-675-3817	Essex
Furman Clinic, Inc., The	201-670-1940	Bergen
Future Health Systems, Inc. (Paramus)	201-261-3784	Bergen
Future Health Systems, Inc. (Summit)	201-273-0426	Union
Hispanic Health and Mental Health (La Esperanza)	609-541-6985	Camden
Hunterdon County Drug Program	201-788-6401	Hunterdon
Hunterdon Drug Awareness Program	201-788-1900	Hunterdon
Hope House	201-361-5555	Morris
Institute for Human Development	609-345-4035	Atlantic
Integrity House, Inc.	201-623-0600	Essex
Integrity, Inc.	201-322-2110	Union
Intercounty Council on Drug and Alcohol Abuse	201-997-4003	Hudson
Jersey Shore Addiction Services, Inc.	201-988-8877	Monmouth
Kids of Bergen County, Inc.	201-487-4100	Bergen
La Esperanza (Hispanic Health & Mental Health Association of Southern NJ)	609-541-6985	Camden
L & L Clinics	201-373-2010	Essex
Monmouth Chemical Dependency Treatment Ctr	201-222-5190	Monmouth
Monsignor Wall Social Service Center	201-342-2565	Bergen
Mt. Carmel Guild Narcotic and Rehabilitation Center	201-596-4000	Essex
Mt. Carmel Hospital (Straight and Narrow)	201-345-6000	Passaic
NEDAC (Alpha and WHO)	201-783-6655	Essex
Newark Renaissance House, Inc.	201-623-3386	Essex
New Brunswick Counseling Center	201-246-4025	Middlesex
New Horizon Treatment Services, Inc.	609-394-8988	Mercer
New Well	201-242-0715	Essex
Northeast Life Skills Associates, Inc.	201-777-2962	Passaic

NAME OF FACILITY	TELEPHONE	COUNTY
Ocean City Resource Center	609-398-4200	Cape May
Operation Junction (Cape May County)	609-729-1404	Cape May
Overlook Hospital Drug Treatment Program	201-522-2837	Union
Paterson Counseling Center, Inc.	201-523-8316	Passaic
Plainfield Treatment Center, Inc.	201-757-8450	Union
Post House	609-726-7155	Burlington
Princeton House	609-921-7700 X 421	Mercer
PROCEED	201-351-7727	Union
RAFT	201-266-8433	Essex
Raritan Bay Medical Center (ESCAPE Center)	201-442-3700 X 2170	Middlesex
Raymond E. Banta Valley Center	201-445-4357	Bergen
Reality House, Inc. (Cherry Hill)	609-428-1300	Camden
Reality House, Inc. (Woodbury)	609-848-0035	Gloucester
Reality House, Inc. (Williamstown)	609-728-0404	Gloucester
Red Bank Outreach	201-842-2000	Monmouth
Resource Center for the Chemically Dependent, Inc.	201-267-2066	Morris
ROAD	201-266-8630	Essex
Salem Outreach Center (SODAT)	609-769-2126 X 22	Salem
SODAT	609-845-6363	Gloucester
Somerset Drug Clinic	201-722-4406	Somerset
Soul-O-House	201-643-3888	Essex
South Jersey Drug Treatment Ctr.	609-455-5441	Cumberland
Spectrum Health Care (Jersey City)	201-860-6100	Hudson
Spectrum Health Care (Newark)	201-596-2850	Essex
Straight and Narrow (Alpha House, Cedar Outpatient, Dismas, Mt. Carmel Hospital))	201-345-6000	Passaic
Suburban Clinic	201-687-7190	Union
Substance Abuse Center of Southern Jersey, Inc.	609-757-9190	Camden
Together, Inc.	609-881-7045	Gloucester
Toms River Outreach Center	201-244-1600	Ocean
Turning Point (Center for Addictive Diseases	609-228-4200 X 10	Camden
Union County Program for the Prevention of Drug Abuse and Narcotic Addiction	201-527-4854	Union
Veterans Administration Hospital (East Orange)	201-676-1000	Essex
Veterans Administration Hospital (Newark)	201-645-2420	Essex
Vocational Adjustment Center	201-223-5112	Ocean
Wayne Drug Abuse Program	201-694-1234	Passaic
West Orange Family Youth Service	201-325-4141	Essex
Women's Resource and Survival Center	201-264-4111	Monmouth
Woodbridge Action for Youth	201-634-7910	Middlesex