Overview

It appears that the cocaine epidemic that swept through the nation during the 1980s may now be subsiding, leaving in its wake large numbers of people with long-term dependencies.

Drug use in general, and the problems associated with it, are still at very high levels by historic standards, and the street violence surrounding drug trafficking may yet grow worse over the next several years, especially in the inner city. However, available indicators of drug use show that both initiation rates and the total number of people using drugs are declining.

The composition of the drug-using population has also begun to change. The data indicate that the sharpest reductions in drug use have occurred in suburban areas and among the educated middle class: It is likely that changing attitudes (e.g., increasing concern about the dangers of drug use and decreasing social approval) rather than enforcement efforts have influenced occasional users to quit using drugs.

Unfortunately, over the last decade as cocaine became cheaper, more readily available, and more addictive in the smokable form of “crack,” it appears that both poor and criminal segments of the population, especially in the inner cities, began to use the drug more heavily. As a result, these people now represent a larger share of the drug-using population. The data also point to an increasingly strong association between cocaine use and health problems, and cocaine use and crime. This in part may explain why, in the face of declining drug use, we may see continued or even increasing drug-related health problems and violence in the inner cities.

Below we describe some of the apparent changes in the trends and composition of the cocaine-using population over the last decade.

National Surveys of Drug Use

The most widely reported measures of drug use are provided by two national surveys funded by the National Institute on Drug Abuse (NIDA): the High School Senior Survey (HSSS), conducted annually by the University of Michigan; and the periodic National Household Survey on Drug Abuse (NHSDA), which reports on drug use in the general population.

The weaknesses of the surveys are well known, but they are not likely to distort general trends. For example, the surveys exclude populations known to be rich in drug users: The HSSS does not include school dropouts, and the NHSDA excludes institutional populations (such as those in prison) and the homeless. The surveys also rely on the willingness of individuals to report disapproved behavior. Since approval of drug use has declined over the last decade, it is likely that the willingness to report such use has also declined. Thus, one cannot use the data to estimate the number of heavy drug users, and the trends may be less sharp than they appear in the surveys. However, the trendlines certainly point in the correct direction.

Figure 1 shows the percentage of successive high school classes reporting use of marijuana, cocaine, or any illicit drug within the last 30 days.

![Graph showing percentage of students reporting drug use]

**Fig. 1:** Trends in drug use among high school seniors, 1975–1991 (High School Senior Survey, HSSS)

After a steep rise in the late 1970s, drug use in general (dominated by marijuana use) declined sharply. For cocaine,
the pattern is somewhat more complicated. Cocaine use rose from about 2 percent in 1975 to nearly 6 percent in 1979, where it remained except for a sharp peak in 1985 (6.7 percent). From 1985 to 1991, usage declined steadily to 1.4 percent.

Figure 2 shows a similar pattern in the NHSDA for 18-25 year olds, the age group with the highest drug-use rates. Marijuana use rose sharply in the late 1970s and then fell throughout the 1980s. For cocaine, use increased in the late 1970s, then leveled off and did not begin to reverse until the mid-1980s.

As noted above, it appears that the driving force behind these trends has been an increasing awareness of the dangers of drug use and a growing sense of social disapproval. Certainly, decreased availability is not a factor. The proportion of HSSS respondents reporting marijuana as readily available or available has been around 85 percent every year. For cocaine, perceived availability rose from 46 percent in 1979 to 59 percent in 1989, before falling to 51 percent in 1991.

**Urinalysis Measures**

Drug testing of adult arrestees reveals a very different picture. Usage within this segment of the population is much higher, and although rates are no longer rising, they still remain near their peaks. In the District of Columbia, which has the longest-standing and most comprehensive drug-testing program, the percentage of arrestees testing positive for cocaine rose from 15 percent in March 1984, when testing began, to over 60 percent in 1986. As Figure 3 shows, the percentage held steady for about a year and then began to decline in 1989. Even so, two years into the decline, 50 percent of the arrestees were still testing positive for cocaine.

It is important to note that arrest is not a rare event for young-adult urban males. For example, RAND estimated that nearly one quarter of all males born in the late 1960s and living in the District of Columbia were arrested between the ages of 18 and 21. Thus the drug-testing data point to very high usage rates in a significant portion of the young-adult urban male population.

The new Drug Use Forecasting (DUF) system created by the National Institute of Justice shows that this extraordinary rate of drug involvement is not restricted to the District of Columbia. DUF currently collects urinalysis data from a sample of arrestees in 23 cities, mostly from persons arrested for nondrug felony offenses. The data show that in the first quarter of 1990, over 50 percent of male arrestees in all 20 cities tested positive for at least one illicit drug (including marijuana), and in 7 of the cities 50 percent or more of the arrestees tested positive for cocaine. Drug-positive rates in most of the cities continue to be near their peaks.

However, there is some good news. It appears that the rate of drug use among young arrestees has declined. The District of Columbia data show that in September 1987, 45 percent of juvenile arrestees tested positive for drugs. By September 1991, this figure had dropped to 19 percent. Over this same time period, the rate of those testing positive for cocaine dropped from 19 to 9 percent. These low rates for juvenile arrestees suggest that drug use is declining even among those at highest risk of becoming most seriously harmed by drugs. In addition, interviews with street dealers in Washington and Newark found that, unlike their older counterparts, few of the younger sellers were using drugs. Given these findings, it seems reasonable that high research and policy priority should be placed on finding ways to discourage young people from entering the trade and on helping them exit the trade if they are already in it—before they begin using drugs and become addicts who must sell to support their own habit.

**DAWN Emergency Room and Coroner Reports**

The NIDA Drug Abuse Warning Network (DAWN) is an important data set that has been used to gauge patterns and trends among those most heavily involved with illicit drugs. We believe that it has been given too much weight in that role, though it is very useful for gaining other insights into changing characteristics of drug use.

The DAWN system collects information from a sample of emergency rooms and county medical examiners, primarily in 21 metropolitan areas. Each emergency room (ER) and
medical examiner (ME) is asked to provide information on all drug-related episodes or deaths. (ME cases do not include homicide victims whose deaths may have been related to drug market activities.) Prior to 1989, the sample was opportunistic and did not permit estimation of the absolute number of ER cases. In 1989, NIDA implemented a new sampling scheme that allowed estimation of the total numbers of ER episodes related to particular drugs or classes of drugs in individual metropolitan areas.

Cocaine-related ER admissions and deaths in the opportunistic DAWN sample increased about tenfold over the decade (Figure 4). Only in late 1989 did the ER figures start to decline (Figure 5).

The DAWN data also show that the decline in cocaine-related ER episodes from their peak in the third quarter of 1989 was much stronger in suburban than in metropolitan areas (Figure 6). During this period, cocaine-related ER episodes in major cities fell by 17.5 percent, as compared to 50 percent outside the cities. Thus it appears that persistent heavy drug use leading to acute incidents is becoming increasingly concentrated within the cities.

Both ER and ME data show a sharp aging in the heavy-user population, suggesting that a defined cohort of users is moving through the pipeline. In 1982, about 50 percent of those dying from cocaine use were over age 30; by 1989, the figure had risen to 76 percent. Correspondingly, the percentage of those aged 18–24 dying from cocaine use had fallen from 23 to 14 percent.

Recent ER data reflect a similar pattern: Between the first quarter of 1989 and the third quarter of 1990, the percentage of cocaine-related ER episodes involving men over age 30 increased from 46 to 55 percent, and the percentage of episodes involving women over age 30 increased from 35 to 42 percent.

DAWN records also provide information on why the individual used drugs (e.g., psychic effects, recreation, drug-dependence) and why he or she sought admission to an emergency room (e.g., unexpected reaction, requesting detoxification). These data show that an increasing fraction of the cocaine-related ER episodes have involved dependent users seeking either treatment or relief from health problems associated with chronic drug use. Thus, the upturn in DAWN ER episodes in 1991 may be driven by a growing number of users or heavy users of cocaine than by the aging of a fixed user-population increasingly troubled by the health consequences of its own drug use.

Discussion

It is important for the policy and research communities to try to determine how the drug problem is likely to change, so that policies and programs can be adjusted accordingly. It seems probable that the prevalence of drug use will continue to decline for some years. This is largely due to changing attitudes about drug use in general and the recognition of crack cocaine for what it is—a drug with a strong potential for dependency, and one that may well send the user to the emergency room or the morgue. Even the young sellers we interviewed in Newark referred desirously to their cocaine clients as “fiends.”

What is not declining, and perhaps may do so only slowly, is the number of people dependent on illicit drugs—and unfortunately most of the social problems associated with drugs, including crime and violence, the spread of the Human Immunodeficiency Virus (HIV), and the rising burden
on publicly funded hospitals, come not from new users but from addicts.

Looking at the end of the heroin epidemic in American cities in the mid-1970s may help us understand where we are in the cocaine epidemic and what lies ahead. By 1975, very few people were becoming heroin users for the first time; in that sense the epidemic was over. But the number of heroin users in inner city communities has not even now, 15 years later, shown much decline. Most of those who became addicted in the late 1960s and early 1970s at the height of the drug’s popularity have not been able to shake their addiction, even though many have been in and out of treatment frequently. New initiates were sufficient to replace those addicts who died or stopped using, but initiation rates were quite low, at least until the end of the 1980s.

While a number of factors may influence the rise and fall in popularity of a particular drug such as heroin or cocaine, one of the strongest determinants seems to be the effects of the drug itself. At their introduction, the focus is on the pleasurable effects of such drugs. Five or ten years later, the degradation of the users’ physical and social lives has become a self-evident warning to initiates of the cost they will pay. In this sense, the cocaine epidemic, like the heroin epidemic ten years earlier, may be burning itself out. However, there will be many “hot spots,” many residual effects, for years to come.

One important distinction between the heroin and cocaine years must be made. Selling heroin was never an important source of economic mobility for young, poorly educated inner city males; selling cocaine has appeared to be so. And it is likely that much of the cocaine dealers’ income has come from selling to middle class users. As this market declines, competition will increase among dealers, perhaps violently. In addition, since selling cocaine has been the primary source of earnings for poor adult males dependent on cocaine, these individuals may turn to other forms of crime to finance their continued consumption, relying more on muggings, burglary, and shoplifting for income, just as heroin user/dealers have done for many years.

Equally troubling is the possibility that the drug markets in inner cities have led to a change in how young males view violence. Increasingly over the last decade, the most visible role models in terms of upward economic mobility have been drug dealers, whose success is related to the use of force. Violence may now be seen as a way to improve one’s lot in life.

Although we may be nearing the end of the widespread use of cocaine, poor urban communities are going to be the last to benefit. And given the possibilities discussed above, it seems clear that even though the indicators encouragingly point to the passing of an epidemic and a strong decline in new users, the nation’s drug problems are far from over. The law enforcement community must be prepared for the possibility of even more crime and violence in the inner city. Health care systems will have to cope with an increasingly ill population of aging users. And treatment programs must find ways to expand their efforts to rehabilitate the large cohort of cocaine users who will need help for many years to come.

References


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