

MEDICAL ASPECTS OF DRUG ABUSE

Office of Medical Services

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Foreword

This paper on Medical Aspects of Drug Abuse has been prepared by the Office of Medical Services and is based on the latest professional literature and our own Agency experiences in matters of drug abuse. It is in two parts:

Part I - An Introduction to Drugs of Abuse, and

Part II - Some Behavioral Aspects of Drug Abuse in Youth

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PART I

AN INTRODUCTION TO DRUGS OF ABUSE

When discussing the problem of drug abuse, an understanding of the following terms is important in order to comprehend the complexity of the issues. The term drug addiction is a broad one and the exact definition is controversial. The argument can be narrowed by considering addiction to be a combination of the following three elements:

(1) Psychic Dependence or Habituation

A drive or craving which causes the periodic or chronic use of a drug for purposes of pleasure or relief of psychic discomfort.

(2) Physical Dependence

A state reached after continuous use of certain drugs in which the body has become accustomed to the drugs and has incorporated them as metabolic needs. When this state exists, and the drugs are withheld, the individual will become ill, and the symptom complex which is produced is called withdrawal. As a rule, the symptoms seen in the withdrawal phase of a drug are opposite to the symptoms produced by that drug, i.e., if the drug produces calmness and sleep, the withdrawal effect will be excitement, insomnia, and even convulsions

(3) Tolerance

The ability of the body after long exposure to certain drugs to resist the action of those drugs in such a way that, in order to produce the desired effect, a higher dose is required than when the drug was first used.

Adverse or Toxic Effects of Drugs - To understand fully the problems caused by drugs it is necessary to consider their effects in broad terms. Two very important areas which will not be considered in the discussion which follows are the social or behavioral changes (they will be discussed in more detail in Part II), and secondary medical problems which result from the life style, diseases, and debilitation often associated with chronic drug use. These secondary problems will not be discussed, since it is unlikely that any agency employee would reach this level of drug usage without other administrative action being taken. Direct toxicity to a drug itself can be divided into two basic categories:

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(1) Acute Toxicity

Toxicity of this sort is directly related to dosage and causes immediate serious medical problems up to and including death.

(2) Chronic Toxicity

This can be viewed as a summation of long-term mild insults to various body systems resulting in an abnormality many years later. An example of chronic toxicity is lung cancer following many years of smoking, or cirrhosis of the liver after ten or twenty years of alcohol usage. The delayed nature of the chronic toxicity makes it much more difficult to prove scientifically that the given problem is related directly to a specific drug. This accounts for much of the current disagreement related to the danger of the hallucinogens (particularly marijuana).

THE DRUGS

All the drugs of abuse affect the central nervous system (the brain). Daring and the desire for new experiences have caused young people to try a great variety of drugs ranging from highly potent and well understood pharmacological agents to bizarre items such as banana peels and peanut oil. Since it is usually those persons deeply involved in the drug culture who use some of the more bizarre items, this paper will confine itself to the better known drugs which are the cause of perhaps 99 per cent of the drug problem.

A convenient way to look at these drugs is to divide them on the basis of their effect on the brain. Viewed in this way one finds many pharmacological similarities between the drugs within a given drug group. The symptoms which are produced in general are quite uniform, and the withdrawal effects from the drugs within the same group are also similar. The drug user can often substitute one drug for another in the same group and prevent or ameliorate withdrawal symptoms. Despite this similarity, there are, however, unique features for each drug. The discussion of the four categories below outlines the important characteristics which in general can be applied to the drugs in each group. Specific information on individual drugs is beyond the scope of this paper.

CATEGORY I - THE DEPRESSANTS

These drugs depress brain function in direct proportion to the dosage used, starting with the function of the higher

brain levels. First, interference is noted in cognitive functions, followed by abnormalities of coordination and movement, and finally, depression of primitive activities such as breathing.

EXAMPLES:

Alcohol

Barbiturates

Volatile Hydrocarbons (including the anaesthetics and airplane glue)

Nonbarbiturate sleep-producing agents (i.e., Quaalud)

Tranquilizers

DRUG ACTION:

These drugs all act very similarly to alcohol. The individual taking them when under their influence will appear to be very much like the usual drunk, exhibiting lowered consciousness, confusion, slurred speech, and staggering.

PSYCHIC DEPENDENCE:

Yes

PHYSICAL DEPENDENCE:

Yes. The time required for physical dependence to develop will depend upon the type of drug used.

Alcohol - about 10 years of heavy drinking

Barbiturate - about 9 months to a year of continuous dosage at a level several times the standard dose

Quaalud - as short a time as one month

WITHDRAWAL SYMPTOMS:

These include tremulousness, weakness, anxiety, insomnia, delirium, visual hallucinations, and convulsive seizures. The withdrawal effect from drugs in this category is extremely dangerous, and individuals undergoing withdrawal must be managed carefully in a hospital setting. Death in untreated cases is not unusual.

TOLERANCE:

Tolerance does occur with most drugs in this category, except to a relatively limited degree, and is, therefore, not of major consequence.

ADVERSE EFFECTS:

Acute Toxicity - This is directly related to the dose of the drug. At high doses there is a marked depression of the primitive brain functions, such as breathing, and an individual may die in deep coma due to cessation of respiration. It should be noted that the drugs in this category are additive in action, and many deaths are due to the combined depressant effect of alcohol and barbiturate. Sniffing the volatile hydrocarbons such as airplane glue, in addition to the foregoing, can produce permanent mental damage by causing brain swelling and destruction, or death due to heart irregularities.

Chronic Toxicity - Less group uniformity exists in this regard:

Alcohol - Causes cirrhosis of the liver and chronic brain and nerve damage.

Barbiturates - To a lesser extent than alcohol, these drugs may cause chronic brain damage resulting in permanent tremors, staggering gait, double vision, dizziness, and slurred speech.

CATEGORY II - THE STIMULANTS

Stimulants increase the activity of the brain and also, to varying extents, the heart and blood vessels, depending on the specific drug used. These are the only drugs known that truly enhance mental function at appropriate doses. This enhancement, however, is quite limited, and, if the dose is exceeded, deterioration of mental activity follows.

EXAMPLES:

Amphetamines

Methamphetamine ("speed")

Cocaine

Preludin

There are other mild stimulants such as caffeine, but these are not of major consequence. Drugs in this category may be taken in pill form, but often, due to their rapid metabolism and the tremendous stimulatory effect of sudden high doses, the stronger ones are either sniffed or taken intravenously.

DRUG ACTION:

These drugs produce a sense of well-being, increased confidence and alertness; fatigue is diminished and, in addition, there is an associated feeling of increase in strength (not documented by testing). The appetite is suppressed, existing depressions are relieved, and the mood is elevated.

PSYCHIC DEPENDENCE:

Strong psychic dependence is produced by the stimulants, probably due to their intense excitatory effect when given intravenously. Individuals who are users of these drugs, particularly cocaine and methamphetamine intravenously, prefer stimulants to heroin, and it has been the experience of some physicians that it is at least as difficult to cure the speed freak, or the cocaine devotee, as the heroin user.

PHYSICAL DEPENDENCE:

No. Individuals can take these drugs, including cocaine, for long periods of time without developing withdrawal symptoms when the drug is stopped.

TOLERANCE:

Tolerance is not produced by drugs in this category. This lack of tolerance can be unfortunate for those individuals who look for greater kicks by increasing their dosage since the toxic level is reached more quickly.

ADVERSE EFFECTS:

Acute Toxicity - This is directly related to the dosage. After the initial stimulatory effect, which at its height may produce epileptic-like convulsions, heart irregularities or large increases in blood pressure, the drug then produces a marked depressive effect which can result in death either from severe brain depression or from failure of the heart.

Chronic Toxicity - Long-term heavy usage of stimulants may cause marked weight loss and debilitation, perforation of the lower portion of the septum of the nose in those who sniff the drug. There is the possibility of a paranoid psychosis in

individuals who take the drug at high dosages. There is also some indication that inflammatory disease of arteries can occur, producing strokes in young persons.

CATEGORY III - NARCOTICS

Narcotics by definition consist of a group of drugs that reduce pain, depress mental function, and produce sleep. They are highly useful in medical treatment, but are also the group of drugs which causes the most harm to chronic users.

EXAMPLES:

Opium - an exudate of the oriental poppy

Morphine and codeine - the active ingredients of opium

Heroin - a chemically treated morphine

Demerol and Methadone - synthetic narcotics which are produced in the laboratory

DRUG ACTION:

The symptoms produced by the narcotics are usually euphoria associated with mental clouding and drowsiness. There is reduced physical activity with impaired performance of both physical and mental functions. The users exhibit a diminished appreciation of pain and their limbs feel heavy; they experience a generalized itching sensation, and are often seen rubbing their noses or scratching various parts of their bodies, sometimes to such an extent that their bodies are covered with excoriations. Narcotics have a marked constricting effect upon the pupil of the eye, and the most characteristic sign indicating that a person is under the influence of a narcotic is an extremely small pupil. The duration of the narcotic effect is about four to six hours, the last part of which is usually passed in sleep.

PSYCHIC DEPENDENCE:

A strong psychological dependence is produced by the narcotics. Intensive long-term efforts are required to treat this problem. As a rule, the shorter the time a person has been taking narcotics, the more likely it is that abstinence from the drug can be achieved. It also appears that persons beyond age 25 respond to treatment more favorably. Perhaps this is related to a tendency of the users to give up the drug spontaneously as they age (known as the "maturing out phenomenon").

PHYSICAL DEPENDENCE:

The tendency to develop physical dependence is marked and depends upon which drug is used, the duration and frequency of drug use, and the method of administration (intravenous route produces the most rapid dependence). The dependence potential of these drugs follows roughly the therapeutic strength with regard to pain relief. Giving morphine an arbitrary value of 1 with regard to its ability to produce physical dependence, the others are as follows:

Heroin - 3 or 4

Methadone - 1

Demerol - 1/8

Codeine - 1/12

Even heroin will not produce instantaneous physical dependence. For example, it requires four or five days of intravenous heroin usage before withdrawal symptoms can be seen when the drug is stopped.

WITHDRAWAL SYMPTOMS:

The withdrawal symptoms of narcotics can be divided into two overlapping phases:

(1) PURPOSEFUL PHASE - Begins about 6 to 8 hours after the drug was last taken and lasts 24-36 hours. The user feels uncomfortable, anxious and irritable, and will begin to take positive action to obtain more drug.

(2) NON-PURPOSEFUL PHASE - Occurs after about 12 hours, reaching its peak at about 36 to 72 hours, then declining to a point of disappearance in 4 or 5 days. During the non-purposeful phase, the individual is actually ill, and experiences anxiety, chills, fever, nausea, vomiting, diarrhea, marked pains in the muscles and abdomen, spasmodic twitching and jerking of the extremities, and occasionally an epileptic-like seizure. He will appear to be in distress, will have insomnia, show frequent yawning, sneezing, running of the eyes and nose, and profuse perspiration. (The pupils of his eyes will be widely dilated in contrast to the small pupils seen when he is actually on the drug.)

TOLERANCE:

The profound tolerance which the narcotic user develops adds significantly to the drug problem. After a number of

months of heavy narcotics use, a person may require 8 or 10 times the amount of drug he needed initially. Since he will be physically dependent on the drug by that time, maintaining a supply at this high level is necessary if he is to avoid the agony of withdrawal. He takes the drug now to avoid pain as much as to derive pleasure. Obtaining the large amounts of money needed (circa \$60 plus per day) requires his maximum efforts, often leading to robbery or, in the case of women, prostitution. The supply problem at times has become so severe that some users have been known to turn themselves in to the authorities to be treated and kept away from narcotics long enough to lose their tolerance, thus permitting a return to the drug habit at a much lower dosage after release.

ADVERSE EFFECTS:

Acute Toxicity - The acute toxicity of the narcotics is directly related to dosage. One of the important actions of the narcotics is the depression of the breathing center in the brain, and high doses of the drug will produce cessation of respiration. This, combined with the diminished appreciation of pain and discomfort, results in death by suffocation. There is a less well understood phenomenon involving the lungs, which seems to be a direct toxic effect of the drug on the blood vessels in the lungs of certain individuals. When this occurs (usually in heroin users), the blood vessels of the lungs lose their ability to hold fluid, causing the lungs to fill with water, drowning the individual in his own secretion. This mode of death is second only to respiratory depression as a direct drug-related cause of death in narcotics users.

Chronic Toxicity - Chronic toxicity of the narcotics is disputed. Most of the chronic problems are related to secondary disease; however, there has been some indication that vascular inflammations, causing strokes, can occur. The dispute arises because most dependent long-term users use the intravenous route and cut the drug with many unknown substances, with the result that the vasculitis cannot be definitely attributed to the narcotic.

CATEGORY IV - THE HALLUCINOGENS

The previous categories, for the most part, contain drugs which are reasonably well understood either as the result of widespread use in the past or because they are medically important and have been subjected to extensive scientific investigation. Most physicians have little doubt that the drugs already discussed are potential health hazards. The hallucinogens, however, are a relatively new experience for man, and there is still much to learn regarding their long-term effects. There are many drugs in this category,

and the controversy concerning them has led to a great deal of confusion. Only the most frequently used hallucinogens are discussed below, and the statements made regarding their adverse effects should be considered tentative and incomplete.

EXAMPLES:

LSD - Though LSD occurs naturally, that used in the drug scene is usually made in clandestine laboratories.

MESCALINE - Its origin is the peyote cactus.

MARIJUANA and HASHISH - Products of the cannabis plant (relatively weak hallucinogens).

DMT and STP as CHEMICALS - Can produce hallucinations and are substitutes for LSD.

DRUG ACTION:

The effect of a strong hallucinogen is to alter the user's perception of any or all sensations. For example, colors are brighter and may seem to contain sound; a person's perception of his body image may be blurred and he may seem to be a part of the chair in which he is sitting. It is usually a uniquely strange experience which may be either highly satisfying or terrifying.

PSYCHIC DEPENDENCE:

All the drugs in this category can produce psychic dependence.

PHYSICAL DEPENDENCE:

Not produced

TOLERANCE:

Not produced

ADVERSE EFFECTS:

The comments which follow will be limited to the two drugs which are of the most concern in this category, LSD and the cannabis products (principally marijuana).

(1) LSD

LSD (lysergic acid diethylamide) is the most potent hallucinogen known. Sixty micrograms (60/1,000,000 of a

gram) is sufficient to produce one trip. The amount can be better appreciated when it is realized that enough drug for a thousand LSD trips weighs approximately the same as one drop of water. The effects are noted about one hour after taking the drug, and if the individual is having a pleasant experience, he usually sits quietly appreciating the sensations. He may feel a chilliness in the extremities and exhibit some perspiration; his face may be flushed and some mild breathing irregularities may be noted. The experience lasts for about 8 hours and is typically the type of altered perception described above, under drug action.

Toxicity - The acute toxicity of LSD regarding its lethal effect is very low; to date no deaths have occurred due to the direct chemical action of the drug. There are, however, psychological problems that can occur with a single dose. These include bad trips, psychotic reactions, and suicides. There has been concern that the drug has caused physical problems such as chromosomal abnormalities and birth defects. Studies are still in process regarding both of these possibilities, but because most LSD users also take many other drugs, the matter is still unsettled. Regarding chromosomal abnormalities the published studies seem to be about even as to whether LSD is or is not the causative factor. Birth defects have not been as widely studied, but the drug is known to cause these in animals. A study from George Washington University, involving approximately 150 pregnancies where the mother had used LSD during pregnancy, showed an increased incidence of abortions and a higher rate of fetal abnormality (8 major birth defects per 83 live births compared to the national average of 5 to 10 major birth defects per 1,000 live births).

(2) MARIJUANA

Marijuana, with the exception of alcohol, is the pleasure-giving drug most widely used by young people. It is the ground-up leaves of the cannabis plant and is usually smoked. The active ingredient is delta-9-tetrahydrocannabinol, which is a strong hallucinogen though not as strong as LSD. The amount of this ingredient in any given batch of marijuana depends upon where the plants have been grown. The most potent form is grown in India, and the weakest form in the United States, with the Mexican material being intermediate in strength. For this reason, it is difficult to make scientific determinations based upon street experience where individuals have been taking material of variable strength. As with the other hallucinogens, the drug produces psychological dependence but no physical dependence or tolerance. The feelings produced by the drug depend upon the strength and also the setting in which the drug is taken. Because of the weakness of the usual product, hallucinations as seen with LSD are rare in marijuana; rather, people experience a euphoria, increased self-confidence

and sociability, and feel enhanced perceptual capability. When the drug is taken by smoking, the experience begins within 3 to 5 minutes and may last up to 4 hours. A person can appear and act quite normal, but usually will show some reddening of the whites of the eyes due to the direct action of the drug, and may exhibit a mild incoordination. Scientific studies have shown that the drug produces an inability to judge time and space with accuracy, decreases the individual's ability to concentrate, and produces a defect in short-term memory that is sometimes noted in the individual's speech and writing patterns as rambling and disjointed thought processes.

Toxicity - The toxicity of the drug with regard to its lethal effect is, like LSD, very slight. It is uncertain whether any individual has died due to the chemical effect of this drug. As with LSD, at times there have been bad trips, psychotic reactions, and suicides connected with its use. The toxicity of long-term use is an area of great controversy and intense study with regard to the cannabis products. Most physicians believe that experimental, low-dose usage, except for the occasional psychiatric complications, causes little harm. The effects of long-term heavy usage, however, are still very much open to question. The answer will be difficult to derive since long-term heavy users are almost always using other drugs as well. Although some control studies are now being done under the auspices of the National Institute of Mental Health, it will probably be years before the question is finally settled. A recent study published by that Institute, involving Jamaican canefield workers, found no significant difference between those who used marijuana chronically and those who did not. This study has been criticized, however, by noting that Jamaican canefield workers are not Americans, their work is relatively primitive compared to our work requirements; also their method of smoking does not involve deep inhalation as practiced by our marijuana users. Case reports from other areas of the world indicate that there may be some difficulty with long-term usage of the drug. The study of US soldiers in Germany showed diminished lung function in heavy users of hashish (a stronger cannabis product than marijuana). A group of young, chronic marijuana smokers in Britain showed suggestive evidence that brain atrophy might occur. Experience in North Africa, where more potent cannabis products are used, indicates that long-term usage may increase the incidence of psychotic reactions requiring hospitalization, and also may cause vascular inflammation resulting in leg amputations. In the US the "drop-out syndrome" is much discussed, but it is uncertain whether this is directly due to the drug or due to the life style of the chronic users.

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The aforementioned possibilities at this point can be considered only suggestive and the final answer to all of these questions will not be available in the near future. At the present time, however, it seems clear that some people using these drugs on a chronic basis at significant dosages exhibit changes in life style and attitudes. Whether these changes are a direct result of the drug itself or secondary to sociological phenomena cannot be determined at this time.

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PART II

SOME BEHAVIORAL ASPECTS OF DRUG ABUSE IN YOUTH

Recent problems with drugs in American society (except for alcohol) have been centered primarily in the adolescent and early adult population. In the Agency's experience, the observations have been similar. The adolescent surge for independence and the loosening of bonds to parental ties have always led youth to seize upon factors in the environment as means of expressing and grappling with the issues of maturity and adulthood. In our present era, these issues have been especially disruptive for youth.

Today, in contrast to the past, a broadly shared and stable world view that people of intelligence and good will could agree upon and take for granted -- such as the inevitability of human progress and the concept of human perfectability -- is in disarray. Most of the basic assumptions about the nature of reality, and what can be expected from it, have been called into serious question for the youth of today. For example, we are told that madness is a higher and better reality, or at least a road to it (Ronald Laing, 1967), or that mental illness is a hurtful myth perpetuated by physicians (Thomas Szasz, 1961). Homosexuals openly reproach society for castigating what they claim is an equally viable choice of alternative life style. Both the more radical and the more moderate women's organizations censure society for its view of women and accuse it of contributing to the perpetuation of social and psychological degradation of women. In addition, there is a profusion of competing world views to contend with the previously shared Western culture of science. For example, Theodore Roszak (1969) proposed an anti-scientific, anti-technological counterculture ideology which promises a new and presumably improved value system within a different perspective of reality. Zen, Sufi, and other Eastern traditions suggest still other alternatives to our achievement-oriented, science-based, materialistic Western culture.

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The claims made by the proponents of the drug culture of a new, different and expanded inner reality are part of the competing array which the adolescent must consider. Encouragement from the environment toward achieving satisfaction without planning, discipline and work flows from the fantasy brought to life before the eyes of youth in television, moving pictures, and frequently in examples of parents given to dependence on tranquilizers, alcohol and tobacco.

Experience with drugs among current-day youth varies considerably with respect to incidence, type and intensity. In the mid-1960's, for example, experimentation with drugs was most intense in urban universities on both coasts of the United States and less frequent in small rural Southern denominational colleges. A wide variety of drugs has been used, from the hallucinogens such as LSD and marijuana, to mood alterants such as amphetamine, and sedatives. Narcotics such as heroin have also been used. Usage may be conditioned by social fads as well as by the degree of availability, with price a determinant. Recently, alcohol has been consumed increasingly among high school and college youth, while the use of other drugs has declined somewhat. Many surveys have been made of the incidence of drug usage among youth. For example, a 1971 survey of 60 college campuses in the five geographical areas of the country was conducted through a questionnaire of 3,000 students by Playboy Magazine. (This study was a sequel to a 1970 survey with computer generated randomly selected campuses and students, the distribution approximating the national average.) Of the respondents, 13 percent had tried LSD and 30 percent had used amphetamines at least once. Marijuana had been used by 62 percent; 40 percent had used the drug 10 or more times.

The pharmacological effect of a drug on an individual exerts a powerful pull toward repeating the experience if the sensation has been a pleasurable one. This pull is compounded in the case of narcotics such as heroin, where not only an increasing dosage is required for the feelings of well-being to be maintained, but at least a steady intake is necessary to avoid the rigors of discontinuation.

Besides these factors, however, the importance of the personality of the user cannot be overestimated. The seeking of pleasure, while a human propensity, if unleashed from the bonds of reality, becomes an end in itself so that the individual becomes crippled in dealing with reality and the demands of life. Probably many of the youth who resort to drugs as a mode of coping with the pressures and stresses of life belong to the category of the addictive personality. Certainly the ease with which one drug is given up for another suggests that this is a quest for external relief of tension deriving from well-springs within the personality, expressed in the

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dependence now on one drug and now on another.

The importance of personality factors in the use of drugs is seen from another angle in the experience of American soldiers using drugs, including heroin, in Vietnam. While some serious addictive problems have been incurred as a result of heroin usage, most veterans, upon leaving the situation, have not continued to be dependent on narcotics, and the fears of returning "dope addicts" after the Vietnam demobilization have proven to be overblown.

Peer pressure and other environmental encouragement to experiment with drugs may be cast off easily or constitute a brief phase in the case of many youths. But in others who are still struggling with the issues of identity, exposure to drugs can lead to chronic use with a loss of drive, motivation, goals and ambition. The chronic dulling effect of continuing drug usage has led to the coining of the phrase "drug freak," the result of the exposure of an addictive personality to a chronic intake of drugs. The phenomenon of the "flashback" is seen occasionally (1 to 2 percent of cases). In such instances, the drug user experiences a reliving of a previous experience with drugs -- generally frightening and uncomfortable -- at a later time when his nervous system is physically drug free. Such phenomenon may be related to other experiences such as amnesia, de-personalization and change in body image. The possibilities of chromosomal damage is still being assessed. In summary, the effects and dangers of drug usage are related to the type, frequency and intensity of drug used, but of equal importance is the personality makeup and motivation of the individual himself. Heavy, frequent, chronic usage probably occurs among youngsters with addictive personalities.

In the Agency experience, the number of new employees who have had experiences with drugs has increased notably in recent years. As is the case in the general population, the preponderance has been with marijuana, and has represented experimental usage as opposed to chronic, regular intake. Undoubtedly the chronic heavy users of drugs have been screened out earlier in the selection process in this setting. Although no statistics are known to exist, the Office of Security policy of warning new employees about the use of illegal drugs appears to have worked well. The same may be said in the case of summer employees.

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As might be expected, some adolescent children of Agency employees, both in the US and overseas, have had isolated problems with drugs which have come to the attention of the Office of Medical Services. While the true incidence is unknown, overseas dependents with drug problems may be expected to come to the attention of Agency medical officers more quickly than in the case of teenagers in the US. The most dramatic overseas experience has been in [REDACTED] in 1971-1972. 25X1A
At that station the attitude of both the youngsters and their parents was notable for the apparent laissez-faire attitude which they evidenced toward the use of heroin. Among some ten youngsters from eight different families who were returned from [REDACTED], each family was offered the assistance of the OMS; the Overseas Medical Benefits Program was also available to them. In only two or three instances were these resources utilized. (In these [REDACTED] cases, the youngsters may have been treated or evaluated in other environments, although this is not known.) No comparable problem has surfaced since then, either in [REDACTED] or elsewhere overseas. 25X1A
Perhaps the establishment of such centers as the Teenage Halfway House in [REDACTED] to which the Agency contributed financially, and teenage centers in other overseas locations, is associated causally with this course of events. 25X1A

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