

# Drug Abuse Dips in Kids, but Increases in Seniors

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WASHINGTON — Abuse of illegal drugs by young adults increased between 2004 and 2005, and drug abuse by adults in their 50s has climbed by nearly two-thirds over the last 4 years, according to survey data reported by the Substance Abuse and Mental Health Services Administration.

Moreover, the use of any illegal drug in the past year among those 65 years old or

older nearly doubled during 2004-2005, from 0.9% to 1.7%, and the portion in the 60-64 age group reporting past-year drug abuse rose more than 50%, from 2.0 in 2004 to 3.2% in 2005, according to data from the 2005 National Survey on Drug Use and Health (NSDUH), formerly called the National Household Survey on Drug Abuse.

Despite these figures, abuse of most illegal drugs by minors dropped between 2004 and 2005, according to NSDUH data presented at a press briefing.

SAMHSA officials characterized the overall data as evidence that their programs have been successful. "The news today is there is a fundamental shift in drug use among young people in America," acting deputy SAMHSA administrator Eric Broderick, D.D.S., said in a statement.

Still, persons in the 18- to 25-year-old age group had the greatest reported prevalence of drug use in 2005, the report noted.

From 2004 to 2005, the number of past-month users increased among young

adults for almost all drugs. For these young adults, reported use of marijuana in the past month rose from 16.1% to 16.6%, according to the report. Similar small increases were noted in use of psychotherapeutics (from 6.1% to 6.3%), cocaine (2.1% to 2.6%), and inhalants (0.4% to 0.5%), whereas past-month use of hallucinogens remained at 1.5%. For all illicit drugs other than marijuana, the percentage of users in the past month in the 18-25 group rose between 2004 and 2005, from 8.1% to 8.8% of respondents.

Notably, self-reported use of any illicit drug among those aged 50-59 has risen each of the last 4 years, from under 3% in 2002 to more than 4% in 2005—an increase of 63%.

The NSDUH data do show some decreases in drug use. For persons aged 12-17 years, self-reported use of marijuana in the preceding month has dropped in each of the last 4 years; past-month marijuana use between 2004 and 2005 decreased from 7.6% to 6.8% of this middle-school and high-school age group.

Also, past-month illegal use of prescription psychotherapeutics among 12- to 17-year-olds decreased from 3.6% in 2004 to 3.3% in 2005, and past-month illegal use of inhalants and hallucinogens each remained the same, at 1.2% and 0.8%, respectively.

For cocaine use, however, there was a slight increase in past-month use in the 12-17 age group, from 0.5% to 0.6%.

For all persons queried in the NSDUH (aged 12 and older), the percentage indicating past-month use of marijuana dropped from 6.1% in 2004 to 6.0% last year; the number of persons of all ages who reported first-time use of methamphetamine in the previous year declined 40% between 2004 and 2005, from 318,000 to 192,000. That number had risen 22% between 2003 (260,000) and 2004.

Methamphetamine in particular saw a precipitous drop. For all ages, "lifetime methamphetamine use declined 19% since 2002 and dropped 12% in a single year, the 2004-2005 period," John Walters, director of the White House Office of National Drug Control Policy, noted at the briefing. The mean age at which marijuana was first used rose slightly from 17.1 years in 2004 to 17.4 years in 2005, compared with 17.0 years in 2002 and 16.8 years in 2003, he said.

Overall past-month tobacco use for all age groups increased slightly from 2004, from 29.2% to 29.4%, but among those aged 12-17 years, overall use declined, from 14.4% to 13.1%. Underage alcohol use posted a slight decline from 2004, from 28.7% to 28.2%.

The most recent NSDUH was administered to nearly 68,000 persons in the United States. The survey is given in respondents' homes and excludes inmates, hospital patients, nursing home residents, military personnel, homeless not living in shelters, and persons younger than 12 years.

For the past 2 years, the survey has paid respondents \$30 for participating; any influence this practice might have had on responses is not discussed in the report. The sampling for the survey also changed in 2005, from being based on census area segments to being based on census tracts. ■



## Assessing patient activity: An important clinical measure in COPD

The decline of lung function in patients with chronic obstructive pulmonary disease (COPD) is insidious. Its impact usually first becomes evident when patients perform daily activities.<sup>1</sup>

### ► Compensating for COPD

Too often, patients simply compensate for COPD by gradually changing their behavior to reduce physical exertion.<sup>1</sup> For example, they may take an elevator rather than climb the stairs—without even noticing that there is a problem. This behavior is compounded by the fact that early COPD is not always initially obvious on physical examination.<sup>2</sup> As a result, patients with COPD are typically not diagnosed until they have reached a moderate level of severity.<sup>1</sup>

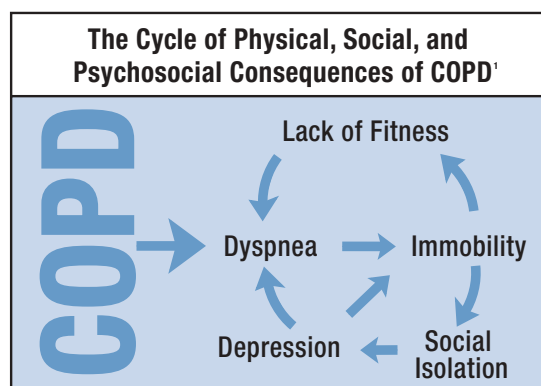
### ► Establishing baseline activity levels

Once COPD is diagnosed, the physician's ongoing assessment should include the impact of the disease on patients' activity.<sup>1</sup> Establishing a baseline activity level is helpful because, in addition to using spirometry, physicians may use changes in activity levels to determine COPD severity. For instance, patients with moderate COPD may only have dyspnea on exertion, while those with severe COPD may experience fatigue and shortness of breath when doing everyday activities.<sup>1</sup>

### ► Breaking the cycle of COPD

The impaired ability to exercise negatively impacts patients' quality of life.<sup>1</sup> By improving patients' exercise tolerance—an important goal in COPD management—physicians can affect the cycle of COPD. Helping patients consider what

they can do physically, in addition to how they feel, can help lead to positive gains in other aspects of COPD and increase functional and social independence—another goal of COPD management.<sup>3</sup>



From the *Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease*, Global Initiative for Chronic Obstructive Lung Disease (GOLD): Updated 2005. Available from <http://www.goldcopd.org>.

### ► Conducting ongoing activity assessments

It is valuable to monitor the activity level of patients with COPD—both at the time of diagnosis and after diagnosis.<sup>1,2</sup> Activity assessment is a key indicator that may help physicians evaluate the clinical efficacy of COPD treatments.

**References:** 1. Global Initiative for Chronic Obstructive Lung Disease. *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease*. Updated 2005. Bethesda, Md/Geneva, Switzerland: National Heart, Lung, and Blood Institute/World Health Organization; 2005. Available at: <http://www.goldcopd.org>. Accessed March 8, 2006. 2. Celli BR, MacNee W, and ATS/ERS Task Force committee members. Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. *Eur Respir J*. 2004;23:932-946. 3. Chronic obstructive pulmonary disease. In: Beers MH, Jones TV, Berkowitz M, et al, eds. *The Merck Manual of Geriatrics*. 3rd ed. Merck Research Laboratories: Whitehouse Station, NJ. Available at: <http://www.merck.com/mrkshared/mmg/sec10/ch78/ch78a.jsp>. Accessed March 8, 2006.



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