

NATIONAL INSTITUTE ON DRUG ABUSE

Assessing Drug Abuse Within and Across Communities

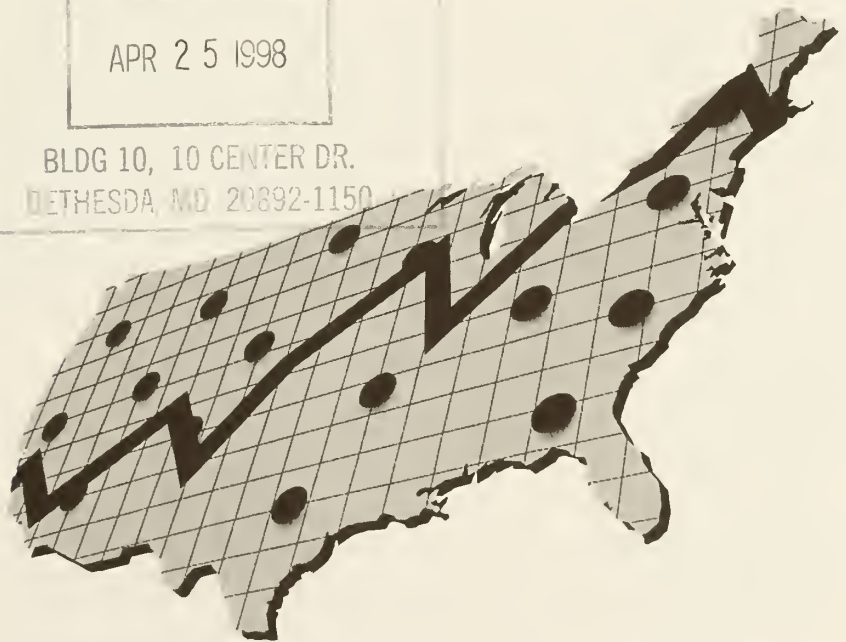
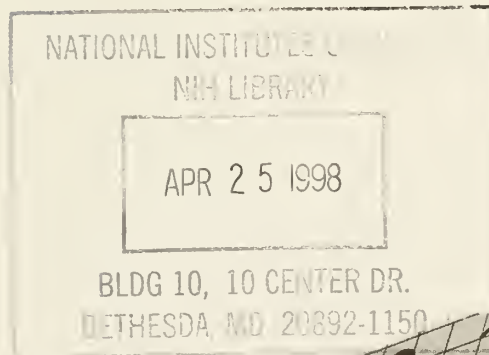
*Community Epidemiology Surveillance
Networks on Drug Abuse*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH



Assessing Drug Abuse Within and Across Communities

***Community Epidemiology Surveillance
Networks on Drug Abuse***



DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

National Institute on Drug Abuse
Division of Epidemiology and Prevention Research
5600 Fishers Lane
Rockville, Maryland 20857

4V
5801
A87
1998

This publication was written under the scientific direction of Nicholas J. Kozel, M.S., Associate Director and Zili Sloboda, Sc.D., Director, Division of Epidemiology and Prevention Research, National Institute on Drug Abuse and was produced under Contract No. NO1DA-6-5054 .

All material in this volume is in the public domain and may be used or reproduced without permission from NIDA or the authors. Citation of the source is appreciated.

The U.S. Government does not endorse or favor any specific commercial product or company. Trade, proprietary, or company names appearing in this publication are used only because they are considered essential in the context of the studies described here.

National Institute on Drug Abuse

NIH Publication No. 98-3614

Printed April 1998

Preface

Drug abuse and addiction have a devastating impact on a community. They lead to increased rates of crime and violence, family disintegration, childhood developmental barriers, illness, and even death. Addiction is not discriminatory. It is an “equal opportunity destroyer,” affecting all aspects of society.

The National Institute on Drug Abuse (NIDA) supports over 85 percent of the world’s research on drug abuse and addiction. Through NIDA’s research program, much has been learned about how drugs affect us—what they do to our brains, our bodies, our behavior, our relationships, our communities, and our society. Great strides have been made in understanding the biological, behavioral, social, and environmental influences that place individuals at risk for drug abuse and addiction. Importantly, research has also yielded major advances in preventing and treating drug abuse.

Communities can play an active role in preventing and reducing drug use in their own local environment. Science has taught us much about the fundamental principles underlying successful drug abuse prevention, principles that can be applied locally to both evaluate existing prevention efforts and develop new programs. These principles are outlined in NIDA’s science-based guide to drug abuse prevention, *Preventing Drug Use Among Children and Adolescents—A Research-Based Guide*, published last year. This booklet was specifically designed to aid communities in their local prevention efforts.

Understanding the local environment is essential if a community is to successfully address drug abuse problems. It sets the context in which both prevention and treatment programs must operate. Research has shown that to be maximally effective both prevention and treatment efforts must be tailored to current local needs. However, local drug abuse problems are not easy to detect, quantify, and categorize. Patterns change as new drugs become available, new combinations become popular, and users experiment with new ways of administering drugs.

To help communities understand their local drug abuse problems, NIDA has developed this guidebook. It will be a useful tool as you develop a drug abuse epidemiologic surveillance system to assess local drug abuse patterns and trends. This model can be used by States, counties, cities, and communities. It is based on the work of NIDA’s Community Epidemiology Work Group (CEWG), a national surveillance network composed of researchers from around the country that has been meeting biannually for more than 20 years to monitor drug use and abuse trends.

This particular model has proven to be useful in assessing local drug abuse patterns and trends, and especially emerging problems. It has been successfully applied in many States, and by countries and regions internationally. The information generated by the networks is used to alert prevention, treatment, and public health officials, as well as the general public, so that appropriate and timely action can be taken. Researchers, too, find the information useful in developing and assessing hypotheses explaining changes in drug use patterns and the characteristics of drug users. States, counties, and smaller communities interested in developing a surveillance network capability will find this guide useful.

There is great efficiency in using data sources to assess the nature of the drug abuse problem in a community. Analyses of information gathered through these means will suggest where additional research is needed, which groups or areas need to be targeted for preventive and treatment interventions, and what questions need to be answered for both policy and programmatic decisions. However, it is important to note that this is but one of several approaches that might be used to assess the drug abuse problem at the local level.

We hope this guide proves useful in improving the quality of the Nation's prevention and treatment efforts. We would welcome feedback from users about both its usefulness and ways we might improve upon it.

Alan I. Leshner, Ph.D.
Director
National Institute on Drug Abuse

Contents

Community Epidemiology Surveillance Networks on Drug Abuse	1
What Are Community Epidemiology Surveillance Networks?	1
Where and How Did Surveillance Networks Get Started?	2
Why Are Networks Established?	2
What Are the Advantages of a Network?	4
What Sources of Information Do Networks Access and Use?	4
How Are Local Networks Organized?	5
How Should the First Network Meeting Be Organized?	7
What Types of Problems are Encountered By Networks?	8
Who Should Be Invited to the First Network Meeting?	9
Accessing Data From Different Sources	12
<i>Treatment Data</i>	12
<i>Treatment Episode Data Set</i>	18
<i>Uniform Facility Data Set</i>	18
<i>Methadone Treatment Programs</i>	19
Medical Examiner and Coroner Data	19
<i>State Data on Alcohol and Drug Deaths</i>	21
<i>Underlying vs. Multiple Cause Tapes</i>	24
<i>Use of Hard Copies of Death Certificates</i>	24
<i>Age Limits</i>	26
<i>Direct Death Causes</i>	26
<i>Indirect Death Causes</i>	26
<i>Uses of the Death Data</i>	27
<i>Hospital Emergency Departments</i>	29
Drug Abuse Warning Network (DAWN)	30
<i>How DAWN Works</i>	31
<i>How DAWN Data Are Disseminated</i>	32
<i>National Hospital Ambulatory Medical Care Survey</i>	32
<i>Hospital Data</i>	32
<i>Purpose of Studying Hospital-Based Drug-Related Discharges</i>	37
<i>Where Can A Network Obtain Hospital Data?</i>	37
<i>Development of the International Classification of Diseases</i>	39
<i>Drug-Related ICD-9-CM Diagnostic Related Groups</i>	39
<i>Limitations of Using Hospital Data</i>	42
<i>Information Networks Should Request</i>	42
<i>Hospital Data Needs and Issue Development</i>	43
<i>Outcomes of a Comprehensive Hospital-Based Drug-Use Report</i>	44
Law Enforcement Data	45
<i>Uniform Crime Reports</i>	46
<i>Data from Crime Laboratories</i>	50
<i>Drug Trafficking Reports</i>	56
<i>Domestic Monitor Program</i>	56
<i>Price and Purity Data</i>	56
Arrestee Drug Abuse Monitoring Program	58
Surveys	59
<i>National Surveys</i>	60
<i>State Surveys</i>	61
<i>Local Surveys</i>	61
HIV/AIDS Data	62
Telephone Hotline Data	63

Other Useful Data Sources	64
<i>Census Data</i>	64
<i>University Researchers</i>	66
<i>Community-Level Sources</i>	67
Establishing and Developing Relationships with Information Sources	68
<i>Public Versus Private Information Sources</i>	68
<i>Preparation/Making Contact</i>	68
<i>Developing Relationships</i>	68
Key Informants	69
Short-Term Ethnography Studies	71

Reporting	74
------------------------	-----------

References	76
-------------------------	-----------

Glossary	78
-----------------------	-----------

Exhibits

A-1	Standard Data Request Form	14
A-2	Characteristics of Drug Abuse Treatment Admissions By Selected Primary Substances, Baltimore City—1996	15
A-3	Demographic Composition and Admission Rates of Drug Treatment Population, Baltimore City—1992-96	17
B-1	Drug and Alcohol Abuse Mortality, Texas	22
B-2	A Sample of Deaths from Opiate Abuse, Texas—1992	25
B-3	Cocaine- and Heroin-Related Deaths in Bexar County, Texas	28
C-1	DAWN Data: Estimated Number of Emergency Room Drug Abuse Episodes/Mentions, San Diego—1992-96	33
C-2	Biannual Estimated Number of Emergency Room Drug Abuse Episodes/Mentions, San Diego—1995-96	33
C-3	DAWN Data: Number of Emergency Room Mentions By Drug, Phoenix—1993-96	34
C-4	Suggested Emergency Department Record Layout, Drug- or Alcohol-Related Episodes	35
D-1	Shreveport Drug Arrests	46
D-2	Shreveport Drug Arrests—1996	46
D-3	Drug Arrests By County, Texas—1994	48
D-4	Drug Arrests By Race/Ethnicity, Texas	49
E-1	Maryland State Police Arrests for Cocaine (HCL)	51
E-2	Maryland State Police Arrests for Crack Cocaine	52
E-3	Maryland State Police Statewide Cocaine (HCL) Prices—1993-94	52
E-4	Maryland State Police Statewide Crack Cocaine Prices—1993-94	53
E-5	Maryland State Police Statewide Low-Purity Heroin Prices—1993-94	54
E-6	Maryland State Police Price of Heroin and Amount of Purchase	54
E-7	Maryland State Police Statewide Marijuana Prices—1991-94	55
E-8	Quarterly Price Data in Dollars for Marijuana—April-June 1996	57
E-9	Annual Price and Potency Data in Dollars for Marijuana, National Range	58
F-1	Reported Alcohol/Drug Helpline Data, Washington State—1990	64

Appendices

Appendix A:	National CEWG Members	A-1
Appendix B:	National CEWG Report Format	B-1
Appendix C:	Statistical Analysis Centers by State	C-1
Appendix D:	Method for Assessing Hospitalization Related to Drug and Alcohol Misuse by Youth and Young Adults	D-1
Appendix E:	State Contacts for Uniform Crime Reports	E-1
Appendix F-1:	1994 Drug-Related Arrests of Persons Over Age 17 by Age, Gender, and Race/Ethnicity—State of Maryland	F-1
Appendix F-2:	1994 Drug-Related Arrests of Persons Under Age 18 by Age, Gender, and Race/Ethnicity—State of Maryland	F-2
Appendix G:	DEA Division Offices	G-1
Appendix H-1:	Excerpts from 1995 Drug Prospectus Report, Criminal Intelligence Division, Maryland State Police	H-1
Appendix H-2:	Additional Drugs of Abuse Reported by Criminal Intelligence Division, Maryland Department of State Police	H-7
Appendix I:	Ethnographic Studies	I-1
Appendix J:	Sample Format for State Reports	J-1

Community Epidemiology Surveillance Networks on Drug Abuse

What Are Community Epidemiology Surveillance Networks?

Community Epidemiology Surveillance Networks are multi-agency work groups with a public-health orientation which study the spread, growth, or development of drug abuse and related problems. The networks have a common goal—the elimination or reduction of drug abuse and its related consequences.

... network members access existing information from multiple sources ...

To achieve this goal, network members access existing information from multiple sources including drug abuse treatment agencies, public health offices, law enforcement agencies, hospital emergency departments, medical examiner and coroners' offices, and local school and household surveys. Members meet periodically to review, compare, and draw conclusions from the data. The data are reported in a standardized format to facilitate the review and comparative analyses. Qualitative studies may be conducted to help members understand the quantitative findings from existing data sets.

The primary objectives of the network members are to:

- identify drug abuse patterns in defined geographic areas;
- identify changes in drug abuse patterns over defined time periods to establish trends;
- detect emerging substances of abuse; and
- communicate and disseminate the information to appropriate community agencies and organizations so it can be used in developing policies, practices, prevention strategies, and research studies.

Network members are individuals who are in a position to contribute and assess information about drug use in specific geographic areas. They may represent agencies and organizations that have some responsibility for addressing drug abuse problems or that benefit directly from acquiring information about drug abuse. Researchers and other individuals who have special knowledge about a particular issue or drug-abusing population also may participate. Regularly scheduled network meetings provide a forum for members to share, review, and analyze information on the epidemiology of drug abuse.

This guide focuses on practical ways of accessing and analyzing diverse indicator data from a variety of data sources and on effective ways of reporting such data.

Where and How Did Surveillance Networks Get Started?

The first national level surveillance network was established by the National Institute on Drug Abuse (NIDA) in 1976 to assess current drug use patterns in major metropolitan areas across the country and to identify emerging trends within and across these areas. This network, called the Community Epidemiology Work Group (CEWG), has been meeting semiannually for more than 21 years to fulfill its role as a drug abuse surveillance system. CEWG members represent Atlanta, Baltimore, Boston, Chicago, Denver, Detroit, Honolulu, Los Angeles, Miami, Minneapolis-St. Paul, Newark, New Orleans, New York City, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, Seattle, the State of Texas¹, and Washington, D.C. Appendix A is a list of the CEWG members. Contact them for information specific to their cities and for additional advice on the organization of a local community surveillance network.

Based on the NIDA CEWG model, State Epidemiology Work Groups (SEWGs) have been organized in many States. Other countries also have adopted the model. Similar work groups have been organized or are under development in Asia, Australia, Canada, Central America, Europe, Mexico, and South Africa. Recently, a program has been initiated to establish surveillance networks throughout the countries of the Americas. In addition, an International Epidemiology Work Group (IEWG), which represents a network of national and regional surveillance networks, has been established.

National CEWG information is disseminated by the Division of Epidemiology and Prevention Research, NIDA, through its biannual report series entitled *Epidemiologic Trends in Drug Abuse*. Information on the national CEWG, its reports, and other important data sources can be accessed directly at <http://www.cdmgroup.com/cewg>. In addition, it can also be accessed through NIDA's Home Page <http://www.nida.nih.gov>. Clicking on *organization*, you will find it listed under Division of Epidemiology and Prevention Research.

Why Are Networks Established?

The primary purpose . . . is to share timely and reliable information . . .

The primary purpose of a local surveillance network is to share timely and reliable information about drug abuse. What types of drugs are being used in particular communities? Who is using them? How are they being used? What are the consequences of use? How are the patterns of use changing?

Information of this type is essential to many agencies and organizations, especially those with responsibility for planning and allocating resources to address drug abuse and related problems. Too often,

¹ Originally, data were reported for the city of Dallas. Currently, data produced by the Texas State Epidemiology Work Group also are reported.

Networks . . . contribute to one or more elements of a needs assessment . . .

agencies plan strategies and commit resources without having up-to-date information about the nature and extent of drug abuse problems. These efforts can be wasteful and counterproductive.

Patterns of drug use are determined not only by the availability and cost of different substances, but also by the dynamics and differences within groups, cultures, and communities. Drug abuse patterns are complex, constantly changing phenomena. Like a disease, they can quickly spread through and across communities. Drug abuse has been associated with increasing rates of crime and violence as well as health problems such as human immunodeficiency virus (HIV) infection which causes the acquired immunodeficiency syndrome (AIDS); other sexually transmitted diseases (STDs); and other infectious diseases such as hepatitis. If a pattern is identified early, appropriate action can be taken to control its spread.

By monitoring drug abuse over time, it also is possible to evaluate whether programs are having any impact on particular aspects of drug abuse problems.

Networks do not necessarily conduct needs assessments. Rather, they may contribute to one or more elements of a needs assessment. A needs assessment is a methodology used by administrators and planners to determine the need for specific services in a particular geographic area. The purposes of a needs assessment are to:

- define the problem;
- determine the magnitude of the problem;
- identify the services that are currently available to address the problem;
- identify the demand for services;
- determine the gaps in service;
- determine what additional services/resources are needed to fill the gaps; and
- help prioritize the problems and services so that administrators and planners can determine how limited resources should be used.

Surveillance networks help define and determine the magnitude of drug problems and provide an early warning for emerging problems. It is important for members to understand the specific purpose (goals and objectives) and limits of the network. Through this understanding, local networks are more likely to be successful and contribute to needs assessments.

What Are the Advantages of a Network?

The surveillance network model has many advantages for planning purposes:

- It uses a practical formula.
- It is not costly.
- It makes use of existing resources.
- It has proven to be effective.
- It provides immediate feedback.
- It works on many different levels.
- The information is useful to many agencies and organizations.
- It provides input from different perspectives.
- It establishes a network of people who share information and work together on common problems.
- It builds an infrastructure for further research.

It takes minimal agency support and a few committed people to get a network started

It takes minimal agency support and a few committed people to get a network started. Once established, the network should be self-sufficient. It requires the participants' time to gather and prepare information prior to meetings, meet periodically, and prepare information for dissemination following the meeting.

Often, people who are sought as members of a network already are engaged by agencies or organizations involved in the drug abuse field and may be currently collecting data from or about drug-using populations. In addition, their agency would probably recognize the short- and long-term benefits to be derived from participation in a surveillance network. The only other requirement for startup is a place to meet.

Optimally, meetings should be regularly scheduled about twice each year. This time frame provides a sufficient time gap (6 months) to assess changes in drug use patterns and keep the groups active without placing a heavy burden on participants. At least 1 full day should be set aside for each meeting.

What Sources of Information Do Networks Access and Use?

Networks make use of multiple sources of information. Each source provides information about particular drug-using populations and/or different facets of the behaviors and outcomes of the same or similar populations. The information obtained from each source is considered an indicator of drug abuse. The direction of changes in indicators across time is a measure of relative change in drug abuse behavior and related problems rather than a measure of absolute change. Indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be

... indicators help identify different types of drug abusers ...

increasing or decreasing in size. However, indicators do help identify different types of drug abusers, such as those who have been arrested, treated in emergency rooms, admitted to drug abuse treatment programs, involved in accidents, diagnosed with HIV/AIDS, or died with drugs found in their bodies.

One source can complement and support another and help to validate information on drug use patterns

By comparing information from different sources concurrently, network members can identify and learn more about different drug-using populations, the similarities and differences across groups, and perhaps emerging patterns and trends. One source can complement and support another and help to validate information on drug use patterns.

Networks, at all levels, use many data sources:

- drug abuse treatment and intervention agencies;
- hospitals and hospital associations (which may provide data on drug-exposed newborns);
- State, county, and local health agencies and departments;
- school and community surveys;
- education offices and departments;
- State and county crime and forensic laboratories;
- agencies and departments that collect and report arrest data;
- medical examiner and coroner offices;
- HIV outreach programs;
- studies by university researchers; and
- drug hotlines.

There may be many other potential sources of information, depending on the community itself.

How Are Local Networks Organized?

Generally, the impetus for organizing a surveillance network comes from an agency that recognizes the need for up-to-date information about drug abuse patterns and trends. The agency may be one that coordinates drug abuse data sources or a health planning organization. Sponsoring a network can be of great benefit to an agency, as it provides that agency with important information about drug trends, knowledge about street use, and a network of sources to answer questions. Any agency that deals with the general public, answers questions about drugs, or provides public information will find the investment in sponsoring a local network worthwhile. In addition, it will be possible to provide education and information materials and press releases to inform the public of current trends.

It is best to plan and maintain small work groups . . .

It is best to plan and maintain small work groups so that all participants have an opportunity to contribute to the process. Try to get members from different organizations and with different perspectives. Include the medical examiner, treatment program personnel, HIV street

outreach workers, health planners, university researchers, and local police officers. If the network is composed of representatives of different towns, cities, or counties, the reporting process should be standardized so that comparisons can be more easily made across different jurisdictions.

Initially, one or two staff members can be assigned to review and report on potential benefits, other potentially valuable participants, and accessible sources of information. Representatives of other agencies can be contacted to determine how the information might be useful to them, their level of interest, and who from their agencies might meet the qualifications to participate in the network. This type of review should be completed within a 1–2 month period.

... arrange a small planning meeting of staff from key agencies

If, on the basis of the information, it is decided to begin efforts to organize a surveillance network, arrange a small planning meeting of staff from key agencies. This meeting should include researchers and agency representatives who are familiar with drug abuse issues and sources of data and who are interested in the possibility of establishing a network. The meeting should be structured to:

- establish the rationale for, and the purpose of, a network;
- identify potential sources of data/information;
- identify agencies and individuals with access to information;
- identify individuals who could contribute in other ways to the network;
- develop an agenda for the first meeting;
- determine who should be invited to participate in the first meeting and what they should be asked to contribute;
- establish a time and place for the first meeting; and
- develop a plan for the second meeting, including the date, place, and general themes to be covered.

A preliminary step that has proven useful is to hold a preplanning meeting with officials of selected organizations or agencies to discuss the purpose and goals of the network; how the agency or organization can contribute; the staff capabilities, knowledge, skills, and experience required to contribute; and the benefits to the agency of belonging to the network.

While it is unlikely that an agency official will be a working member of the local network, enlisting the official's support may well increase the agency's participation in and contribution to the network. Unless the official understands the value of the network, he or she may not be willing to support the initiative and the investment of time by the agency. In addition, the official may help identify the most qualified person(s) from the agency to serve on the network. In some instances, it is beneficial to invite both the official and his or her data person to the meeting so the official can become informed of the benefits of the group and the data person can be involved from the beginning in identifying needed information.

How Should the First Network Meeting Be Organized?

The first meeting is critical because it sets the stage for what the surveillance network will be, how it will function, and how it will be perceived by participants and others.

Two interrelated objectives should always be kept in mind:

- obtaining knowledge about drug abuse; and
- developing and strengthening the work group.

Care should be taken to avoid common pitfalls that others have encountered in planning initial network meetings. Four principles should be observed:

1. Start small. Be selective in inviting individuals to attend. It is easy to add individuals once the needs and sources have been identified and to change individuals based on the strengths and interests of the members.
2. Have clear, attainable objectives for the meeting. Avoid trying to overachieve at the beginning.
3. Establish the agenda in coordination with other participants so they feel invested from the beginning.
4. Give each participant a role to play and a contribution to make.

The first meeting should be organized to accomplish several objectives:

- Identify known and potential sources of data and information. Selected participants can be asked to describe particular data sets and to prepare and briefly present data from sources to which they have access.
- Review the types of data sources (indicators) accessed by other epidemiologic networks to determine if they might be obtainable in your area. If they are, determine what steps should be taken to identify agencies and individuals who can provide access to each of these sources.
- Assign participants to follow up (after meetings) and, if appropriate, make contacts to find out what types of data are available, how the data can be made available, and who is most knowledgeable about the data and the data sources.
- Determine how the information from the meetings should be recorded, reported, and disseminated, including to whom it should be sent. A full report with all the information will prove very useful for agency planners, grant writers, and staff associated with the network member agencies. An executive summary that brings all the information together in a quick-refer-

Have clear, attainable objectives for the meeting

Surveillance networks need to remain focused on questions . . .

ence format will prove very popular with the press and the general public.

- Identify current and potential sources of support for organizing and conducting the meeting, and producing and disseminating reports from the meeting. The full report should be based largely on the papers prepared and presented by participants, along with data tables.

Surveillance networks need to remain focused on questions such as; What drugs are currently being used? Who is using them? Are drug use patterns changing from year to year? If so, how?

What Types of Problems Are Encountered by Networks?

It is easy to get sidetracked, especially when extraneous information is presented. As in any work group, individuals who participate in network meetings have self-interests. They are likely to have different backgrounds and different frames of reference. It may not always be clear to them what is expected. If each member is sent the specific format for the presentation in advance, it will be easier to keep the meetings on track and to get the information in a form that is comparable with that submitted by other members. Appendix B is a copy of the format used by the national CEWG.

It must be kept in mind that there is limited time to address the key questions and achieve the network's objectives. It is therefore important for the persons coordinating or chairing network meetings to define carefully what information participants need to present and to keep the meetings focused. Tell each member in advance the time limit for the oral presentation.

Another problem is the turnover in members and finding members who are interested in the network and are willing to commit to the process and collect and report on the information on a continuing basis. The network coordinator should understand that part of the job is an ongoing search for new members and persons who have the time to participate. It is a good policy to routinely call the agency directors to thank them for the past participation of their staff, inform them that another meeting is planned, explain the importance of their agency's participation and the benefit to the agency, and request that the particular staff member be given time and support to prepare the report and participate in the meeting. At times, the director will not know that a meeting has been scheduled, and the local network member will be assigned to another task and be unable to attend the meeting or not have time to gather the needed data.

. . . define clearly what information participants need to present and keep the meetings focused

Who Should Be Invited to the First Network Meeting?

One of the primary objectives of the first meeting is to identify individuals who are in the best position to contribute information . . .

The first meeting should be considered a planning session. The organizers should emphasize that the individuals who attend this meeting will not necessarily be permanent members and they are not obligated to attend future meetings. One of the primary objectives of the first meeting is to identify individuals who are in the best position to contribute information to the network planning process. If a national CEWG member is located in your State, or if there is a planner at the State Alcohol and Drug Abuse Agency who is knowledgeable about sources of data, invite them to the first meeting.

The first meeting should include individuals (generally agency representatives) who are capable of providing information about different sources of data, including the following:

Survey Data

If not yet known, find out if any relevant local surveys have been or are currently being conducted or planned. These would include household, school, and special population surveys that provide information about substance use. Every State Alcohol and Drug Abuse Agency has received a contract from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), to perform surveys in the State, so contact the State to find out who is in charge of these surveys. In addition, some States have contracts from other Federal agencies to perform surveys. In some instances the State agency has done the surveys, while in other States a university or survey research firm has done the surveys. If a relevant survey has been or is being conducted, invite the Principal Investigator or another person who can describe the data collected.

Drug Abuse Treatment Data

If not yet known, find out which agencies collect information about drug abusers entering, undergoing, and/or leaving treatment. Every treatment program that receives funds from the State Alcohol and Drug Abuse Agency is required to report data to the State. Which local drug abuse treatment programs participate in the State system and which are required to report client data to county and city coordinating agencies? Find out who in the coordinating agencies is responsible for coordinating these efforts. Contact these individuals to find out who would be the most appropriate person to participate in the first network meeting.

Law Enforcement Data

If not yet known, find out which agencies, departments, or offices collect drug use data on local arrestees charged with criminal offenses, including drug violations. Drug violations, including arrests for possession and/or trafficking, are reported by counties

. . . find out who would be the most appropriate person to participate in the first network meeting

... find out what types of data related to drug use are collected, and who coordinates such efforts ...

and States. Several different State offices can be contacted to determine sources of arrest data. These include the Uniform Crime Report Office, the Statistical Analysis Center, the Law Enforcement Planning Office, and the Attorney General's Office. In some instances, the same arrest will be reported by the local police, the State police, and Federal agents, so inquire about possible duplicate reporting and overlap. Other law enforcement data which can be very useful include information on price and purity of drugs confiscated. Try to find out which levels of law enforcement agencies are included in a report. State Statistical Analysis Centers assemble statewide criminal justice statistics, act as a clearinghouse for statewide crime information and statistics, and issue periodic reports. The names, addresses, and telephone numbers of center offices in each State are listed in Appendix C.

Hospital Data Pertaining to Drug Use

If not yet known, contact the State, county, and city health departments to identify individuals who can provide information about relevant hospital data sources. If the geographic area covered by the network is relatively small, it may be appropriate to contact administrators of each hospital to find out what types of data related to drug use are collected, and who coordinates such efforts within or outside the hospital.

AIDS Cases and HIV Seroprevalence Data

HIV/AIDS is a reportable condition in all States and territories in the United States. The HIV/AIDS Surveillance System, established by the Centers for Disease Control and Prevention (CDC), monitors the incidence and demographic profile of AIDS cases and describes the modes of HIV transmission among infected persons. State and local health departments conduct active surveillance. Standardized case report forms and software (HIV/AIDS Reporting System) are used to produce local tabulations and to report cases monthly to the CDC. Currently, all 50 States, U.S. territories and possessions, and 6 major cities report through the CDC surveillance system. One of the objectives of surveillance is to identify changing patterns in the modes of HIV transmission. The local health department office responsible for HIV/AIDS surveillance should be contacted to find out who is the best person to report relevant information at the first network meeting. Examples of information could include the percent of injection drug users who have contracted the virus and the number of cases where HIV has been transmitted heterosexually. Look for trends associated with trading drugs for sex and increases in those racial/ethnic, age, and sex categories that may be related to drug use and risky sexual behavior.

In addition, the Ryan White Act requires regional data collection and needs assessment for HIV programs, and the local group that coordinates the Ryan White funds will have valuable information.

These reports may include students who were suspended or dropped out of school because of drug use

Health Data

Since substance abuse also is related to numerous health consequences, such as tuberculosis and sexually transmitted diseases, the State, county, or city health departments will have information on the number of individuals who have these diseases and the prevalence rates for these diseases in your local area. Contact the health department to get the statistics and to obtain information from the street outreach workers who seek out persons with these diseases. In some instances, certain outreach workers concentrate on drug-using populations while others will concentrate on prostitutes and commercial sex trade workers.

School Data

Some school systems, including colleges and universities, maintain records on the number and types of drug use problems identified by schools. These reports may include students who were suspended or dropped out of school because of drug use. In addition, many schools have used their Federal Safe and Drug Free Schools grants to fund surveys, and, in some States, the Center for Substance Abuse Prevention (CSAP) has funded the State Alcohol and Drug Abuse Agency to conduct surveys of school students. If a relevant survey has been or is being conducted, invite the Principal Investigator or another person who could describe the data collected.

Community-Level Data Sources

At the community or neighborhood level, data/information sources can be obtained from smaller entities. Be careful to check that this information is not already included in reports from the various State agencies. These are some suggested local sources of data:

- local hospitals;
- treatment programs (both public and private);
- health clinics;
- community mental health centers;
- schools;
- local Police Department or sheriff's office;
- criminal justice and correctional agencies;
- HIV and STD outreach workers;
- needle exchange programs;
- university researchers;
- medical examiners and coroners;
- recreation facilities; and
- pharmaceutical associations.

Accessing Data From Different Sources

Treatment Data

Data about drugs used prior to entering treatment are generally collected from clients entering treatment programs. If information about the names and locations of drug abuse treatment programs is not currently available to network members, this information can be obtained from the State Alcohol and Drug Abuse Agency. A listing of treatment programs also is likely to be found in the yellow pages of local telephone directories and from directories obtainable from mayor's offices or chambers of commerce. Most publicly funded programs are required to collect and report admission data to the States, and the States report it to the Federal Government. Each State will have its own name for its client data system.

These data have limitations. Drug abusers entering treatment are not representative of drug abusers in the community. They represent individuals referred to drug treatment by criminal justice agencies because they were arrested or incarcerated, they are clients referred from other sources (e.g., family, church, school), or they can be self-referred clients. Usually they have been using drugs for a number of years prior to entering treatment, and their admission to treatment will not be a sign of the emergence of a new drug or new epidemic, but a sign that the client who began using 10 or 15 years ago is now sufficiently impaired to the point of wanting and needing treatment.

Also, individual drug abuse treatment agencies may be structured to treat particular types of drug abusers, although client populations may change over time. In recent years, changes in insurance coverage and managed care have had an impact on these programs and the types of clients served. In addition, information is often reported only by publicly funded programs, and the types of clients who can afford private treatment will not be represented in the information submitted to the State agency. Try to obtain information from the private programs to supplement the information from the public programs.

In contacting drug abuse treatment programs to determine if client data are available, several things should be kept in mind:

- Information that would potentially make it possible to identify an individual client cannot be divulged under penalty of Federal law, so programs cannot provide the information that might be desired except at aggregate or summary levels.
- Treatment programs are in the business of treating clients; not surprisingly, staff see treatment as their primary obligation. Often these staff do not see the potential benefits of research and are likely to feel that any attempt to obtain client data is another demand on their limited time.

-
- The task of treating drug abusers is very difficult and requires a considerable investment of time and resources.
 - The HIV/AIDS epidemic has added considerable pressure on staff and programs, especially those programs that serve clients at high risk for this disease (e.g., injection drug users).
 - Most treatment programs have limited resources and an ongoing need to identify and secure additional financial resources.
 - The current emphasis on managed care has placed considerable pressure on treatment programs to reduce the length of services provided and reduce costs.

Exhibit A-1 is a standard format that could be used to make data requests.

By quantifying treatment data, it is possible to identify the types of drug problems reported by different types of clients. Intake data are particularly useful to epidemiologic networks because these data generally include specific information about drugs used prior to seeking admission to treatment. Typically, programs distinguish the primary, secondary, and tertiary substances used by individuals entering treatment. The primary drug is usually the drug that the client feels is causing him/her the most serious problems. Specific drug data, along with client demographic data, can provide a great deal of information that will enable networks to track drug use patterns and trends within specific geographic areas.

Intake data generally include specific information about drugs used . . .

Exhibit A-2 is an example of how drug abuse treatment data can be quantified for a particular geographic area and what can be learned from such data. This exhibit was used by a member of the national CEWG to report Baltimore City treatment indicator data at the December 1997 CEWG meeting.

These data show the demographic characteristics of different types of substance abusers admitted to Baltimore City publicly funded treatment programs in 1996. As can be seen:

- 53.2 percent of the 14,613 clients reported heroin as the primary drug of abuse.
- 21.3 percent reported cocaine as their primary substance (of these, 76.6 percent are crack abusers).
- 11.7 percent fell into the “alcohol with other drug” category.
- 11.5 percent reported marijuana as their primary drug of abuse.

Much more can be learned about each type of primary drug abuse category from this exhibit. For example, more than half (51.8 percent) of the heroin abusers snorted the drug (primary route of administration), and 48.2 percent injected it. Individuals who snorted heroin were more likely than injectors to be African-American (94.2 vs. 78.3 percent), female (49.5 percent), and younger. Only 26.8 percent of the snorters were 35 years of age or older, compared with 65.7 percent of the injectors.

Exhibit A-1: Standard Data Request Form

CEWG Site _____

Characteristics of Clients Admitted to Treatment

From _____ to _____, 1994
MONTH MONTH

Total number of treatment admissions, excluding alcohol only: <input style="width: 100px;" type="text"/>					
	Alcohol-in-Combination <small>(Exclude Alcohol Only)</small>	Cocaine	Heroin	Marijuana	Stimulant/ Methamphetamine
Total N:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
<small>(Use to derive percentages)</small>					
Gender:					
Male	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Female	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Race/Ethnicity:					
White	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
African American	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Hispanic	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Other	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
1. _____	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Other	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
2. _____	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Age at Admission:					
17 and under	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
18 to 25	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
26 to 34	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
35 and older	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Route of Administration:					
Smoking	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Sniffing	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Intravenous	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Other/multiple	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Secondary Drug:					
Type of Drug	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>
	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %
Tertiary Drug:					
Type of Drug	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>
	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> %

SOURCE: National Institute on Drug Abuse, 1996.

EXHIBIT A-2: Characteristics of Drug Abuse Treatment Admissions By Selected Primary Substance, Baltimore City—1996

Drug Use	Total	Alcohol (with drug)	Heroin		Cocaine		Marijuana
			Injected	Snorted	Crack	Other	
(Number of Admissions)	(14,613)	(1,704)	(3,741)	(4,027)	(2,384)	(728)	(1,686)
Primary Use of Substance	100.0	11.7	25.6	27.6	16.3	5.0	11.5
Other Substances Reported*							
None	27.1	-	18.8	33.7	42.4	25.3	40.5
Alcohol	26.3	-	26.2	22.2	37.5	40.2	44.4
Cocaine	41.4	58.0	72.5	51.3	-	0.1	14.4
Marijuana/hashish/THC	18.9	50.3	9.4	18.9	23.7	27.1	0.1
Heroin/opiates/synthetics	10.8	27.0	3.3	2.0	19.7	41.4	7.8
Demographic Characteristics	%	%	%	%	%	%	%
Gender							
Male	59.6	74.3	56.5	50.5	48.1	70.2	85.9
Female	40.4	25.7	43.5	49.5	51.9	29.8	14.1
Race/Ethnicity							
White	16.9	24.7	20.9	5.4	16.2	22.1	22.0
African-American	82.1	73.6	78.3	94.2	83.1	76.1	75.7
Hispanic	.06	.09	.06	.02	.05	.08	1.5
Other	0.4	0.8	0.2	0.1	0.3	1.0	0.9
Age at Admission							
<18	7.3	14.5	0.5	0.2	0.5	0.3	45.4
18-25	14.3	13.5	5.9	18.0	9.7	12.3	32.2
26-34	37.6	28.0	27.9	55.0	47.0	36.6	13.8
35 +	40.8	44.0	65.7	26.8	42.8	50.8	8.6
Average Age at Admission	32.4 yrs.	31.9 yrs.	37.4 yrs.	31.3 yrs.	33.6 yrs.	34.7 yrs.	21.4 yrs.

* "Other substances reported" adds to more than 100 percent because it includes secondary and tertiary substances.
SOURCE: National Institute on Drug Abuse, 1997.

Most of the primary heroin abusers reported using other drugs. Cocaine was, reportedly, used by 72.5 percent of the heroin injectors and 51.3 percent of the snorters. Marijuana was more popular among the heroin snorters (18.9 percent) than the injectors (9.4 percent).

The Baltimore City data show that there are important differences within and between drug categories. Although treatment data of this type are limited, much can be learned about different populations entering substance abuse treatment.

It also is useful to know where clients are seeking treatment live. Some treatment programs serve clients who live in a particular geographic area that, while others accept clients from distant areas. Information that would identify an individual client is confidential, so it will not be possible to obtain addresses or even ZIP code information on individual clients. The local program should be able to aggregate the client information and provide data on the number of clients who live in each ZIP code, area, census tract, or block numbering area (BNA). Maps of ZIP code areas, census tracts, and/or BNAs for specific geographic areas can be obtained by calling the U.S. Bureau of Census Customer Service number: (301) 457-4100. The information can be ordered in a variety of formats at the following address: U.S. Department of Commerce, U.S. Bureau of the Census, P.O. Box 277943, Atlanta, GA 30384-7943.

... treatment data have been useful in identifying drug abuse patterns and trends and emerging drug problems

It also is possible to compare data from the same sources at different time periods to determine changes in drug use patterns and populations. Historically, treatment data have been useful in identifying drug abuse patterns and trends and emerging drug problems. These data are generally a good indicator of the types of drugs being used in geographic areas over time, but check with your sources to make sure an upswing in admissions or a shift in drug patterns is not due simply to the startup of a new and specialized treatment program. As an example, the Texas Legislature funded a criminal justice treatment initiative that resulted in a very large number of arrestees, prisoners, and probationers being referred to treatment. Some of these clients were severely addicted, while others were not yet addicted to heroin or cocaine. This influx of a significant number of males and clients who were not yet addicted to “hard drugs” resulted in a major change in the drug use patterns that was caused by funding policies rather than shifts in the use of drugs on the street. Exhibit A-3 is an example of how treatment data can be analyzed over time to assess drug abuse trends. This exhibit was used to report Baltimore City treatment indicator data at the December 1997 CEWG meeting.

As can be seen in Exhibit A-3, changes in client characteristics were not substantial over time. However, the rates of use (per 100,00 population) were substantial for some primary drugs of abuse.

There were significant increases in rates of heroin use between 1992 and 1995 and in rates of marijuana/hashish use between 1992 and 1996. Rates of heroin snorting increased significantly from 1993-1995.

EXHIBIT A-3: Demographic Composition and Admission Rates of Drug Treatment Population, Baltimore City—1992-96

	1992	1993	1994	1995	1996
(Number of admissions)	(12,447)	(13,165)	(13,988)	(14,772)	(14,613)
Demographic Characteristic	%	%	%	%	%
Gender					
Male	63.0	58.9	58.5	56.6	59.6
Female	37.0	41.1	41.5	43.4	40.4
Race/ethnicity					
White	19.0	19.6	18.4	17.3	16.9
African-American	80.2	79.4	80.6	81.4	82.1
Hispanic	0.4	0.6	0.5	0.8	0.6
Other	0.4	0.4	0.5	0.4	0.4
Age at Admission					
<18	4.6	4.7	5.9	6.6	7.3
18-25	19.4	19.4	18.0	16.1	14.3
26-34	41.6	41.7	41.0	39.8	37.6
35 +	34.4	34.1	35.1	37.6	40.8
Admissions per 100,000 Population Aged 12 +	1,879	2,015 +++	2,181 +++	2,349 +++	2,372
Primary Substance					
Alcohol with secondary drug	314	295	278	247 ---	277 ++
Cocaine	572	569	564	535 -	505 -
Smoked (crack)	312	381 +++	401	410	387 -
Injected	141	88 ---	79	57 ---	52
Snorted	112	94 --	78 --	64 --	60
Other	6	6	6	4	6
Marijuana/hashish	70	100 +++	144 +++	220 +++	274 +++
Heroin/opiates/synthetics	890	1,023 +++	1,173 +++	1,328 +++	1,300
Injected	575	586	600	622	607
Snorted	285	407 +++	535 +++	670 +++	654
Other	30	29	38 ++	36	39
PCP	9	12	9	8	7
Stimulants	2	•	•	•	1
Methamphetamine	•	•	•	•	•
Amphetamine/stimulants	2	•	•	•	•
All other	22	16 -	12	11	9

* Less than 1 per 100,00 population.

+/- Significant increase/decrease over previous year=s rate: +++/-p<.01; +/-p<.05.

SOURCE: National Institute on Drug Abuse, 1997.

Treatment Episode Data Set

The Treatment Episode Data Set (TEDS) is administered at the Federal level by the Office of Applied Studies (OAS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) and can be accessed at <http://www.samhsa.gov>.

TEDS collects the following anonymous information on each client: date of admission; number of prior treatments; source of referral; date of birth; gender; race/ethnicity; education level; employment status; primary, secondary, and tertiary substance problems; usual route of administration for each problem substance; frequency of use; age of first use; and services provided. Additional data can be collected on diagnostic code, psychiatric problems, pregnancy at time of admission, veteran status, living arrangements, primary source of income or support, health insurance, expected source of payment for treatment, marital status, and time waiting to enter treatment. The local program or the State Alcohol and Drug Abuse Agency should be requested to generate tables on client characteristics from the TEDS data.

Uniform Facility Data Set

The annual Uniform Facility Data Set (UFDS) survey, which was previously known as the National Drug and Alcohol Treatment Unit Survey (NDATUS), is another source for sociodemographic information on clients in various programs. UFDS is an annual Federal survey administered by the State Alcohol and Drug Abuse Agency. In some States, reporting by all programs is mandatory, while in other States reporting by private programs is optional. UFDS, which is administered by OAS, is available at <http://www.samhsa.gov>. The Web site will have information aggregated at the State level, but it will not have the information reported by each program.

The local program fills out information on the UFDS form based on the operations and clients in treatment on a particular day, such as September 30. The form collects information on the number of clients by race/ethnicity, gender, age group, and treatment modality, (e.g., detoxification, residential, outpatient, methadone). The form also collects information on the capacity of the program; ownership; licensure status; qualifications of staff; kinds of services provided (assessment, therapy, testing, health care, transitional, continuing care, and community outreach); availability of services targeted to special groups, such as women or youth; and revenue sources. It does not provide information on which drugs were being abused by the clients, but it does show the differences in characteristics between the public and private programs. Until 1995, the form was in triplicate so the local programs could keep a copy of the completed questionnaire and the State also could keep a copy, so it should be easy to get historical information on local programs. Since 1995, the form was not on triplicate paper, so it might be more difficult to obtain information on the individual programs unless the State or each of the local programs kept their own copy of the form.

Methodone Treatment Programs

Another source of data can be the reports that local methadone maintenance programs file with the State methadone licensing authorities each year. This information will vary by State, but it probably includes information that is not collected elsewhere. Some States have a methadone registry that also can provide information on heroin addicts.

In reporting treatment data at a network meeting, it is important to have a standardized format so that participants can easily assess the information. If there are sufficient numbers of clients, it is possible to distinguish drug use patterns by age, ethnic group, and gender. It also is useful to include data from prior years so that comparisons can be made to determine relative change in drug use patterns and drug-using populations, as well as changes in program capacities.

Medical Examiner and Coroner Data

Medical examiners and coroners (ME/Cs) are responsible for investigating sudden or violent deaths and for providing accurate, legally defensible determinations of the causes of these deaths. Information provided by ME/Cs plays a critical role in the judicial system and in decisions made by public safety and public health agencies. The records of ME/Cs, which provide vital information about mortality patterns and trends in the United States, are an excellent source of data for epidemiologic networks.

Death investigation practices vary considerably among jurisdictions

Death investigation practices vary considerably among jurisdictions (whether State, county, district, or city). The most noticeable difference is that some jurisdictions use the medical examiner system, while others use the coroner system. The type of system used may be uniform throughout a State or may vary from county to county within a State. Medical examiners may have State, district, or county jurisdiction. Usually they are appointed and must be licensed physicians; some are expert forensic pathologists. In comparison, coroners or justices of the peace may have district or county jurisdiction, are usually elected, and need not be physicians. Many are required only to be of a minimum age (often 18) and a resident of the county or district.

Often, ME/Cs or members of their staff will be interested and active participants in a network, because they need to know what drugs are on the street and changes in purity or combinations that could be causing a series of overdose deaths.

A second variation in death investigation practices involves which deaths are actually to be investigated. About 20 percent of deaths in the United States are investigated by ME/Cs, although the percentage varies by State. The guidelines for which deaths are to be investigated also vary widely by jurisdiction, but most jurisdictions require that the following deaths be investigated:

-
- deaths caused by homicide, suicide, or accidental causes such as motor vehicle crashes, falls, burns, or the ingestion of drugs or other chemical agents;
 - sudden or suspicious deaths (e.g., due to sudden infant death syndrome [SIDS]) and unattended deaths;
 - deaths caused by an agent or disease constituting a threat to public health;
 - deaths that occurred while the decedents were at work;
 - deaths of people in custody or confinement and of those institutionalized for reasons other than organic disease; and
 - deaths of people to be cremated.

The thoroughness of death investigations (and as a result, the completeness of death investigation records) also varies from case to case. Sometimes a postmortem examination may consist of only an external examination of the body. The record of a complete death investigation, however, includes the following items:

- the initial report of the death made to the ME/C office (e.g., by a family member, police officer, or attending physician);
- a determination of circumstances surrounding the death;
- findings of a scene investigation;
- findings of a postmortem examination or autopsy;
- results of laboratory tests to determine the presence of drugs, toxins, or infectious agents; and
- certification of the cause and manner of death.

Until recently, death investigation information was not readily available to the public health community or to other human resource programs. Making this information more available is one of the goals of the Medical Examiner and Coroner Information Sharing Program (MECISP). In 1986, because of the lack of uniformity in death investigation policies, the frequent lack of communication between jurisdictions, and the need for more widespread distribution of death investigation data, CDC established the MECISP. These are the primary goals of the MECISP:

- to improve the quality of death investigations in the United States and to promote the use of more standardized policies on when and how to conduct these investigations;
- to facilitate communication among death investigators, the public health community, Federal agencies, and other interested groups;
- to improve the quality, completeness, management, and dissemination of information on investigated deaths; and
- to promote the sharing and use of ME/C death investigation data.

Through financial and technical support, the MECISP helps ME/C offices to collect, manage, and disseminate data. The MECISP also publishes a directory that describes death investigation laws and lists the contact persons for all ME/C jurisdictions in the United States.

Information about the MECISP and ME/C data can be obtained from

Surveillance and Programs Branch
Division of Environmental Hazards and Health Effects
National Center for Environmental Health, Mail Stop F35
Centers for Disease Control and Prevention
4770 Buford Highway, NE
Atlanta, GA 30341-3724

State Data on Alcohol and Drug Deaths

R. T. Ravenholt (1984) published a widely used listing of causes of deaths due to alcohol or other drugs, and this listing has been updated by the Department of Health and Human Services (U. S. DHHS 1987) and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) (Dufour and Caces 1993). Because of changing drug use patterns and diseases, different versions of the list exist. Exhibit B-1 is the list as used by the Texas Commission on Alcohol and Drug Abuse (TCADA) in 1996.

The death certificate is submitted . . . to the State health department . . .

Causes of death are listed on death certificates, which are filled out by local doctors, coroners, and justices of the peace, among others. In some jurisdictions, the certificate must be filled out by trained medical personnel such as pathologists or medical examiners, while in other locations, elected officials with no formal training fill out the certificate. This variation exists not only among the States, but also within local jurisdictions. Discrepancies and nonreporting can occur for various reasons. In some jurisdictions, the staff of the medical examiner will not be consistent in their reports; one will specify the exact drugs involved while another will denote only "drug abuse," even though the toxicological reports are available. In other instances, to spare the feelings of the family, the coroner will not mention drugs on the certificate. In an area where suicide has a negative religious connotation, the death certificate will not mention drugs or suicide as a motive. There is no way to tell how widespread such underreporting is.

The death certificate is submitted by the local official to the section of the State health department that is responsible for handling birth and death data. This certificate may be submitted immediately, or there may be a significant lag. In some instances, a completed certificate will be submitted, while in other instances, the cause of death will be shown as "pending," and an amended certificate will be issued later after toxicology or pathology reports have been received. Because of the lag, it may take 6-10 months to get the complete data for the previous year.

Exhibit B-1: Drug and Alcohol Abuse Mortality, Texas

Alcohol Mortalities		
Direct Causes	Percentage	Age
Alcoholic psychoses (291)	100%	≥10
Alcohol dependence syndrome (303)	100%	≥10
Alcohol abuse (305.0)	100%	≥10
Alcoholic polyneuropathy (357.5)	100%	≥15
Alcoholic cardiomyopathy (425.5)	100%	≥15
Alcoholic gastritis (535.3)	100%	≥15
Alcoholic fatty liver (571.0)	100%	≥15
Acute alcoholic hepatitis (571.1)	100%	≥15
Alcoholic cirrhosis of the liver (571.2)	100%	≥15
Alcoholic liver damage, unspecified (571.3)	100%	≥15
Excessive blood level of alcohol (790.3)	100%	≥15
Alcohol poisonings (E860.0-E860.1)	100%	≥15
Indirect Causes	Percentage	Age
Respiratory tuberculosis (011-012)	25%	≥35
Cancer of the lip, tongue, oral cavity, pharynx (140-149)	50%*	≥35
Cancer of the esophagus (150)	75%	≥35
Cancer of the stomach (151)	20%	≥35
Cancer of the liver and intrahepatic bile ducts (155)	15%	≥35
Cancer of the larynx (161)	50%**	≥35
Diabetes mellitus (250)	5%	≥35
Essential hypertension (401)	8%	≥35
Cerebrovascular disease (430-438)	7%	≥35
Pneumonia and influenza (480-487)	5%	≥35
Diseases of esophagus, stomach and duodenum (530-537)	10%	≥35
Other cirrhosis of the liver (571.5-571.6)	50%	≥35
Acute pancreatitis (577.0)	42%	≥35
Chronic pancreatitis (577.1)	60%	≥35
Motor vehicle accidents (E810-E825)	42%	≥0
Other road vehicle accidents (E826-E829)	20%	≥0
Water transport accidents (E830-E838)	20%	≥0

*The percentage is 40 percent for females.

**The percentage is 32 percent for females.

SOURCE: Texas Commission on Alcohol and Drug Abuse, 1996.

(continued)

Exhibit B-1 (continued)

Indirect Causes	Percentage	Age
Air and space transport accidents (E840-E845)	16%	0
Accidental falls (E880-E888)	35%	15
Accidents caused by fires (E890-E899)	45%	0
Accidental drownings (E910)	38%	0
All other accidents (E867-E869, E900-E909, E911-E929, E980)	25%	15
Suicides (E950-E959)	28%	15
Homicides (E960-E969)	46%	15
Drug Mortalities		
Direct Causes	Percentage	Age
Drug psychoses (292)	100%	10, 64
Drug dependence (304)	100%	10, 64
Nondependent abuse of drugs (305.1-305.9)	100%	10, 64
Drug withdrawal syndrome in newborn (779.5)	100%	0, 64
Accidental poisoning by drugs, medicaments, and biologicals (E850-E859)	100%	10, 64
Heroin, methadone, other opiates and related narcotics, and other drugs causing adverse effects in therapeutic use (E935.0-E935.2, E937-E940)	100%	10, 64
Suicide and self-inflicted poisoning by drugs and medicinal substances (E950.0, E950.4)	100%	10, 64
Homicidal poisoning by drugs and medicinal substances (E962.0)	100%	10, 64
Injury undetermined whether accidentally or purposely inflicted from poisoning by drugs, medicaments, and other (E980)	100%	10, 64
Human immunodeficiency virus infection (042-044)	19%	10, 64
Viral hepatitis B (0.70.2-070.5)	13%	10, 64
Viral hepatitis non-A, non-B (070.4-070.5)	21%	10, 64
Acute and subacute infective endocarditis (421)	14%	10, 64
Homicides (E960.0-E961)	28%	15, 64

*The percentage is 40 percent for females.

**The percentage is 32 percent for females.

SOURCE: Texas Commission on Alcohol and Drug Abuse, 1996.

Nosologists at the State health department classify the death certificate according to the World Health Organization's *International Classification of Diseases (ICD-9), 3rd Edition*. While the classifications differentiate among types of drugs, the use of the words "acute intoxication" will result in one classification, while the use of "toxicity" will result in a different classification. Exhibit B-2 is a shortened list of the 1992 deaths involving alcohol or other drugs in the State of Texas, and it shows the impact that different terms have on the ICD coding of deaths involving the same drug. The wording from the death certificate is entered in the "AOD Cause from Death Certificate" column.

Underlying vs. Multiple Cause Tapes

After all death certificates have been received and classified, the information is computerized. Two different computer tapes are normally available from the National Center for Health Statistics (NCHS) and the State health departments. One tape is based on the Underlying (or primary) Cause of Death. The Underlying Cause of Death is defined as "(a) the disease or injury which initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury." A second computer tape includes Multiple Causes of Death. This tape not only provides the underlying (or first) cause, but also additional or multiple cause codes. A maximum of 20 causes of death can be captured on a record for multiple cause purposes. While the Multiple Cause Tape is more complex to handle, it is recommended for use, because many alcohol- and drug-related deaths are not recorded as the underlying (or first) cause.

The Multiple Cause Tape will provide more substance abuse data. As an example, the computer record for a person who is intoxicated and dies in an automobile accident may list the first cause as an injury and the secondary cause as intoxication or alcohol abuse. In addition, the Underlying Cause Tape does not pick up the information from the amended death certificate. It will show "799.9—Pending." Notice that in exhibit B-2, the ICD codes for the first cause of death is listed in the "Cause Death" column; these same ICD codes are shown in exhibit B-1. This further demonstrates the value of searching through the Multiple Cause Tape.

In comparing the Underlying and Multiple Cause Tapes, staff at TCADA found in 1992 that the number of direct alcohol deaths increased from 993 to 1,533, the number of indirect alcohol deaths increased from 6,459 to 7,582, and the number of direct drug deaths increased from 473 to 1,952.

Use of Hard Copies of Death Certificates

If possible, obtain from the health department actual copies of death certificates, which mention specific information on the sub-

... the Multiple Cause Tape is ... recommended for use ...

Exhibit B-2: A Sample of Deaths from Opiate Abuse, Texas—1992

FILENBR	AOD CAUSE FROM DEATH CERTIFICATE	CAUSEDTH	DEATHCNTY	RESCNTY
106187	alcohol and drug abuse	303	COMAL	COMAL
120279	alcohol/drug abuse	303	DALLAS	DALLAS
62213	IV drug abuse-cocaine, opioids	303	HARRIS	HARRIS
94347	chronic ETOH and drug abuse	303	NUECES	NUECES
53045	ETOH & IV drug abuse	303	TARRANT	TARRANT
21095	acute mixed drug intox-cocaine, heroin, salicylate	410	TARRANT	TARRANT
109591	IV drug abuse	420	HARRIS	HARRIS
40417	IV drug use	421	BELL	BELL
118110	IVDA	421	TRAVIS	TRAVIS
6640	narcotic/alcohol addiction	422	TRAVIS	TRAVIS
53605	IV drug abuse	429	DALLAS	DALLAS
114776	ETOH & IV drug use	703	CAMERON	CAMERON
60013	IV drug abuse	703	HARRIS	HARRIS
95012	IVDA	1177	TARRANT	TARRANT
36241	ETOH & IV drug abuse	1550	DALLAS	DENTON
4136	alcohol & drug abuse	1550	HARRIS	HIDALGO
45247	acute and chronic narcotism	3049	ARANSAS	ARANSAS
95378	intravenous narcotism	3049	BEXAR	BEXAR
77462	heroin addiction	3049	GUADALUPE	GUADALUPE
103314	acute and chronic narcotism	3049	NUECES	NUECES
6776	drug & alcohol abuse	3059	BEXAR	BEXAR
5625	drug abuse	3059	DALLAS	DALLAS
20624	intravenous drug abuse	3059	DALLAS	DALLAS
36039	narcotic abuse	3059	DALLAS	DALLAS
92142	illicit drug abuse	3059	HARRIS	HARRIS
41357	ETOH/IVDA abuse	3059	NUECES	LIVE OAK
65085	drug abuse	3059	TARRANT	TARRANT
80985	IV drug abuse	3059	TARRANT	TARRANT
96580	IVDA	3059	TARRANT	TARRANT
93748	drug abuse	3059	TRAVIS	TRAVIS
85663	IV drug use	3249	BEXAR	BEXAR
112648	alcohol and drug abuse	3453	JEFFERSON	JEFFERSON

SOURCE: Texas Commission on Alcohol and Drug Abuse, 1996.

stances involved in deaths, such as inhalants, heroin, narcotics, cocaine, intravenous drug abuse (IVDA), etc. While death certificates are public records, identifying information about the decedents should be blacked out and not used in reports.

Codes that are routinely requested for copies of death certificates include 304.6, 305.9, 850.0 through 858.9, 862.4, 869.2, 869.8, 950.0, 980.0, and 980.4. Inhalant deaths that resulted from industrial accidents are excluded. However, the computer tape is used to generate a listing of all cases with direct drug death codes, and this listing should be matched against the hard copies to obtain a more precise listing. By entering the wording on the actual certificates, it is possible to see how different coroners categorize deaths (exhibit B-2).

... many deaths are listed as IVDA, with no particular drug specified

One of the major problems is that many deaths are listed as IVDA, with no particular drug specified. Because of such classifications, the only solution may be to create a listing that includes all the categories that could be considered “hard drugs,” including IVDA (e.g., cocaine, heroin, other opiates). County of death, rather than county of residence, is used to map the distribution of such drugs. County of death will provide insight as to where people go to obtain and use their drugs.

Age Limits

Ravenholt (1984) used deaths only where the age was 15 or above, which is probably too old, given that the average age of first use of alcohol in Texas is 13.5 according to the school survey and 12.7 for youth entering treatment. DAWN uses only deaths of persons older than 6. If there is no lower limit, then the data is skewed because of accidental overdoses of aspirin or other pills swallowed by toddlers. An upper age limit of 65 is used because examination of the copies of death certificates showed many very elderly persons dying primarily from advancing age, but in many instances digitalis or other prescribed drugs were shown as secondary causes of death. Exhibit B-1 shows the upper and lower age limits that TCADA uses.

Direct Death Causes

Direct causes are deaths in which 100 percent of the cases can be directly attributed to alcohol or drugs.

Indirect Death Causes

Ravenholt (1984) also listed causes of death where a proportion of the deaths could be attributed to alcohol or drugs. The indirect drug death list is quite outdated, since it allocates only 20 percent of homicides to drug involvement. This is probably too low a proportion, given the recent relationship between crack cocaine and violence. It is difficult to determine the percent of homicides or other violent deaths associated with crack cocaine. In 1995, TCADA used a causal factor of 28 percent, based on a 4-year study of toxicology screenings for drugs

(cocaine, heroin, and others) and alcohol on homicide victims in Bexar County, Texas. Since the drug scene has changed in the past decade, particularly in terms of increased violence, an even higher percentage of drug-related homicides may be documented later.

Using the Multiple Cause Tape will require prioritizing the causes of death in terms of direct vs. indirect causes. If a person committed suicide by an overdose of alcohol, then the death is classified either as a direct cause (overdose of alcohol) or as an indirect cause (suicide). Priority should be given to searching the data files first for direct causes and then searching the remaining records for indirect causes.

The list of indirect death causes developed by Ravenholt (1984) do not include AIDS-related categories, and work needs to be done to develop the proportions of deaths caused by AIDS-Related Diseases (ARD) that involve substance abuse. In many instances, if ARD causes are included in the computerized data set, then it is easy to match the copies of the death certificates that mention drugs as one of the multiple causes. The proportion of ARD deaths that indirectly involve drug abuse will vary by State based on the rates of transmission by risk category; the Texas proportion is shown in exhibit B-1.

Uses of the Death Data

One of the most frequently asked questions concerns the number of persons dying from alcohol and drug abuse. Epidemiology networks can use the Ravenholt (1984) categories to get an annual listing, the direct and indirect alcohol deaths, and direct drug deaths. The rates for deaths involving alcohol or other drugs can then be compared by county or sub-State planning region on a per 100,000 population basis.

Looking at the characteristics of persons who die from one particular drug or class of drugs can show a very different drug abuser than is seen in treatment or arrest data. For example, in Texas, the overdose death data provide insight into needs that are not normally seen in other areas. Looking at the characteristics of persons who die from overdoses of depressants or “downers” can show a substance abuse problem among women who overdose on these drugs combined with alcohol, often as suicides. Death certificates indicating inhalant abuse show a very different picture from that shown by other data sources. According to Texas school surveys, inhalant abusers were young (pre-teen or early teens); they were equally likely to be male or female; and Hispanic youth reported the highest lifetime use (26 percent), followed by Anglo youth (24 percent) and African-American youth (16 percent). Adolescent inhalant abusers entering treatment were young (average age of 14.7 years), male (78 percent), and Hispanic (84 percent).

Yet overdose death data for Texas present a very different picture. From 1990 through 1993, an average of 15 deaths involving inhalants were reported each year. Persons who died of inhalants were male (94 percent) and Anglo (90 percent), and the average age was 26 years. The

most common substance mentioned on the death certificates as the cause of death was freon, with an average of six deaths per year, and there is a pattern of abuse by air conditioning mechanics and technicians. The other common substances were toluene and trichloroethane. Trichloroethane can be contained in typewriter correction fluid, transparent tape, or spot remover. In addition, nitrous oxide was the cause of at least one death per year.

Analysis of overdose deaths where methadone was mentioned showed that in Texas in 1991 through 1994, 86 percent of the decedents were Anglo and the average age was 35.8 years, whereas only 38 percent of the addicts entering publicly funded treatment were Anglo and the average age for this group was 38.9 years.

In summary, death data involving alcohol or other drugs are difficult and complex to work with, but they are integral to assessing trends and patterns in the community. An essential point is that multiple drug abuse indicators must be analyzed in order to obtain an accurate picture. Single indicators may present a specific and somewhat biased view.

... death data involving alcohol or other drugs are difficult and complex to work with ...

An example of the type of forensic data that can be obtained is shown in exhibit B-3, which depicts cocaine- and heroin-related deaths reported over an 8-year period in a Texas county. In this case, the medical examiner is very interested in drug abuse patterns, and he has tracked this information over the years.

EXHIBIT B-3: Cocaine- and Heroin-Related Deaths in Bexar County, Texas

Year	Cocaine Only	Heroin Only	Cocaine/Heroin	Total deaths (Cocaine & heroin)	Percentage of total drug deaths	Total deaths (Toxic cause)
1987	7 (27)	7 (9)	13 (2)	27 (38)	(30%)	71
1988	8 (38)	23 (3)	12 (9)	43 (50)	(54%)	102
1989	14 (29)	25 (12)	9 (7)	48 (48)	(51%)	93
1990	6 (34)	20 (5)	7 (13)	33 (52)	(52%)	64
1991	15 (74)	17 (4)	6 (12)	38 (90)	(49%)	78
1992	27 (82)	12 (5)	6 (22)	45 (109)	(45%)	100
1993	14 (67)	22 (8)	9 (8)	45 (83)		
1994	23 (68)	33 (3)	14 (10)	70 (81)	(72%)	113

SOURCE: Bexar County Forensic Science Center, Bexar County, TX, 1995.
 NOTE—Numbers in parentheses are non-overdose, "incidental" detections.

Hospital Emergency Departments

The American Hospital Association defines an emergency department (ED) as “an organized hospital facility for the provision of unscheduled outpatient services to patients whose conditions are considered to require immediate care. An ED must be staffed 24 hours a day.” The operative principle is that the patients arriving are, or may be, acutely ill and at risk of severe complications or death if they do not receive attention within minutes or hours.

Trauma centers are specially equipped and staffed emergency departments designated by level . . .

In 1990, there were 5,472 hospital EDs in the United States, according to the American Hospital Association annual survey (American Hospital Association 1991). There were 92,080,647 ED visits in 1990, an increase of more than 40 percent from approximately 65,000,000 in 1973. ED visits amounted to about 25 percent of the 368,183,598 total outpatient visits seen by hospitals in 1990. The first examination for board certification in emergency medicine (as one of the 23 major medical specialties) was given in 1980 (Krentz 1989; Poppy 1990).

In 1992, there were 10,000 board-certified emergency physicians. There were also around 65,000 ED nurses; 21,000 belonged to the Emergency Nurses Association.

Today’s ED is the nexus of a sophisticated emergency medical services system whose most complex element is the trauma center. Trauma centers are specially equipped and staffed emergency departments designated by level (from 1 to 3, in descending order of complexity) to treat patients who have severe burns or injuries. Trauma is the leading cause of death in Americans under the age of 45. The rate is especially high among young African-American males; trauma causes around 140,000 to 160,00 deaths each year (Gibbs 1990; Thal and Rochon 1991; U.S. Government Accounting Office [GAO] 1991). It is estimated that between 64 and 80 percent of trauma patients can be saved and will recover if they are treated promptly (Thal and Rochon 1991; U.S. GAO 1991).

Drug Abuse Warning Network (DAWN)

The Drug Abuse Warning Network (DAWN) includes:

- an annual national probability survey of drug-related problems treated in hospital emergency departments (EDs); and
- drug-related death data collected from a nonrandom sample of medical examiners and coroners' offices (ME/Cs).

Since 1972, DAWN has been a source of data on drug-induced or drug-related emergency department visits and medical examiner or coroner deaths. This surveillance system is managed by the Office of Applied Studies, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Health and Human Services. More than 500 EDs provide data for DAWN. They are part of a scientifically selected sample of general hospitals in the country. The DAWN sample is constructed to produce estimates of substance abuse visits to emergency departments across the Nation and to 21 metropolitan areas.

Information on drug-related and drug-induced deaths, involving both legal and illegal drugs, is collected from ME/Cs representing 175 jurisdictions. ED and ME/C data are collected and reported from the following metropolitan areas: Atlanta, GA; Boston, MA; Buffalo, NY; Chicago, IL; Dallas, TX; Denver, CO; Detroit, MI; Los Angeles, CA; Miami, FL; Minneapolis, MN; New Orleans, LA; New York, NY; Newark, NJ; Philadelphia, PA; Phoenix, AZ; San Diego, CA; San Francisco, CA; Seattle, WA; and Washington, D.C. ED data also are reported from hospitals in Baltimore, MD and ME/C data are reported by ME/Cs in Kansas City, KS/MO.

DAWN excludes cases involving alcohol as the sole substance of abuse and excludes cases involving children under age 6. Information is presented on the characteristics of the decedents by gender, race/ethnicity, age, and manner of death, along with this information by type of drugs mentioned. DAWN information is posted at the following Web site: <http://www.samhsa.gov>.

DAWN reports include detailed data summaries for each metropolitan area and show (1) distribution of drug abuse episodes by demographic characteristics, number of episodes, and drug group and (2) distribution of drug mentions by reason for emergency department contact, classified by drug group. DAWN also reports the number of mentions per 100,000 population for certain drugs on a semiannual basis by metropolitan area, so it is possible to see if the rates of mentions are going up or down and to compare the metropolitan area rates with the national rates. Reports are available at <http://www.samhsa.gov>.

Data from DAWN can be used to identify substances associated with drug abuse episodes reported by DAWN-affiliated facilities; to monitor drug abuse patterns and trends and detect new abuse entities and new combinations; to assess health hazards associated with drug abuse; and to provide data for national, State, and local drug abuse policy and program planning.

DAWN reports include detailed data summaries for each metropolitan area . . .

DAWN has several advantages in that it is ongoing and, thus, continually provides current and consistent information; it identifies specific drugs being used and it provides data for selected metropolitan areas as well as a composite national picture.

DAWN collects information on drug abuse-related medical examiner cases and on all patients treated in an ED because of problems induced by or related to drug abuse. In general, drug abuse-related cases must meet these criteria to be reported to DAWN:

- the use of prescription drugs in a manner inconsistent with accepted medical practice;
- the use of over-the-counter (OTC) drugs contrary to approved labeling;
- the use of any other substance (heroin, marijuana, peyote, glue, aerosols, etc.) for psychic effect, dependence, or suicide; and
- the use of alcohol alone is not reported.

How DAWN Works

In each facility (hospital ED or medical examiner's office) that participates in DAWN, a reporter is assigned to data collection activities. Ideally, an ED nurse (or other medical personnel) reviews all ED records daily and completes a one-page DAWN form on each drug abuse-related case. This report records basic patient demographic data and detailed substance abuse information. When ED staff are not available, other service departments (such as social services, medical records, pharmacy, poison control, volunteer departments) may be recruited to participate in the reporting process. In some cases, the hospital may designate an independent reporter (i.e., not a hospital staff person) to report DAWN data. The DAWN staff are bound by Federal laws protecting patient confidentiality. The data collection form does not include any patient identifying information.

DAWN reporters submit completed forms, along with weekly log sheets listing case totals, to SAMHSA's DAWN operations contractor. Each participating facility or its designee (e.g., the reporter, nurses' fund) receives a small honorarium for submitting data. The DAWN operations contractor assumes responsibility for the other costs incurred in reporting, such as mailing reports, training facility personnel, telephone communication between facility reporters, and the contractor staff who review DAWN reports.

Contractor staff review, verify, and compile DAWN data. They are supported by regional field liaisons who travel to facilities to provide training, evaluation, and problem-solving as needed.

Approximately 13,000 drug abuse episodes are processed monthly through DAWN. Data accuracy is ensured through a combination of

quality assurance activities. For example, adherence to DAWN reporting guidelines is monitored through periodic record reviews and reabstracting studies. Particular emphasis is placed on training and on continuing support and followup provided by the field liaisons and central office data monitors.

How DAWN Data Are Disseminated

On a regular basis, the Office of Applied Studies (OAS) of SAMHSA publishes the DAWN semiannual and annual reports. The semiannual report presents data on recent trends in mentions of selected drugs, while the annual report displays calendar year data according to drugs used, patient/decedent characteristics, and drug use patterns. Both reports reflect data aggregated at the total DAWN system level and at the metropolitan area level. These reports are sent to DAWN facilities and are available on request to the general public, drug abuse researchers, public officials, and other regular users of DAWN statistics.

DAWN reports published by SAMHSA are available at the Web site: <http://www.samhsa.gov>.

As an example, exhibits C-1 and C-2 display San Diego metropolitan area DAWN mentions for 1992 through 1995. These tables were compiled for and presented at the June 1997 national CEWG meeting. The data show a relatively high number of methamphetamine/speed mentions ($n = 679$) in 1995.

Exhibit C-3 shows the Phoenix metropolitan area DAWN emergency room mentions for the period from 1993 through the 1996. These data show a relatively high number of methamphetamine mentions in all 4 years, but a slight decrease in such mentions in 1996 ($n=690$) compared with the preceding year ($n=761$).

National Hospital Ambulatory Medical Care Survey

Another potential source of useful information is the National Hospital Ambulatory Medical Care Survey (NHAMCS), which was initiated in 1991 by the National Center for Health Statistics (NCHS) to gather information about the health care provided by hospital emergency and outpatient departments. This survey has a broader definition of substance abuse-related visits, which includes alcohol as a primary diagnosis as well as injuries and illnesses sustained because of drug and alcohol use (e.g., the driver of a car hit by an intoxicated driver or a person caught in the crossfire between drug sellers). NCHS does not report which hospitals participate in its survey.

Hospital Data

The need for emergency department data is critical to understanding the usage patterns of drug abusers in a given community. Since emergency department personnel are often extremely busy, they may not normally collect information on drug use practices. Therefore,

Exhibit C-1: DAWN Data: Estimated Number of Emergency Room Drug Abuse Episodes/Mentions, San Diego—1992-95

	1992	1993	1994	1995
Drug episodes	6,088	5,310	5,051	4,601
Drug mentions	10,291	9,033	8,701	8,065
Alcohol-in-combination	1,722	1,515	1,377	1,384
Cocaine	1,149	869	668	638
Heroin/morphine	1,022	842	695	682
PCP/PCP combinations	73	65	54	60
LSD	58	48	47	53
Amphetamine	245	364	381	421
Methamphetamine/speed	931	929	913	679
Marijuana/hashish	416	479	513	480

SOURCE: National Institute on Drug Abuse, 1997.

Exhibit C-2: Biannual Estimated Number of Emergency Room Drug Abuse Episodes/Mentions, San Diego—1995-96

	Jan-Jun 1995	Jul-Dec 1995	Jan-Jun 1996
Drug episodes	2,318	2,283	2,429
Drug mentions	4,133	3,932	4,211
Alcohol-in-combination	701	683	752
Cocaine	319	319	336
Heroin/morphine	301	382	462
PCP/PCP combinations	30	30	17
LSD	25	28	47
Amphetamine	254	167	146
Methamphetamine/speed	408	271	238
Marijuana/hashish	228	252	242

SOURCE: National Institute on Drug Abuse, 1997.

Exhibit C-3: DAWN Data: Number of Emergency Room Mentions By Drug, Phoenix—1993-96

Drug	Emergency Room Mentions							
	1993 Jan-Jun	1993 Jul-Dec	1994 Jan-Jun	1994 Jul-Dec	1995 Jan-Jun	1995 Jul-Dec	1996 Jan-Jun	1996 Jul-Dec
Drug Episodes	3,152	2,778	3,175	3,704	3,935	3,738	3,569	33,614
Drug Mentions	5,225	4,785	5,325	6,238	6,660	6,211	6,141	6,010
Cocaine	487	350	499	568	618	480	606	721
Heroin	251	236	246	236	226	261	274	350
Alprazolam	85	91	108	115	116	137	118	88
Marijuana	123	103	159	294	275	195	315	277
Diazepam	149	113	75	151	172	171	135	124
Amitriptyline	105	81	77	112	152	135	119	104
Diphenhydramine	93	53	105	102	75	73	45	69
Methamphetamine	229	252	379	434	435	326	365	325
Lithium-Carbonate	83	72	84	99	139	121	136	124
Clonazepam	108	107	105	131	145	167	118	96
Amphetamine	37	62	153	249	286	162	133	163
Trazodone	54	55	48	72	50	79	52	40
Carisoprodol	141	130	119	167	189	215	166	125

SOURCE: National Institute on Drug Abuse, 1997.

strategies need to be developed to convince those with the data to share it with the network. The purpose of collecting the data needs to be made clear to these groups.

It should be explained to hospital staff that there are three primary purposes for collecting local data on emergency department visits. First, such data will allow hospitals and the hospital associations to identify the extent to which substance abuse treatment in EDs affects hospital operations and resources. Second, data will highlight the impact of substance abuse on the local community and help the hospital and public agency planners identify the appropriate future resources needed to serve this population. Third, collecting and sharing these data will allow community-based providers and hospitals to work more closely to provide better case management and aftercare services. Exhibit C-4 shows a sample of an ED record layout.

Undoubtedly, one of the major hurdles in analyzing these data is integrating dissimilar data bases. For example, the general hospital data and State hospital data could be run on two separate systems, forms, or programming languages. Retrieving the information from private

Exhibit C-4: Suggested Emergency Department Record Layout, Drug- or Alcohol-Related Episodes

Data Set Element	Description
Medical Record Number	Unique Patient Identifier
Service Date	Year, Month
Date of Birth	Year, Month, Day
Sex	Male/Female
Race	White, African-American, etc.
Zip Code	5-Digit Zip Code
Hospital Number	6-Digit Medicare Provider Number
Primary Diagnosis	Drug/Alcohol-Related or Not
Secondary Diagnoses	Drug/Alcohol-Related or Not
Disposition of Patient	Home, Outpatient, Other Hospital
Source of Payment	Medicare/Medicaid, Private, HMO, etc.
Patient Origin	Jurisdiction of Patients' Residence
Source of Admission	Other ER, Institution, Home, etc.

SOURCE: National Institute on Drug Abuse, 1997.

Hospital based drug use data are difficult to collect, aggregate, and analyze

psychiatric hospitals is either too expensive or not possible because of the private hospital's claim that information is proprietary or confidential. However, if a representative of the private hospital is a member of the surveillance network, it may be possible to get aggregate patient information from this facility. To integrate these data sources, to the extent possible, the network might establish a special work group.

Given the difficulties associated with accessing and analyzing these sources of data, and the limited time and resources of a network, it is advisable to identify someone at the State or local level who has the knowledge, skills, and time to do the necessary work. Ideally, this person would access, prepare, and report these data at the network meeting in a simple format so that the data can be used along with other data sources to assess drug use patterns and trends. There should be periodic independent investigations on a sampling basis of the quality and accuracy of the data system(s).

Hospital-based drug use data are difficult to collect, aggregate, and analyze. Most hospitals collect information, maintain records, and report on the types of drug-related problems and the specific drugs used by patients. However, the lack of uniformity among public, private, and not-for-profit hospital data bases makes it increasingly difficult to report the extent of substance abuse in any jurisdiction, region, or on a statewide basis.

In attempting to obtain information about hospital patient drug use, three problems are usually confronted. Because hospitals tend to be complex organizations, it is difficult to identify individuals within them who have responsibility for patient data. Second, hospital staff who have responsibility for patient data tend to be very busy, difficult to reach, and reluctant to share information. Third, the reporting of drug-related medical problems (e.g., drug overdoses) often does not include specific information about the drugs involved.

To obtain information, contact should be made with the hospital's executive director, the official in charge of planning or marketing, or the hospital's epidemiology department. If the hospital is relatively small, it should be fairly easy to identify the appropriate hospital representative.

As an illustration, an ethnographer in one site made an effort to obtain patient drug use data from three local hospitals, two of which were public and one of which was a private hospital, to identify some of the difficulties that might be confronted. He started by making telephone calls to all three hospitals, explaining that he was associated with a local university and was interested in obtaining information regarding hospital admissions (e.g., drug overdoses) for the network (explaining the purpose and activities of this group).

The ethnographer's experiences with each of the hospitals was different. At the public hospitals, he found a general understanding of the information desired and genuine efforts to be helpful. The nurse to whom the ethnographer was referred at the University Hospital was very cooperative. She had her staff conduct a computer run on emergency room mentions for poisoning. Within a day of the request, the nurse faxed the ethnographer a report. The data included poisoning/overdose admissions, but they were not specifically related to drugs. The General Hospital staff also were helpful, but it was difficult to identify the potential sources of patient drug use data. Finally, the ethnographer was referred to the director of the outpatient drug abuse treatment program and was able to obtain some data.

The private hospital was much more concerned about patient confidentiality. The ethnographer was referred to a nurse who requested a letter explaining the purpose of the inquiry, the identification of the organization for which the ethnographer worked, and the specific information desired. She explained that the patient drug use data collected by the hospital was similar to the data collected by public hospitals. The drug overdose cases recorded did not include the names of the specific drugs involved. It was learned that it would be necessary to go to the doctors' charts for specific drug information.

Hospitals treat a broad range of drug use-related conditions . . .

Hospitals treat a broad range of drug use-related conditions and populations presenting those needs. Detoxification and medical rehabilitation are two of the primary services provided in a hospital. The research shows that about 5 percent of alcoholics and drug abusers require hospitalization or a medical setting for detoxification (Whitfield 1982). However, some drug abusers who do not have health insurance use the hospital emergency room as their source for primary and other care. Some chronic drug abusers relapse from time to time and “wear out their welcome” at one emergency room and then seek care at the next closest hospital. Others are admitted to the hospital for a medical or psychiatric illness that is a consequence of drug-using behavior. Each of these individuals is difficult to track within the addiction continuum of care, and each needs differing levels of care and case management to avoid future hospitalizations. Generally, alcohol and drug abuse patients receive care in three basic types of hospitals: acute general, private psychiatric, and State psychiatric hospitals.

Purpose of Studying Hospital-Based Drug-Related Discharges

Developing a drug abuse hospital data base is important because hospitals are the only treatment facilities open 24 hours a day, 365 days a year to provide emergency detoxification and rehabilitative and other inpatient treatment. Every hospital is in a position to test patients for alcohol and drug abuse treatment. Often, serious complications from drugs and alcohol occur at times when the hospital is the provider. Also, accidents and illnesses are often complicated by drug or alcohol use. Or, there may be a “comorbid” condition, such as affective disorder coexisting with drug or alcohol dependence. Hospital-based drug use data can provide a valuable resource for local networks.

Hospital-based drug use data can provide a valuable resource for local networks

Because of the recession in the early 1990s, State governments began to reduce their budgets. Some of the first services to be cut were drug-related nonhospital detoxification, intermediate care, halfway houses, and long-term drug abuse treatment facilities. Other reductions in Medicaid attempted to cut eligibility requirements of recipients and services reimbursed under each State’s Medicaid plan. This in turn has continued to have an impact on public agencies, which have long waiting lists for treatment in all types of facilities. In the private sector, managed care and aggressive utilization review programs severely curtailed admissions to and occupancies of hospital-based and free-standing substance abuse treatment programs. Some general hospitals closed their detoxification units in exchange for more profitable service lines.

Where Can a Network Obtain Hospital Data?

The first step is to find out who in State or local government collects and analyzes hospital data. One can contact the State health planning or hospital rate-review agency; State alcohol, drug abuse, and mental health administrations; local health departments; or a regional or

. . . identify a researcher who can assist the network in collecting and analyzing the data

statewide hospital association. Each agency might have some or all data for general, private, or State hospitals. It is good practice to collect data from more than one resource so that the data can be cross-validated.

Unless there is a network member who has knowledge of and expertise in accessing and analyzing hospital data sets, a second step might be to identify a researcher who can assist the network in collecting and analyzing the data.

If the network is concerned about a relatively small geographic area (a region with one or two hospitals), it may be possible to obtain information directly from the local hospital. Initial contact should be made with the hospital's chief executive officer, official in charge of planning or marketing, or epidemiology department. Because of comorbidity (i.e., with mental illness), it is important to inquire whether the hospital has a director of psychiatry who might be a potential collaborator to collect drug use information. It is useful also to ask directors of other hospital divisions about the effect of substance abuse on their patients.

Remember to make inquiries regarding data bases of private psychiatric hospitals and State psychiatric hospitals. Both State and private psychiatric hospitals sometimes have units dedicated to the dually diagnosed patient or dedicated to the addicted patient population. For State psychiatric hospital data, one should contact the State mental health authority and become familiar with its data system and the people who maintain it. If the private psychiatric hospital data are not in a State data base, this information will be harder to access; one will need to visit each private psychiatric hospital to determine to what extent these hospitals serve drug-using populations. One might want to see if there is a separate association of private psychiatric providers in the area who might be interested in the network data collection project.

If you need statewide or comprehensive regional data that are not supplied by a State agency, the network may consider approaching the State's hospital association or major payers (e.g., Medicaid, Medicare, Blue Cross/Blue Shield). Remember to perform a comprehensive assessment; acute general, private psychiatric, and State psychiatric hospital data must be retrieved. Do not be surprised if each of these data types is on a separate data base, with one system based on fiscal years and others based on calendar years. If there are no centralized data bases, be prepared to inquire at each hospital regarding its data base. Contacting each hospital is a time-consuming and daunting task. However, the knowledge that will be gained during this data collection experience will prove invaluable, because network members will be the only persons who know how the system fits (or does not fit) together.

The next question is: What data elements does the network need to retrieve? The following section will explain how drug use diagnoses are categorized.

Development of the International Classification of Diseases

Diagnostic coding dates back to 17th-century England, where statistical information was gathered through a system known as the London Bills of Mortality. By 1937, this method of tracking information evolved into the International Causes of Death. The World Health Organization (WHO) published a statistical listing in 1948 that could be used to track both morbidity and mortality.

The International Classification of Diseases (ICD) led the way for the current text in international use today, the International Classification of Diseases, 9th Revision (ICD-9-CM). This version precisely delineates the clinical picture of each patient, providing exact information beyond that needed for statistical groupings and analysis of health care trends.

Another classification system is the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association (APA 1994). In DSM-IV, psychoactive substance use means “the persistence of psychoactive substance use for at least 1 month or repeatedly over a long period of continuing use despite the recurrence or persistence of one or more known adverse consequences or taking of recurrent physical risks such as driving while intoxicated.” Nearly all of the DSM-IV classifications are identical to ICD-9-CM codes.

Drug-Related ICD-9-CM Diagnoses and Diagnostic Related Groups

Since the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Diagnostic Related Groups (DRGs) have been used to set limits on Medicare reimbursement. This patient classification scheme can be used to provide surveillance networks with information about the types of drugs used by hospital patients. Since it requires considerable knowledge and expertise to work with these data, networks should, as noted earlier, identify a researcher who knows how to access and analyze the information. This might be someone who is associated with a hospital, health department, or university.

Computer systems can usually use either the ICD-9-CM or DRG classification system. For basic information, it is preferable to use DRGs. For more complex questions, running the 51 ICD-9-CM codes would be more appropriate.

The ICD-9 classification system provides principal, secondary, and tertiary diagnostic codes. It will be useful to look at secondary (and perhaps tertiary) codes. For example, drug dependence, psychosis, or nondependent abuse are often diagnosed in conjunction with mental

For basic information, it is preferable to use DRGs

and emotional disorders. It is frequently difficult to tell which impairment came first. Treatment for a drug problem may be necessary before effective treatment for mental illness can be initiated. There may be as many drug cases that fall into the secondary diagnostic codes as fall into the principal diagnostic codes. The majority of cases where the drug code is not the principal code may have a mental health code (e.g., affective disorder, adjustment reaction) as the principal code. Other conditions that may have a secondary code related to drug or alcohol dependence, psychosis, or nondependent abuse are pregnancy, accidental poisoning, and fractures.

Below are the addiction-related DRG codes matched to ICD-9-CM codes.

DRG 433: Alcohol/Drug Abuse or Dependence, Left Against Medical Advice

DRG 434: Alcohol/Drug Abuse Dependence, Detoxification or Other Symptomatic Treatment with Complication Condition

Principal ICD-9-CM codes:

291	Psychosis, alcoholic
292	Psychosis, drug
303.0	Intoxication, acute alcoholic, or alcoholism
303.9	Other and unspecified alcohol dependence
304	Dependence, drug
304.9	Other and unspecified drug dependence
305.0	Abuse, alcohol; nondependent
305.2	Abuse, cannabis; nondependent
305.3	Abuse, hallucinogen; nondependent
305.4	Abuse, barbiturate, similarly acting sedative or hypnotic; nondependent
305.5	Abuse, opioid-mixed; nondependent
305.6	Abuse, cocaine; nondependent
305.7	Abuse, amphetamine; nondependent
305.8	Abuse, antidepressant; nondependent
305.9	Abuse, unspecified drug; nondependent
790.3	Excessive levels of blood alcohol

DRG 435: Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment Without Complicating Condition

DRG 436: Alcohol/Drug Dependence with Rehabilitation Therapy

Principal or secondary ICD-9-CM codes:

291.0	Delirium, alcohol withdrawal
291.1	Syndrome, amnestic, alcohol

291.2	Dementia, alcoholic, other
291.3	Hallucinoses, alcoholic withdrawal
291.8	Psychosis, alcoholic, specified
291.9	Psychosis, alcoholic, unspecified
292	Drug withdrawal syndrome

DRG 436: Alcohol/Drug Dependence with Rehabilitation Therapy
 303.0 Intoxication, acute alcoholic, alcoholism

Secondary ICD-9-CM codes: Non-operating room procedures
 94.61 Rehabilitation, alcohol
 94.64 Rehabilitation, drug
 94.67 Rehabilitation, combination alcohol and drug

DRG 437: Alcohol/Drug Dependence with Combined Rehabilitation and Detoxification Therapy

Secondary ICD-9-CM codes:
 Non-operating room procedures
 94.63 Rehabilitation/detoxification, alcohol
 94.66 Rehabilitation/detoxification, drug
 94.69 Rehabilitation/detoxification, alcohol and drug

In addition to these DRG codes and the 24 ICD-9-CM codes corresponding to them, there are drug-related ICD-9-CM codes that are not matched to DRG codes, including the following:

265.2	Pellagra (alcoholic)
357.5	Alcoholic polyneuropathy
357.6	Polyneuropathy due to other toxic agents (specific illicit drugs can be found in E codes 850-854)
425.5	Alcoholic cardiomyopathy
535.3	Alcoholic gastritis
571.0	Alcoholic fatty liver
571.1	Acute alcoholic hepatitis
571.2	Alcoholic cirrhosis of liver
571.3	Alcoholic liver damage, unspecified
572.3	Portal hypertension
573.3	Hepatitis (unspecified toxic)
648.3	Complications of pregnancy due to drug dependence
648.4	Complications of pregnancy due to alcohol and drugs
655.4	Suspected damage to fetus from alcohol
655.5	Suspected damage to fetus from drugs
760.71	Fetus affected by alcohol (fetal alcohol syndrome)
760.72	Fetus affected by narcotics
760.73	Fetus affected by hallucinogenic agents
760.75	Fetus affected by cocaine
965.00	Poisoning by opium

965.01	Poisoning by heroin
965.09	Poisoning by other drugs
967.0	Poisoning by barbiturates
967.4	Poisoning by methaqualone compounds
967.8	Poisoning by other sedatives and hypnotics
968.5	Poisoning by topical and infiltration anesthetics (e.g., cocaine)
970.0	Poisoning by central nervous system stimulants analeptics
970.1	Poisoning by central nervous system-opiate antagonists
980.0	Toxic effect of alcohol

Limitations of Using Hospital Data

How do hospitals decide which medical conditions are drug related? Typically, the association is made because a condition occurs with unusually high frequency in patients already diagnosed as addicted. Cirrhosis of the liver is one example. However, cirrhosis of the liver is an outcome (a scarring of the liver) that is not a specific disease, and it has a variety of causes besides alcohol use, including viral and other infections and exposure to other drugs and chemicals. Thus, without knowledge of a patient's alcohol consumption, it may be difficult to make a diagnosis of alcoholic cirrhosis. Another example is alcoholic cardiomyopathy (alcohol-related damage to the heart muscle). This diagnosis is made by exclusion if every other known cause of heart muscle damage is ruled out.

Limitations of the ICD-9-CM also handicap efforts to assess the true nature and magnitude of drug-related health consequences. There is no code-specific category for acute alcoholic pancreatitis or drug-related HIV transmission. Therefore, it is impossible to separate drugs or alcohol from other causes of illness; when presenting the information, one can say the utilization data being prepared present a conservative estimate, since the data do not include all drug-related conditions (Dufour and Caces 1993).

Some complexities involved in using ICD-9-CM codes, and ways they are being used, are described in Appendix D by epidemiologists and researchers at the Washington State Department of Health.

Information Networks Should Request

The information the network asks for depends upon the questions members are attempting to answer. If a network desires general information from hospitals, one should ask for information by DRGs 433–437 for discharges, patient days, and average length of stay for the last 3–5 years to track trends. Depending upon network needs, one may ask that these data be developed either by the jurisdiction of a patient's residence (where the individual lives) or by where a patient received services (jurisdiction of the hospital provider). For more intricate data

All drug-use data can be run for primary, secondary, and tertiary diagnoses . . .

inquiries, it is suggested that the data be run by the above ICD-9-CM codes. Many current data bases can perform data runs by socioeconomic factors; demographic factors such as gender, race, and age (specify age groups by children and adolescents younger than 18, adults ages 18–25, 26–34, and 35 and older); ZIP code; principal, secondary, and tertiary diagnosis; source of admission; marital status; payer source; and disposition of patient (where the patient was discharged).

All drug-use data can be run for primary, secondary, and tertiary diagnoses in order to describe the full impact of substance abuse upon the hospital and community. For comparison purposes, it might be interesting to know what percentage of all discharges are drug-use related; this requires that a broader set of data be developed. Finally, be sure to check the confidentiality laws in the State to ensure that confidential data are not unknowingly revealed.

Hospital Data Needs and Issue Development

The search for data will, hopefully, lead to the hospital data base. Below are some examples of why one would want to query the hospital data base. Network members do not need to have the programming experience to actually run these programs, but must know enough about the issue and data base to develop a written request and draw an example of the printout being requested.

One should develop a data request form so that output can be produced in the same format. Examples are listed below.

Example #1: Request that the patient identifier number be run for drug-related use primary and secondary diagnoses, DRGs 433–437. You will probably only retrieve recidivism data from that particular hospital and cannot track whether an individual receives treatment at any other hospital(s).

Example #2: Request that the following ICD-9-CM codes be run by patient origin (jurisdiction of residence):

648.3	Complicated pregnancy due to drug dependence
648.4	Complicated pregnancy due to alcohol and drugs
655.4	Suspected damage to fetus from alcohol
655.5	Suspected damage to fetus from drugs
760.71	Fetus affected by alcohol (fetal alcohol syndrome)
760.72	Fetus affected by narcotics
760.73	Fetus affected by hallucinogenic agents
760.75	Fetus affected by cocaine

Example #3: Have the programmer run, by age group, the following ICD-9-CM codes:

305.0	Abuse, alcohol; nondependent
-------	------------------------------

305.2	Abuse, cannabis; nondependent
305.3	Abuse, hallucinogen; nondependent
305.4	Abuse, barbiturate, similarly acting sedative or hypnotic; nondependent
305.5	Abuse, opioid-mixed; nondependent
305.6	Abuse, cocaine; nondependent
305.7	Abuse, amphetamine or related sympathomimetic; nondependent
305.8	Abuse, antidepressant; nondependent
305.9	Abuse, other, mixed, or unspecified drug; nondependent

Example #4: Request that each ICD-9-CM code be run by age, residence, and ZIP code.

In each of the above examples, have the programmer run at least 3 years of data so you can make comparisons between previous years' data. The data will probably be received in a Lotus spreadsheet format. The data should be checked to see if the data answer the question being asked, to ensure the data's accuracy, and to see if the data make sense. After some experience working with the data base(s), members can probably ask better questions and begin to challenge the limits of the data base(s). An advanced application of drug use data is geo-coding, a computerized mapping application that plots data against a State, jurisdictional, or subregional map.

Explain the purpose and potential usefulness of the data to the network

Finally, appreciate programmers and let them know why you want the data. Explain the purpose and potential usefulness of the data to the network. Do not overburden the programmer with data requests that are too complicated or relatively unimportant. Give the programmer enough lead time to complete the request. Develop your own graphs and charts from the data received, and thank the programmers each time for their help. If the network wants further data runs, have the data funneled through one person instead of having many individuals inundating the programmer with requests.

Outcomes of a Comprehensive Hospital-Based Drug-Use Report

A 1993 study in Maryland compared the use of the DRGs and the ICD-9-CM codes to analyze hospital-based drug (ab)use discharges. Initially, this report showed that closure of detoxification and rehabilitation drug abuse programs, changes in State Medicaid policies, and increased utilization review and managed care programs decreased the number of hospital discharges between 1990 and 1992 DRGs and ICD-9-CM codes (Gentile 1993). Using the ICD-9-CM drug codes produced 10 percent more drug use discharges when compared with DRGs. However, using primary and secondary ICD-9-CM drug-related discharges showed four times as many admissions compared with only primary DRG diagnoses (45,000 vs. 13,000 discharges). The data

showed that the ICD-9-CM codes will better identify the extent to which alcohol and drug abuse is a problem in each jurisdiction and hospital. It was estimated conservatively that about 45,000 drug users (Maryland residents) are treated in Maryland hospitals annually, or that about 1 in every 12 admissions is drug related.

A significant finding . . . is the importance of mental health data . . .

A significant finding of this and other studies is the importance of mental health data and their relationship to drug use data. Five of the top 10 primary nondrug diagnoses are mental health diagnoses whose secondary diagnosis is drug-related. Recent studies and reports surveying the mental health population found that 50–80 percent of mentally ill individuals also have a drug-use diagnosis. The report points out significant data gaps in obtaining secondary drug-use diagnoses from State psychiatric hospitals and the lack of a systematic method to collect emergency room data.

Law Enforcement Data

There is considerable variability in the way different law enforcement departments collect and report arrest data. Police Departments generally assign someone primary responsibility for the task of collecting, managing, and reporting arrest data. If a Police Department is relatively large, this responsibility is likely to be delegated to a particular division. For example, the Denver, Colorado, Police Department has a Research and Development Division that collects and reports arrest data. The Division produces annual reports that categorize different types of criminal offenses by geographic location, police district, and demographic category (the information is presented in table form). Unfortunately, there is only one category for drug-related offenses, and drug types are not specified.

Other city Police Departments in Colorado collect arrest data differently. For example, the Police Department in Aurora only records the most serious offense when an arrest is made. The specific information about a drug-related arrest is not recorded. If a person is arrested for driving under the influence (DUI) and drugs are found, the arrest report only includes the DUI (the greater of the two offenses). Being arrested for possession of an injection device is not considered a major arrest and would not be recorded in the data base. Similarly, the Police Department in Arvada, another city in Colorado just north of Denver, does not report specific information about drug arrests. (The type of drug involved in the arrest is not reported.) Crimes are reported as specific legal offenses.

Police Departments generally assign someone primary responsibility for the task of collecting, managing, and reporting arrest data

The Police Department in Shreveport, Louisiana, uses a standard format to report the number and types of arrests in the city by year. Exhibit D–1 shows the number of annual drug arrests reported by the Shreveport Police Department from 1989 to the first half of 1997.

The table in exhibit D–2 is an example of how the Shreveport Police Department categorizes specific types of drug arrests for adults and juveniles.

Exhibit D-1: Shreveport Drug Arrests

Year	Drug Arrests	% Change from previous year
1989	662	10
1990	688	4
1991	667	-3
1992	1,076	61
1993	1,114	4
1994	1,136	2
1995	1,399	23
1996	1,501	7
Jan-June 1997	849	NA

SOURCE: Office of Alcohol and Drug Abuse, State of Louisiana, 1997.

Exhibit D-2: Shreveport Drug Arrests—1996

Drug Group Type	Adults and Juveniles			Juvenile Arrest Only*		
	Sale/ manufacture	Possession	Total	Sale/ manufacture	Possession	Total
Schedule II (Cocaine and their derivatives: morphine, heroin, codeine)	274	307	581	12	17	29
Schedule I (Marijuana and other opiates)	109	588	697	6	50	56
Others	0	223	223	0	13	13
Total	383	1,118	1,501	18	80	98

*Persons arrested under the age of 17.

SOURCE: Office of Alcohol and Drug Abuse, State of Louisiana, 1997.

Uniform Crime Reports

All law enforcement agencies are required to report arrest data to State authorities who, in turn, report them to the Federal Bureau of Investigation (FBI) for inclusion in the Uniform Crime Reports (UCR), which include both national and local data. Only six States (Indiana, Michigan, Missouri, New Mexico, Ohio, and Tennessee) and the District of Columbia do not send UCR data to the FBI. Caution should be exercised when using these data, since comparisons between States may be invalid because of variations in reporting procedures, (e.g., what constitutes an “aggravated assault” may differ between Vermont and California because of definitions of the crime in State law).

A few States provide data online. If data are not readily obtainable from the State, one can request local data from the FBI. However, one should expect this process to take several weeks and be prepared to pay a moderate fee. The FBI assists all States in developing State UCRs compatible with the national program. A standardized format has been developed for this purpose. A listing of these UCR programs is provided in Appendix E. These programs report the data that go to the FBI.

The format includes data on arrests for drug trafficking (sale, growing, or manufacturing) and unlawful possession. Four different drug categories are reported: opium or cocaine or their derivatives, including morphine, heroin, and codeine; marijuana; synthetic narcotics, including demerol and methadone; and other dangerous non-narcotic drugs such as barbiturates and benzedrine. Because of the groups (such as combining opium and cocaine) and the variation in reporting “synthetic narcotics” and “other dangerous non-narcotics” (LSD might be included in either category), it is impossible to analyze trends except for marijuana as a proportion of all drug arrests. Alcohol arrests, including driving under the influence, public drunkenness, and liquor law violations, can be very helpful in pointing out at-risk populations and juvenile drinking. However, all of these offenses are influenced by local law enforcement priorities. If there is a campaign against drunk driving, arrests will go up, even though the prevalence of alcohol use may change little. Likewise, if the police crack down on underage drinking during spring break, the arrest rates will go up. In addition, some of the alcohol-related arrests are influenced by whether or not the reporting county is a “wet” or “dry” area.

Recorded offenses are maintained by the municipality and county in which they occur. Procedures for handling juveniles vary among departments more than do procedures for handling adult offenders. Juvenile offenders are often handled informally so the records on these arrests are incomplete. In addition, some printouts and publications from the State Uniform Crime Report program will group youth as younger than 18 while other reports from the same agency will group them as younger than 17, so use caution when summarizing these statistics.

In addition, the UCR reports provide information on the race and ethnicity of persons arrested. The race categories are White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander. The ethnic categories are Hispanic and Not Hispanic. However, agencies differ in the way that these data are compiled. Generating distribution tables based on both race and ethnicity may be problematic. Check with the UCR agency to see how it gathers information on race and ethnicity.

From the UCR it is possible to obtain annual data on the number of arrests for trafficking and possession of drugs by county . . .

From the UCR it is possible to obtain annual data on the number of arrests for trafficking and possession of drugs by county and by every law enforcement agency that reports within the county. The individual agency can be very helpful, for example, if the network is looking at drug and alcohol arrests by college students and the college police have reported such arrests.

Caution, however, must be exercised because duplicate reporting can occur. One should assume that all arrests made by a local law enforcement agency have been sent to the UCR, so do not add local statistics to the arrests reported by the UCR. Check with the UCR agency to see if State police arrests are reported in the UCR or are reported separately, and inquire about arrests made by Federal agencies and whether or not they are reported in the UCR.

Examples of the type of arrest data available from the UCR, as reported by the Texas Commission on Alcohol and Drug Abuse, are shown in exhibits D-3 and D-4.

Appendix F includes two UCR tables compiled by the State of Maryland. One includes demographic variables for arrested persons older than 17 years of age. The other includes similar data on adolescents younger than 18.

EXHIBIT D-3: Drug Arrests By County, Texas—1994

County	Traffic All Drugs	Traffic Marijuana	Possession All Drugs	Possession Marijuana
Bexar	2,651	99	5,512	2,940
Brazolia	298	78	481	353
Dallas	2,104	457	9,621	3,627
Fort Bend	104	30	838	531
Galveston	114	20	1,245	492
Harris	695	75	11,171	4,283
Jefferson	564	119	2,506	1,147
Midland	123	103	327	197
Smith	145	26	289	191
Tarrant	795	81	4,743	2,229
Traves	404	26	3,115	1,105

SOURCE: Texas Commission on Alcohol and Drug Abuse, 1996. Includes counties that have at least 100 arrests in 1994 for drug trafficking.

Exhibit D-4: Drug Arrests By Race/Ethnicity, Texas

Classification of Drug Offenses	White	African-American	Hispanic	American Indian, Native Alaskan, Asian
Trafficking, Sale, and Manufacturing				
Opium/cocaine or derivatives	1,384	4,237	1,858	9
Marijuana	1,050	394	655	3
Synthetic narcotics	320	256	307	1
Non-narcotic drugs	170	128	54	1
Possession				
Opium/cocaine or derivatives	5,828	12,478	6,029	41
Marijuana	13,637	6,451	10,605	33
Synthetic narcotics	1,094	335	346	3
Non-narcotic drugs	1,363	1,203	821	7

SOURCE: Texas Commission on Alcohol and Drug Abuse, 1996.

A substantial amount of criminal justice system data can be accessed through the Internet. For example, the Bureau of Justice Statistics (BJS), a component of the Office of Justice Programs in the U.S. Department of Justice, is the primary national source for criminal justice statistics. BJS collects, analyzes, publishes, and disseminates information on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government.

The BJS clearinghouse, called the National Criminal Justice Reference Service (NCJRS), provides a variety of services to the public through a toll-free number. One can request copies of BJS reports and mailing list information, criminal justice statistics, custom literature searches of the NCJRS Data Base, referrals to other sources of crime data, and data assistance from information specialists at the clearinghouse. Internet users can obtain documents online either by ordering them through e-mail or actually reading or downloading them. Such documents tend to contain mostly national data, with very little local data. The Internet address is <http://www.ncjrs.org>.

A substantial amount of criminal justice system data can be accessed through the Internet

In 1978, BJS established the National Archive of Criminal Justice Data (NACJD) to facilitate and encourage research in the field of criminal justice through the sharing of data resources. NACJD seeks to provide (1) computer-readable data for the quantitative study of crime and the criminal justice system through the development of a central data archive that disseminates computer-readable data, as well as (2) technical assistance in selecting data collections and the computer hardware and software for analyzing data efficiently and effectively. NACJD currently holds more than 500 data collections relating to

ICPSR provides access to the world's largest archive of computer-readable social science data

criminal justice. One can obtain the raw data upon which the clearing-house reports are based by calling the archive. In addition, NACJD's Web site allows browsing and downloading access to most of the archive's data and documentation at no charge. A sampling of variables one can search under includes year; State and county Federal Information Processing Standards (FIPs) codes [numerical codes given for States]; county population; drug abuse violations, drug abuse possession, and drug abuse sale/manufacture by opium, cocaine, marijuana, synthetics, and other; driving under the influence; liquor law violations; and drunkenness. NACJD's internet address is <http://www.icpsr.umich.edu/NACJD/home.html>. One can ask questions of NACJD staff via the internet by writing nacjd@icpsr.umich.edu. The mailing address is NACJD/ICPSR, Institute for Social Research, P.O. Box 1248, Ann Arbor, MI, 48106.

The NACJD is but one of many sources of data available through the Inter-University Consortium for Political and Social Research (ICPSR), located in the Institute for Social Research at the University of Michigan. ICPSR provides access to the world's largest archive of computer-readable social science data. Numerous discrete files are currently on deposit with ICPSR, and detailed descriptions of the data holdings are available. ICPSR's data holdings may be searched online by students and researchers at member institutions. (An online list is available of the more than 325 member colleges and universities in the United States and Canada, as well as the several hundred institutions served by members in Europe, Oceania, Asia, and Latin America.) Data holdings cover a broad spectrum of academic disciplines, including sociology, public health, criminal justice, and the law. A few relevant subject headings include Census Enumerations: Historical and Contemporary Population Characteristics, Health Care and Health Facilities, and Social Institutions and Behavior (including Minorities and Race Relations, Crime and the Criminal Justice System, Vital Statistics, Family and Gender). A large number of local data sets also can be obtained through ICPSR's holdings.

Data from Crime Laboratories

In most States, crime laboratories have been established to coordinate lab results and other sources of information about illicit drugs and to report on the quantities, price, and purity of drugs seized and arrestee urinalysis results. These laboratories are generally operated by the State police department or police departments in large cities. In a large State, obtain the report from the State laboratory that serves the network's area and also see if there is a metropolitan laboratory used by the city.

State and county crime laboratories can be identified in each State by contacting the State UCR (see Appendix E) or the State Statistical Analysis Center (see Appendix C).

Based on information collected and analyzed, State laboratories often report on drug availability, trafficking, and trends. Looking at the number of drug analyses by drug type and by year will show changes in availability of various drugs. While the formal reports may be by general drug types (marijuana, cocaine, stimulants, opiates, etc.), the labs are often able to identify new types or combinations of drugs and how many samples and dosage units of a specific substance have been analyzed. For example, the State crime lab on the Lower Texas border with Mexico reported that the number of flunitrazepam (Rohypnol) pills examined each year increased from 194 pills in 1992 to 25,966 in 1995.

In another example, the Criminal Intelligence Division of the Maryland State Police, the State crime laboratory, produces quarterly and annual reports based on lab results and data/information collected. Exhibits E-1 through E-7 provide examples of data tables included in the 1995 report. Exhibits E-1 through E-4 show data on cocaine hydrochloride (HCL).

Exhibit E-1: Maryland State Police Arrests for Cocaine (HCL)

Race/Ethnicity	1993		1994	
	Male	Female	Male	Female
Black	107	25	104	13
White	99	37	89	35
Hispanic	1	---	3	---
Asian	---	---	1	---
Total	207	62	197	48
Age	1993		1994	
17 and under	7		4	
18 to 25	77		66	
26 to 30	73		45	
31 to 35	48		54	
36 and over	57		72	
Total	262		241	

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

Exhibit E-2: Maryland State Police Arrests for Crack Cocaine

Race/Ethnicity	1993		1994	
	Male	Female	Male	Female
Black	115	18	127	14
White	45	16	43	19
Hispanic	1	---	---	---
Asian	---	---	---	---
Total	161	34	170	33

Age	1993	1994
17 and under	12	15
18 to 25	68	63
26 to 30	33	43
31 to 35	36	25
36 and over	46	44
Total	195	190

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

Exhibit E-3: Maryland State Police Statewide Cocaine (HCL) Prices—1993-94

User Quantities	1993	1994
1/4 gram	\$27	\$21
1/2 gram	\$48	\$38
1 gram	\$89	\$72

Dealer Quantities	1993	1994
1/8 ounce (3.5 grams)	\$240	\$258
1/4 ounce (7 grams)	\$420	\$409
1/2 ounce	\$775	\$657
1 ounce	\$1,300	\$1,155
2 ounces (57 grams)	\$2,445	\$2,150
4 ounces (113 grams)	\$4,350	\$4,140

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

Exhibit E-4: Maryland State Police Statewide Crack Cocaine Prices—1993-94

User Quantities	1993	1994
\$10 crack	.10 grams	.11 grams
\$20 crack	.17 grams	.19 grams
\$40 crack	.29 grams	.34 grams
\$50 crack	.37 grams	.40 grams
Dealer Quantities	1993	1994
1 gram	\$105	\$119
2 grams	\$155	\$172
1/4 ounce (7 grams)	\$410	\$435
½ ounce (14 grams)	\$765	\$775
1 ounces (28 grams)	\$1,295	\$1,125

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

The price of cocaine (HCL) is determined for 2-gram and 1-gram amounts. Most users do not buy more than 1 gram of cocaine at a time. The average purity is based on all samples seized, regardless of the amount seized or how the cocaine was obtained. Contrary to popular belief, there is no relationship between the amount seized and purity. The dividing line between user and dealer seizures is 2 grams. Larger quantities are bought by dealers who repackage the cocaine into smaller amounts for resale.

Maryland's Criminal Intelligence Division concluded that between 1993 and 1994, drug prices decreased for both user and dealer quantities of cocaine (HCL). The only apparent increase was observed in the 1/8-ounce amount; this "finding" can be explained primarily by the small sample size.

When drug users buy marijuana or cocaine, both the price and the amount received can be negotiated. A slightly larger or smaller amount has a commensurate change in price. This has not been true for purchases of crack cocaine. At the street level, the price of crack is fixed, for example, at \$3-\$5 per vial, and the buyer accepts whatever the dealer offers. Therefore, changes in availability are measured by the average amount paid for purchases of crack.

The average purity is based on all samples seized. As with cocaine (HCL), there is no relationship between amount and purity, which is expected because crack is a purified form of cocaine. There is no dividing line between user and dealer quantities of crack. Users typically smoke the crack immediately after purchase. Therefore, it is unusual to find user amounts of crack during routine investigations.

During 1994, crack users received more crack for their money, reflecting a decrease in price. Dealer prices for crack cocaine appear to have increased; however, this is more a reflection of the way purchases break down by county. In rural counties, midsize purchases of crack are generally more expensive than in urban areas, so that rural figures inflate the average statewide price for the drug.

According to Maryland's Criminal Intelligence Division, the price for heroin is determined based on a 1-gram purchase of low-purity heroin. The price is not determined for street-level purchases of high-quality heroin, since they are rare. As a general rule, high-quality heroin is four to five times more expensive than a comparable amount of low-purity heroin shown in exhibit E-5. Between purchases and seizures, there is a sufficient sample each month to determine purity for both high and low categories. The vast majority of purchases and seizures are for small quantities or are larger amounts repackaged for street-level sale, so combining uncut and cut heroin is not an issue.

Because heroin is typically purchased at the street level in \$10 and \$20 bags, it is more useful to determine how much of the drug is received for the amount paid at each level (exhibit E-6).

Exhibit E-5: Maryland State Police Statewide Low-Purity Heroin Prices—1993-94

Amount	1993	1994
½ gram	\$43	\$35
1 gram	\$85	\$67
2 grams	\$170	\$107
¼ ounce	\$340	\$310
½ ounce	\$655	\$595
1 ounce	\$1,300	NA

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

Exhibit E-6: Maryland State Police Price of Heroin and Amount of Purchase

Price	1993	1994
\$10	0.19 grams	0.17 grams
\$20	0.27 grams	0.31 grams

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

It was reported that an oversupply of heroin has enabled dealers to sell higher purities at the street level. The higher purities permit alternative use methods such as snorting, thus helping to create a new population of heroin users. Casual drug users are more likely to take drugs by inhalation or smoking rather than by injection. Therefore, smokable or snortable heroin can be used by the same methods as cocaine. Also, using heroin in smokable or inhalable form eases the anxiety of users who want to avoid contracting AIDS and other blood-borne diseases through injection. The marketing of heroin is gaining ground in Maryland, as evidenced by the increased number of addicts appearing in heroin abuse programs from 1990 to 1994 who became addicted through smoking or inhaling.

In 1994, 40 percent of the 15,324 heroin abusers who entered drug treatment in Maryland reported that inhalation was the route of administration, compared with 28 percent in 1992.

In Maryland, marijuana price is determined for 1/8-ounce and 1/4-ounce purchases; 75 percent of the purchases statewide are made for these amounts. The purity, or in the case of marijuana, potency, is not included because of insufficient data. The dividing line between user and dealer amounts is 16 grams, or slightly more than 2 ounces, because a natural break occurs in the data at this point, and intelligence information suggests that this is the dividing line between the user and dealer levels (exhibit E-7).

The Maryland State Crime Laboratory reports data on a variety of other drugs. This information can be found in Appendices F-1 and F-2.

Exhibit E-7: Maryland State Police Statewide Marijuana Prices—1991-94

Amount	1991	1992	1993	1994
1/8 ounce	\$42	\$37	\$38	\$34
1/4 ounce	\$61	\$63	\$61	\$59
1/2 ounce	\$101	\$115	\$106	\$108
1 ounce	\$167	\$205	\$190	\$158
2 ounces	NA	\$380	\$355	\$227
4 ounces	NA	\$730	\$680	\$515

SOURCE: Criminal Intelligence Division of the Maryland State Police (CIDMSP), 1996.

Drug Trafficking Reports

The regional offices of the Drug Enforcement Administration (DEA) prepare quarterly intelligence reports that provide information on drug trafficking patterns. Some of these reports are available to the public, and the intelligence analysts are a good source of information on who the wholesalers are as compared with the street traffickers for the different drugs.

Each division office also has a diversion control unit that concentrates on the diversion of legal prescription drugs. This group can provide information on which prescription drugs are being diverted and the patterns of diversion. In addition, the State Pharmacy Board and State Medical Board usually have investigators who can provide additional information on the diversion of prescription drugs.

Appendix G provides a listing of the DEA division offices.

State drug trafficking reports also can be obtained by contacting State and local narcotics officers. These intelligence drug trafficking reports can help network members understand when, how, and from where illicit drugs are transported into the State. These reports provide information about drug availability cost and trends. In many instances, the reports can be obtained by contacting the State police or criminal justice agency.

Appendix H provides an example of drug trafficking information included in the 1995 Drug Prospectus Report produced by the Criminal Intelligence Division of the Maryland State Police Department.

Domestic Monitor Program

The Domestic Monitor Program (DMP) of the DEA reports on sources, kinds, cost, and purity of retail-level heroin. This information is based on actual undercover heroin purchases made by the DEA on the streets in selected cities. The buys provide information on whether the heroin was Asian, Mexican, Colombian, or undetermined, and what adulterants and diluents were present. In addition, the DMP indicates where the buy was made, the brand name, the purity, and the price per milligram pure. Because the validity of this information is dependent on the number of buys made by the DEA, it is important to determine the specific number of buys. One or two buys would provide inconclusive evidence. Information on the DMP can be obtained from the local DEA field offices

... the DMP provides information on where the buy was made, the brand name, the purity, and the price per milligram pure

Price and Purity Data

The Domestic Unit of the Strategic Intelligence Section, Drug Enforcement Administration, compiles data on the price and purity of illicit drugs from DEA field division reports. Data are based on illegal drugs confiscated at the local level. These data are used to assess illegal drug availability. A depressed price and an elevated purity might

signal an increased availability of a certain drug. Increased price and declining purity might indicate decreased availability of that drug.

Data on price and purity of illegal drugs should be analyzed over a long term and in conjunction with other available information on drug trafficking and drug abuse patterns.

Exhibit E-8 shows the average price for marijuana confiscated during April-June 1996. Exhibit E-9 includes national price and potency data for marijuana, from 1993 through the first half of 1996.

Illegal Drug Price/Purity Reports can be obtained from local DEA field officers or from the Intelligence Production Unit (IPU), Intelligence Division, DEA Headquarters.

Exhibit E-8: Quarterly Price Data in Dollars for Marijuana—April-June 1996

Division	Primary Source	Pound Commercial	Pound Sinsemilla	Ounce Commercial	Ounce Sinsemilla
National Range	COL/JAM/MEX-THAI/US	200-4,000	1,000-8,000	40-400	100-600
Atlanta	MEX/US	1,200-1,600	1,800-2,000	90-180	230
Boston	COL/MEX/US	300-4,000	1,000-6,000	75-160	100-600
Chicago	COL/MEX/US	850-2,000	2,500-6,500	75-160	420-480
Dallas	MEX/US	500-3,000	NA	60-80	NA
Denver	MEX/US	500-1,800	1,500-3,500	NA	NA
Detroit	JAM/MEX/THAI/US	800-4,000	1,500-3,000	80-250	150-200
Houston	MEX/US	350-900	NA	NA	NA
Los Angeles	COL/MEX/THAI/US	200-1,000	5,000-6,000	250	NA
Miami	COL/JAM/US	700-1,700	2,000-3,000	NA	NA
Newark	JAM/MEX/US	900-4,000	2,400-3,000	90-400	NA
New Orleans	MEX/US	700-1,500	1,600-5,000	100-400	200-600
New York	MEX/US	300-2,000	2,400-3,500	NA	NA
Philadelphia	JAM/MEX/US	1,500-3,200	1,400-3,200	100-250	NA
Phoenix	MEX/US	650-750	NA	75-100	NA
San Diego	COL/MEX/US	400-800	2,000-4,000	50-100	200-400
San Francisco	MEX/THAI/US	350-1,000	1,500-6,000	40-100	200-600
San Juan	JAM/MEX/US	900-2,500	1700	250-400	NA
Seattle	MEX/THAI/US	600-3,000	2,000-8,000	NA	NA
St. Louis	MEX/US	900-2,000	1,500-4,000	NA	NA
Washington, D.C.	JAM/MEX/US	850-2,200	1,100-5,000	100-250	150-500

SOURCE: Drug Enforcement Administration, 1997.

Exhibit E-9: Annual Price and Potency Data in Dollars for Marijuana, National Range

Type	Quantity	1993	1994	1995	1996 (Jan-June)
Commercial Grade	Pound	300-5,000	285-4,000	300-4,000	200-4,000
	Ounce	24-450	40-450	40-400	40-400
Potency (THC)		4.18%	4.06%	3.51%	5.02%
Sinsemilla	Pound	1,000-9,500	900-9,500	800-8,000	700-8,000
	Ounce	75-100	100-1,000	100-900	60-600
Potency (THC)		5.45%	7.29%	7.25%	10.48%

SOURCE: Drug Enforcement Administration, 1997.

Arrestee Drug Abuse Monitoring Program

The National Institute of Justice's (NIJ) Arrestee Drug Abuse Monitoring Program (ADAM) is a survey of arrestees in metropolitan areas across the United States. It is projected that there will be 75 ADAM sites by the year 2000. ADAM is an expansion and enhancement of the Drug Use Forecasting (DUF) program, which was established by NIJ in 1987.

In each site, quarterly interviews and bioassays are obtained from a sample of arrestees. Response rates usually reach 90 percent for the interviews, with approximately 80 percent of those interviewed agreeing to provide urine samples. All urine specimens are sent to a central laboratory for analysis, and they are analyzed for 10 drugs: cocaine, opiates, marijuana, phencyclidine (PCP), methadone, benzodiazepines, methaqualone, propoxyphene, barbiturates, and amphetamines. All positive results for amphetamines are confirmed by gas chromatography to eliminate positives that may have been caused by over-the-counter drugs. For most drugs, the urine test can detect use in the previous 2-3 days, although marijuana and PCP can sometimes be detected several weeks after use.

In 1996, program sites were located in 23 major metropolitan areas and data were collected from 19,835 adult male booked arrestees. Data also were collected from 7,532 adult female booked arrestees at 21 of these sites, and from 4,145 juvenile male and 645 juvenile female detainees at 12 sites and 7 sites, respectively.

Current ADAM sites include Atlanta, Birmingham, Chicago, Cleveland, Dallas, Denver, Detroit, Ft. Lauderdale, Houston, Indianapolis, Kansas City, Los Angeles, Manhattan, New Orleans, Omaha, Philadelphia, Phoenix, Portland, St. Louis, San Antonio, San Diego, San Jose, and Washington, D.C.

Data from ADAM is used to examine drug abuse patterns and trends in arrestee populations and to compare differences across sites. Outreach data collection will provide vital insights into the leading and trailing edges of drug epidemics and into the links between drugs and crime beyond our central cities.

To obtain information, contact the ADAM Program, National Institute of Justice, 633 Indiana Avenue NW, Room 880, Washington, D.C. 20531.

Some States participating in CSAT's Treatment Needs Assessment contract have funded additional arrestee sites through a series referred to as the SANTA program. Contact the State Alcohol and Drug Abuse agency for information on local ADAM or SANTA studies.

Surveys

Surveys are one of the primary sources of epidemiologic data on incidence and prevalence, patterns and trends, and correlates and consequences of drug use and abuse. Network members should be knowledgeable about three ongoing national surveys of drug use and the most up-to-date results of these surveys. These surveys provide regional and national data on drug use prevalence and trends. The data typically show differences in drug use among specific groups, (e.g., by gender, age, and race/ethnicity). A comparison of local versus national data could, theoretically, yield a number of different but useful findings. For example, in a given year, there may be little difference between the local and national prevalence rates and patterns of drug use. Such a scenario would substantiate the validity of the local data.

Network members should be knowledgeable about three ongoing national surveys . . .

Conversely, a comparison of local and national data may show divergent patterns overall or for a particular drug or population group. For example, the national data may reflect the emergence of a new drug or an increased prevalence of a popular drug, such as marijuana, that has not yet become apparent at the local level. Such a divergence could serve as an "alert." Has the trend been missed in local data gathering, or is it a pattern that may emerge in the future? How should local efforts be designed to determine whether the specific drug is or will become a substance of abuse in a confined geographic area?

Knowledge of national surveys can be useful in planning surveys at the State and local levels. The methods and questionnaires used in the national surveys have been tested for utility and for reliability and validity. Sampling strategies, as well as procedures for training data collectors, should be accessible and useful. The instruments are in the public domain and can be used without cost by any interested party.

National Surveys

The National Household Survey on Drug Abuse (NHSDA) provides information on prevalence and trends in the use of illicit drugs, alcohol, and tobacco among members of the household population aged 12 and older in the United States. Information on lifetime (“ever used”), past-year, and past-30-day use is collected on the following drugs: any illicit drug, marijuana, cocaine hydrochloride, crack cocaine, hallucinogens, any psychotherapeutics (nonmedical use of sedatives, tranquilizers, stimulants, and/or analgesics), alcohol, cigarettes, smokeless tobacco, phencyclidine hydrochloride (PCP), anabolic steroid use, inhalants, and heroin. The survey is based on a multistage area probability sample design.

National Household Survey reports can be obtained by contacting SAMHSA, Office of Applied Studies, Rockwall II Building, 5600 Fishers Lane, Rockville, Maryland 20857, or from the following Web site: <http://www.samhsa.gov>.

The Monitoring the Future Study (MTF) reports on the prevalence of drug use and related attitudes among secondary school students (8th, 10th, and 12th grades). Data have been collected since 1975 from 125 to 140 public and private schools to provide a representative cross-section of students throughout the coterminous United States. A followup mail survey is structured to collect data from college students 1–4 years after high school. Information on lifetime, past-year, and past -30-day use is collected on the following drugs: any illicit drug, marijuana, stimulants, cocaine, crack cocaine, hallucinogens, lysergic acid diethylamide (LSD), hallucinogens other than LSD, inhalants, barbiturates, other opiates, tranquilizers, methylenedioxymethamphetamine (MDMA or “ecstasy”), crystal methamphetamine (“ice”), steroids, and heroin.

The reports describing the results of the MTF can be viewed at Web site www.isr.umich.edu/src/mtf.

The Youth Behavior Risk Survey (YBRIS), developed by the Centers for Disease Control and Prevention, monitors risk behaviors among public school youth in grades 9 through 12. Use of alcohol, tobacco, and other drugs, as well as dietary behaviors, physical inactivity, and risky sexual behaviors are the priority risk behaviors surveyed. Illicit drugs covered include marijuana, cocaine, crack, inhalants, heroin, PCP, LSD, MDMA, methamphetamine, crystal methamphetamine, and peyote (mushrooms). Use of licit drugs (e.g., steroids) without a doctor’s prescription also are covered.

Selected summaries of the YRSB surveys can be viewed at <http://www.cdc.gov/nccdphp/dash/problem.htm>.

State Surveys

In recent years, CSAT funded every State to undertake a family of surveys to estimate the need for treatment. Every State has conducted a telephone survey of adults, which has produced both prevalence and abuse/dependence numbers at the sub-State planning level.

In addition, CSAP funded some States to conduct surveys to estimate prevention needs. Many of these are surveys of students. Each State received enough funds to undertake other surveys and to estimate the need for services.

Contact the State Alcohol and Drug Abuse Agency for further information about the surveys conducted.

Some States, as noted, also conduct school surveys. An example is the annual surveys conducted by the Texas Commission on Alcohol and Drug Abuse, in collaboration with the Public Policy Resources Institute, Texas A&M University. Also, a number of States participate in the national YBRS.

Among the States that have conducted household surveys on drug use is Louisiana, where the State Office of Alcohol and Drug Abuse funded a survey of 5,115 Louisiana adult residents in 1996. The NHSDA contractor collaborated with Louisiana State University School of Medicine in the effort.

Louisiana also recently completed an interesting survey that covered not only drug use among youth, but also compulsive gambling. The survey included 12,066 youth in grades 6–12 in both public and nonpublic schools. Included in the questions were lifetime use, past-month, and more regular use of alcohol, tobacco, marijuana, and other illicit drugs (e.g., cocaine/crack, heroin, other narcotics, tranquilizers, hallucinogens, amphetamines, and barbituates), including use of someone else's prescribed drug. The survey, funded in 1995 by the Louisiana Economic and Development and Gaming Corporation, was conducted by Louisiana State University in coordination with school superintendents and the Louisiana State Office of Alcohol and Drug Abuse.

Local Surveys

In many instances, local school districts have used their Safe and Drug Free Schools grant funds to determine the prevalence of drug use and abuse among their students. In some instances, these surveys are in cooperation with statewide efforts, while in other instances, they were done by survey firms that specialize in studying students. The Parents Research Institute for Drug Education (PRIDE), Parents for a Drug Free America, and the American Alcohol and Drug Survey are examples of these private survey efforts.

Local jurisdictions sometimes conduct household surveys on drug abuse

Local jurisdictions sometimes conduct household surveys on drug abuse. For example, Louisiana State University, Baton Rouge, surveyed residents in East Baton Rouge Parish using computer-assisted telephone interviewing following a random-digit dialing sampling technique. In addition, drug and alcohol program administrators, treatment practitioners, and law enforcement personnel were surveyed to gain insight into the nature of the substance abuse problem from those intimately involved in its control, to assess treatment services, and to determine the characteristics of clientele who are processed by treatment and law enforcement agencies.

Local jurisdictions also may survey arrestees to determine the prevalence of drug use in the population. Cities may find support to conduct an ADAM-type study, as was done in Bernalillo County, New Mexico, or they may be a participating ADAM site.

At all such local levels, it will be useful to check whether a survey is compatible with a national or State survey. Using the questionnaire(s) or selected items from the questionnaire(s) will enhance comparability between national and State or local findings. It may be possible to get the State agency to oversample in the area at a minimal cost (compared with running an independent survey). Contact the State Alcohol and Drug Abuse Agency for further information.

HIV/AIDS Data

CDC distributes scientific publications on all aspects of HIV and AIDS, including copies of AIDS-related articles from the *Morbidity and Mortality Weekly Report (MMWR)* series.

CDC NAC ONLINE, a computerized network, offers a direct link to Clearinghouse information and a means for communicating electronically with others who are providing HIV services. Data can be accessed with a personal computer and modem or by telephone. Some of this information is available through <http://www.cdc.gov>.

Each State health department should have a HIV/AIDS unit that collects much of the information that is subsequently submitted to CDC. The State data will be more current and can include additional data elements. Available information typically includes mode of transmission, age, race, and sex data. The data are reported cumulatively from the date that reporting started and also for the current year. The cumulative data include all the data, which will show the full impact of AIDS; however, shifts in modes of transmission will be clearer if the network compares the noncumulative data for 2 successive years. As an example, for modes of transmission in Texas the cumulative percentage of homosexual or bisexual men is 65 percent, compared with 54 percent for 1995. The cumulative percentage of injection drug users is 12 percent, compared with 16 percent for 1995; the cumulative percentage for heterosexual contact is 5 percent compared with 8 percent for

1995. The percentage of men having sex with men and injecting drugs is 9 percent cumulatively and 8 percent for 1995. More importantly, the racial/ethnic distribution changed over time. Cumulatively, 59 percent are Anglo, 24 percent are African-American, and 17 percent are Hispanic; for 1995, 47 percent are Anglo, 32 percent are African-American, and 20 percent are Hispanic.

Check the validity of data with State health department personnel. In some instances, cases of HIV are underreported, while AIDS data are considered more accurate. In addition, to protect the confidentiality of some persons, data may not be reported for small rural counties where only two or three persons have AIDS.

Further, the HIV/AIDS unit will be aware of other local research and data, and, since it administers the Ryan White planning funds, it can direct the network to the local Ryan White Council and the data and plans generated at the State and local levels.

Telephone Hotline Data

Telephone drug hotlines, which are set up to provide information and referral sources, can be a useful source of information about drugs and drug abusers. Typically, hotlines are organized to provide information and counseling services to individuals concerned about or experiencing problems after using drugs. In quantifying the information collected from callers in a systematic way, it is possible to detect potential changes in use of particular drugs and the emergence of new drugs. Although one should keep in mind that hotline information is not based on a scientifically selected sample and is not catalogued for analysis, the counselors can provide valuable insight in explaining new trends and “fads.”

Generally, hotline counselors fill out forms to record information about each telephone contact, including types of problems the caller has experienced, drugs involved, services needed, and assistance/information provided. The information is often recorded on a standardized form by trained staff so it can be aggregated and analyzed systematically and efficiently.

An example of this is the Alcohol and Drug 24-hour Helpline in Washington State, which established a computer data base to record and quantify information collected from callers (Forbes 1991). Through this data base, Helpline staff are able to report periodic increases and decreases in the number of callers who report use of different drugs and the emergence of new substances of abuse. They also are able to monitor use patterns by type of callers and by geographic area. For example, in 1991, LSD use, which was typically reported in only one county, began to be reported in other counties, alerting staff to a potential public health concern. Exhibit F shows a summary of calls reported by the Helpline in 1990 by type of drug and pregnancy status.

Exhibit F-1: Reported Alcohol/Drug Helpline Data, Washington State—1990

Total Calls	32,769
Drugs Mentioned	4,451
Alcohol	140
Amphetamines	20
Barbiturates	747
Cannabis	1,214
Cocaine	64
Narcotics	398
Heroin	45
Other illicit drugs	366
Prescription drugs	58
Tranquilizers	18
Inhalants	46
Nicotine	322
Other	1,013
Pregnant	28
Alcohol	21
Cocaine	10
Marijuana	12
Heroin	6

SOURCE: Forbes, 1991.

Other Useful Data Sources

A number of other data sources can provide useful information for epidemiologic networks. The following are briefly described in this section.

Census Data

Census data, collected and reported by the U.S. Bureau of the Census every 10 years, help characterize populations within particular geographic areas and are therefore useful as a planning resource. The Bureau of the Census established census tracts as units for the study of small metropolitan sections. Census tracts average about 4,000 people. Block numbering areas (BNAs) serve a similar purpose for counties that do not have census tracts. Block groups (BGs), subdivisions of census tracts and BNAs, are the smallest areas for which data are furnished. BG data are provided on microfiche, computer tape, and other products. The Bureau of the Census publishes extensive data for census tracts and BNAs in the report series, *Population and Housing Characteristics for Census Tracts and Block Numbering Areas*. In addition, the Bureau provides 1990 summarized census data for 5-digit ZIP codes throughout the country on computer tape and compact disk-read-only memory (CD-ROM).

Census statistics can be obtained for many different kinds of geographic areas:

- Regions
- Divisions
- States
- Metropolitan statistical areas (MSAs)
- Urbanized areas (UAs)
- Congressional districts
- ZIP codes
- American Indian and Alaskan Native areas
- Counties
- Cities and villages
- Census tracts and block numbering areas
- Block groups
- Blocks

Census tracts and block numbering areas are the most widely used geographic areas as planning resources.

These data provide the following information about the people who live in particular boundaries:

Demographics

- gender
- age
- race/ethnicity

Socioeconomic status

- median family income
- percentage of families living below the poverty level
- percentage of families on public assistance

Crime

- homicide rate per 100,000 population
- robbery rate per 100,000
- breaking and entering rate per 100,000
- larceny rate per 100,000
- major crime rate per 100,000
- percentage of juveniles referred to juvenile court
- percentage of juvenile offenses per juvenile

Health

- death rate per 1,000
- infant mortality rate per 1,000

Housing

- percentage of units without central heating
- percentage of units with 1.01 or more persons per room
- percentage of rental units with rent less than \$40

The U.S. Bureau of the Census also offers a variety of online services to Internet users . . .

Census data have been used in the mental health field to establish rough measures of relative need, identify at-risk populations, and evaluate patterns of service utilization (Bell et al. 1982). Surveillance networks can use census data to learn more about populations in areas where particular types of drug use are prevalent or drug use and trafficking are high.

The U.S. Bureau of the Census also offers a variety of online services to Internet users, including data access tools, from the agency's Home Page. For example, using DataMap, one can view and print profiles of States and counties; 1990 Census Lookup allows the user to create extract files from the 1990 summaries (and includes detailed examples with proper procedures); and the Data Extraction System allows users to create custom data extracts from surveys, including the Current Population Survey and others. Census CD-ROM products can be ordered at the following address: Department of Commerce, P.O. Box 277943, Atlanta, GA 30384-7943. Credit card orders can be made by telephone by calling: (301) 457-4100.

Under the Search option on the Home Page, one can type in key words to access relevant online documents; search for information on localities by place names, ZIP codes, and other identifiers; search for information by pointing and clicking on areas of interest on a map (only available if you have a graphical interface with your Internet subscription); or even perform a staff search of Bureau of the Census employees. Lastly, under the Ask the Experts option on the home page, one can send general questions and comments via e-mail; access phone numbers organized by subject for more specific information; get on relevant mailing lists; and contact regional offices, Census State Data Centers, National Census Information Centers, and other sources of information. One can log onto the Bureau of the Census home page through <http://www.census.gov>.

In addition, the State Census Data Center can provide information on updated census estimates by county for the intervening years between the census. In some instances, this center makes the estimate, while in other instances, another State agency makes the official State and county population estimates for these years.

University Researchers

Often there are local university faculty, especially in health, social science, and science departments, who are interested in alcohol and drug abuse issues or have expertise in research methods that can be used by epidemiologic networks. The network and these faculty members, who may be conducting very relevant research, may be unaware of each other's efforts. In addition to the faculty's research interests, they often have students looking for projects, and these students can be very useful in collecting information and analyzing data, especially since they have access to powerful computers and

. . . faculty members may be conducting very relevant re-search . . .

statistical software programs that the network members may not have. To find these interested faculty, contact academic departments in public health, pharmacy, sociology, anthropology, social work, psychology, criminal justice, nursing, health sciences, and education. Research centers for special ethnic studies also may house researchers who are interested in substance abuse issues.

Community-Level Sources

It is not easy to identify sources of information at the community level, find out what types of information are available from these sources, and establish procedures to obtain relevant information initially and, perhaps, periodically. It must be kept in mind that information about drug abuse is likely to be confidential. The people responsible for collecting and reporting information about drugs are usually very busy and are likely to have reservations about sharing information.

If a network does not already have connections with community data sources through its members, there are two ways to start the process of identifying sources, and both can be done concurrently. The first way is to get local telephone numbers of criminal justice, health, and treatment agencies so that calls can be made to identify potential data sources. The mayor's office, chamber of commerce, or a similar source may have a directory of human resource organizations. Or one might simply use the local telephone directory. Community or local telephone books generally specify, in the front, pages for telephone numbers of local police and sheriff departments. The regular telephone directories may list police and sheriff departments under Government Listings and hospital and treatment programs in yellow pages or the business section (by name). Support staff at network-backed agencies may be helpful in this task.

The second way to start identifying potential information sources at the community level is to start at the top and work down. In attempting to identify sources of arrest data, begin by calling individuals at the State Alcohol and Drug Abuse Agency who can identify and provide a list of the substance abuse treatment programs that are located within or serve particular communities. Also, call the State Police Department and the UCR office to find out who their contacts are at the local level. In trying to identify individuals and departments within hospitals, contact representatives of the State health department to find out what and whom they know.

... calls can be made to identify potential data sources

Establishing and Developing Relationships with Information Sources

... most public organizations ... including Police Departments, are obligated to release data/information

Public Versus Private Information Sources

It should be kept in mind that most public organizations, including police departments, are obligated to release data/information. For example, arrest data collected by Police Departments fall under the category of public information as long as individuals are not identified. Most of these data are collected and reported to another level of authority; for example, city and county Police Departments report to regional Drug Enforcement Administration offices and to State Police Departments. Private hospitals, on the other hand, are not obligated to give information to outside sources other than those to which they are accountable for documenting services provided and costs associated with providing services.

Preparation/Making Contact

Prior to contacting representatives of agencies and departments about the availability of data/information, one must be well prepared. First, it is important to specify whom you represent, the reason for pursuing the information, and how the information will be used and reported. Second, it must be made very clear that this is a public health project and that you do not want the names and identities of individuals who used drugs, but rather, data that have been aggregated and quantified. It might be appropriate to invite individuals who have access to data/information to attend or participate in a network meeting. It is always a good practice to follow up a telephone contact with a letter reiterating whom you represent, confirming your understanding about the availability of data and how it might be obtained and, perhaps, formally inviting the individual to the meeting. It is also helpful to send each individual information about the network and, if available, a copy of a network meeting report or summary or outline of the project being planned.

Developing Relationships

It is important to maintain good relationships with community agency representatives who have access to current and potential data sources. As indicated earlier, it is difficult to identify sources of information at the community level, but once relationships are established it is relatively easy to tap these resources on a regular basis.

... once relationships are established it is relatively easy to tap these resources on a regular basis

Several steps can be taken to develop working relationships with data sources, including inviting representatives to a network meeting; meeting with representatives so they get to know you personally (invite them to your office or visit them); and sending them information, including any documents developed by the network.

Key Informants

At a particular point in time, scientifically based indicator data may not be available on a particular question of interest. The issue may be under study or not yet identified, or, indicator data on the issue may be outdated.

There are a number of informal sources that epidemiology networks can consider tapping when indicator data are unavailable or incomplete. Such informal sources, in fact, can provide useful information even when members have solid, scientifically based indicator data. The types of informal sources described here can be used by networks to add an in-depth understanding to indicator data and serve as interim indicators until more scientific findings are available.

*... informal sources
... can add an in-
depth understanding
to indicator data ...*

In assessing information from different sources, it is useful to know what the different indicators represent. Why do the numbers change from one period to another? Are there factors that the indicator data are not showing? The answer to this last question is almost always yes, given that indicator data are based on a finite population, different time frames, and different sets of measures.

Consider, for example, that

- Police Departments change their tactics from time to time in the kinds of crimes and geographic areas they target;
- lower income people are more likely than other populations to use emergency rooms for general medical care, while higher income people tend to use private health care facilities; and
- the types of clients treated by drug abuse treatment programs vary by type of facility, and these patterns may change because of changes in health insurance regulations and government funding policies.

It is therefore important to obtain background information on the sources of indicator data to understand what the numbers mean. One of the first steps is to ask those who represent the sources from which the indicator data are produced to explain how the indicators reflect certain policies and certain populations. Ideally, a member of the network would be in a position to explain what the numbers mean or who can provide an explanation.

If members do not yet know the reasons or possible reasons for changes, some members may be in a position to find such answers in the days following a network meeting. For example, if the treatment data show that there was a significant increase in primary marijuana users admitted into drug abuse treatment programs during the prior 6 months, it might be useful to contact treatment providers to get their views. If one or more network members volunteered to get this information, they could prepare a brief supplementary report and communicate the information to the other members.

*... some members
may be in a position
to find such
answers ...*

The question of why indicator data change over time may be partially answered when background information about the sources such of data are obtained. For example, an increase in heroin arrests may reflect special efforts made by the Police Department to “crack down” on heroin dealers during a particular period of time. The changes also may reflect something that is happening in the world of drug users.

Surveillance networks generally do not have the time or resources to conduct studies to answer questions on why patterns of drug use are changing. That does not mean that the answers cannot be obtained. Members of the work group may already know or suspect some of the reasons for the changes. It is often surprising to discover what network members already know, especially those who come into direct contact with drug abuse clients. Some members, however, may be reluctant to talk about what they know because they consider the information unscientific.

Another method is to investigate the reason for changes like a reporter approaches a news story. Member(s) could explore the who, what, when, where, why, and how. One or more members of the work group might assume this role. Still another method would be for a member to assume a role similar to that of a CDC field epidemiologist who investigates why, how, and where a disease is spreading. If time and resources permit, members could go out to the community and talk to people close to or directly involved with the drug scene. In gathering this type of information, it might be possible to identify some of the possible causes for the changes and determine whether these changes are likely to be part of a trend.

At a minimum, network members can make phone calls to key people in the field who know the drug scene (e.g., directors of treatment, social service, health clinic, and recreation programs; clinical staff; and outreach workers). In many instances, outreach workers may be in the best position to know why new drug use patterns and trends are emerging.

Another reason for using informal sources of information is to address the question: How can network members broaden their perspective and identify new drug abuse patterns and trends before they emerge through indicator data? One approach is for the network to establish linkages with people who are knowledgeable about the community or particular populations in the community. (This approach, of course, is useful even when indicator data are available.)

Who are These People?

Network members can never be sure (especially when beginning a local group) who might be in a position to contribute new information. Therefore, it is useful for a network to establish a list of such people

... investigate the reason for changes like a reporter approaches a news story

over time. The people on this list may be referred to as key informants, individuals who can be contacted to obtain a better understanding of what is going on in a community. This list might include the following types of persons:

The key is to identify key informants who can be consulted regularly . . .

- a school counselor who deals with problematic drug cases;
- a telephone hotline supervisor;
- an individual who runs a corner convenience store;
- an outreach worker who operates out of a church basement;
- a bartender at a bar or restaurant that drug abusers are known to frequent;
- an ex-drug addict who still knows what is going on in the user community; and
- a local newspaper reporter who covers the drug beat.

The key is to identify key informants who can be consulted regularly to find out if any new drug patterns are emerging or if any new populations of drug users are being seen. Over time, the network members will learn who the best sources are for particular types of information.

Short-Term Ethnography Studies

So far, some specific techniques to obtain information have been outlined, techniques that group members might use to provide context for the indicator data. At some point, though, a work group might decide that more detailed information is needed about some pattern of drug use or what seems to be an emerging trend, something more systematic than current knowledge, telephone calls, or conversations with knowledgeable people can provide.

. . . ethnographic methods can be used to address questions that arise from epidemiologic data . . .

One method that can be used is ethnography. Formerly the province of anthropologists and sociologists, ethnography is now entering the mainstream of social research. There are numerous reasons for using this methodology. The reason most pertinent to a network is that ethnographic methods can be used to address questions that arise from epidemiologic data: who, what, when, where, why, and how. In a time of dramatic and continual change, when organizations and institutions are unsure of the nature of the world and their role in it, ethnography has become a useful way to find some answers, because it focuses on learning about the behaviors of people. It goes beyond objective analytic description to include an analysis of the knowledge and beliefs that underlie behaviors.

At any point during the research, questions are continuously raised based on previous findings. Hypotheses are constantly being developed and tested. Two considerations guide sampling in ethnographic research. First, because of the emphasis on ongoing, high-rapport relationships to elicit needed information, purposive sampling is

generally selected rather than random sampling. Second, significant differences and dimensions within one or more populations are identified only after the ethnographic research is under way, so more appropriate samples emerge over time. Samples are constructed as the research develops; the choices of study subjects are made as the population variation becomes clear. Ethnographers keep a record of the samples as they develop, so that comparison of the ethnographic sample with already available population descriptions can be made later to assess the representativeness of the sample.

The two primary methods used by ethnographers are:

- *participant observation* (listening and observing behaviors in the natural settings of individuals being studied); and
- *formal and informal interviews*.

Ethnographers take time to observe and understand, firsthand, the *world* of the people they are studying. There is often a difference between what people say and what they do and the nature of this difference is very important. One way ethnographers learn what people do is to go out into the community to see how they live, work, and play. To learn why people behave in certain ways, it is important to learn about their culture, values, and traditions.

When ethnographers interview, they listen rather than just ask questions. They probe, validate previous information, and when appropriate, introduce new topics.

The following routine information is collected by ethnographers in their studies of drug abusers:

- drugs used;
- combinations of substances used;
- frequency of use;
- modes of administration;
- social setting in which drugs are used;
- ages and circumstances for initiation to drugs;
- reasons for using drugs;
- drug effects;
- adverse reactions to drugs; and
- consequences of drug use over time.

Field observations and interviews are generally recorded. The tape recordings are transcribed and the data (contained in the transcripts) are coded and sorted by topics. Once sorted, data are reviewed and analyzed for *patterns*. *Patterns* are associated with aggregate statistics on age, ethnicity, gender, and particular types of drugs used and behaviors.

In ethnography, theory emerges out of the data, because the concepts and relationships are uncovered during ethnographic research. The new concepts and relationships are referred to as “grounded theory” because the theory grows from the ethnographic data gathered during a study. In ethnography, control is vested in the persons and situations studied, as the ethnographer learns about the people, their culture and lifestyles, and the world within which they live.

The national CEWG has used ethnography in a number of ways. One model that might be of particular interest to surveillance networks is based on *short-term* studies. This type of ethnographic research, while not a full-scale ethnography, is designed so that an experienced ethnographer in a particular city, who is already working with drug users, can address questions and issues of interest to work group members. Generally, these ethnographic projects can be conducted over a short period of time at relatively little expense and, ideally, should be designed and supervised by ethnographers who have formal training and are already conducting studies in the area.

Short-term ethnographic studies were conducted in 12 of the CEWG cities between 1994 and 1996. Five of these studies are briefly described in Appendix I.

... ethnographic projects can be conducted over a short period of time at relatively little expense ...

Ethnographers often work as faculty in university anthropology or sociology departments, two disciplines with strong traditions of training in the area. Ethnographers now work in other disciplines as well. For example, the field of speech communication discovered “the ethnography of communication” 30 years ago, and now has specialists who have trained in ethnography as well. Since the 1950s, ethnography has been part of public health training in some areas. Many ethnographers now work outside university settings.

In selecting an ethnographer, it is important to review the person’s training, type of degree, publications, professional organization, and affiliation. Also, read the individual’s recently published ethnographic research, especially if it involves the field of drug abuse.

Spend some time with the ethnographer discussing issues and research topics of greatest interest. Give the ethnographer an overview of why the network wants to pursue the study. Are there particular questions that need to be answered? Spend some time with the ethnographer as the study progresses to see what sorts of information are being collected and to see if adjustments need to be made by adding additional questions or by refocusing some of the questions.

When ethnographers interview, they tend to introduce topics and then listen rather than ask questions. There is often a difference between what people say and what they do, and the nature of these differences is important in ethnography. Ethnographers also use documents, archives, memoranda, newsletters, and the like.

Ethnographers can obtain a variety of data from a variety of sources, and systematically assess the constant and variable patterns that range across the data. In addition to observation and interviews, archives, memoranda, newsletters and other documents can be used for analysis. Short-term ethnographic studies conducted by the national CEWG were very successful because they were conducted by experienced ethnographers already at work in the communities.

Reporting

Networks will find it useful to have a somewhat standardized format for reporting findings. This will be useful for several reasons. First, as the network evolves over time and produces several reports, a standardized format will make it easier to review data from each reporting period to generate trends across different time periods. Second, for networks that will have a series of papers from different geographic areas or jurisdictions, following a standardized format will make it easier to summarize data across all the areas; it also will aid readers in making their own comparisons across reporting sites. Third, it is likely your network will distribute its reports to busy policymakers, practitioners, and other interested parties. A standard format, together with a clear table of contents in the report, will facilitate their review of the data, especially as they become accustomed to the format after reading several reports over time.

It is important to recognize that your network is not likely to have all the sources of data described in earlier sections as it begins its surveillance work. Yet, much can be learned in initial efforts. An example is the Louisiana State Epidemiology Work Group, which held its third meeting in December 1997. The effort involved seven parishes. Parish representatives reported treatment data obtained from the State Office of Alcohol and Drug Abuse, as well as parish-specific data from a statewide adult household survey on drug use and a statewide school survey on drug use. Some parishes also obtained drug-related data from hospital emergency departments, coroners' offices, law enforcement agencies, and special surveys. The parish reports were prepared in a standard format. Each paper contained an abstract of key findings. The Introduction is used to describe the area and sources of data. Actual findings are presented in the section on "Drug Abuse Patterns and Trends," supplemented by tabular data at the conclusion of the reports. An example of the Rapides Parish report is provided in Appendix J.

... following a standardized format will make it easier to summarize data across all the areas ...

Because Louisiana SEWG parish reports followed a standard format, summarizing key findings did not require an excessive amount of time. The major finding was that cocaine (both HCL and crack) represented the major illicit drug problem in all seven parishes. For example, cocaine/crack accounted for one-half to three-fourths of all treatment admissions for primary abuse of an illicit drug.

The Community Epidemiology Work Group has used a similar format over the years; however, the CEWG format for reporting drug use patterns and trends is more specific and presents findings by drug of abuse (see Appendix B). The city reports are included in NIDA's report series entitled *Epidemiologic Trends in Drug Abuse*, Volume II. Recent reports can be viewed on the CEWG Home Page or the NIDA Home Page cited on page 2.

References

- American Hospital Association. *AHA Hospital Statistics* 1990 ed. Chicago: American Hospital Association, 1991.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association, 1994.
- Beck, M.; Glick, D.; Joseph N.; and Katel, P. State of emergency: Hospitals are seeking radical solutions to ease walk-in patient overload. *Newsweek*, Oct. 14, 1991. pp. 52–53.
- Bell, R.A.; Goldsmith, H.F.; Lin, E.; Hizek, R.K.; and Sobel, S. *Social Indicators for Human Services*. Louisville, KY: Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Louisville, 1982.
- Buechner, J.S., and Waters, W.J. Use of hospital emergency departments for routine medical care. *Rhode Island Medical Journal* 74: 434–435, 1991.
- Criminal Intelligence Division of the Maryland State Police. *Drug Prospectus 1995*. Columbia, MD, 1996.
- Digregorio, G.J. Cocaine update: Abuse and therapy. *Clinical Pharmacology, AFP* 41 (1): 247–250, 1990.
- Drug Enforcement Administration. Illegal drug price/purity report. United States: January 1993–June 1996. *Drug Intelligence Report*. Washington, DC, February 1997.
- Dufour, M., and Caces, F.M. Epidemiology of the medical consequences of alcohol. *Alcohol Health & Research World* 17 (4): 265–271, 1993.
- Dworetzky, T. Crisis in the emergency room: Trauma care units are in shock, but you may be the next casualty. *OMNI* 11: 28, 1992.
- Forbes, A. Alcohol/drug 24-hour helpline. In: *Drug Abuse Trends in the State of Washington: Proceedings of the State Epidemiology Work Group*. Seattle: King County Division of Alcoholism and Substance Abuse Services, Seattle-King County Department of Public Health, 1991.
- Gentile, P. Acute addiction discharges in Maryland general and private psychiatric hospitals, 1990–1992. Maryland Health Resources Planning Commission, September 1993.
- Gibbs, N. Do you want to die? The crisis in emergency care is taking its toll on doctors, nurses, and patients. *Time*, May 28, 1990.
- Gold, M.; Washton, A.; and Dackis, C. Cocaine abuse: Neurochemistry, phenomenology and treatment. In: Kozel, N., and Adams, E., eds. *Cocaine Use in America: Epidemiologic and Clinical Perspectives*. National Institute on Drug Abuse Research Monograph 61. Rockville, MD: National Institute on Drug Abuse, 1985.
- Hagland, J.M.; McNamara, P.; and Hand, D. The sagging safety net: Emergency departments on the brink of crisis. *Hospitals*, Feb. 20, 1991: 26–40.
- Krentz, M.J. Conspectus. *Comprehensive Therapy* 15 (10): 3–7, 1989.
- Maryland State Police. *Crime in Maryland: 1995 Uniform Crime Report*. Pikesville, MD, Dec. 9, 1996.

-
- National Institute on Drug Abuse. *Epidemiologic Trends in Drug Abuse, Volumes I and II: Proceedings, Community Epidemiology Work Group*, Rockville, MD: The National Institute on Drug Abuse, Dec. 1997.
- National Institute on Drug Abuse. *Epidemiologic Trends in Drug Abuse, Volumes I and II: Proceedings, Community Epidemiology Work Group*, Rockville, MD: National Institute on Drug Abuse, Dec. 1996.
- Office of Alcohol and Drug Abuse, State of Louisiana. *Drug Abuse Patterns and Trends in Louisiana: Proceedings of the State Epidemiology Work Group*. Baton Rouge, September 1997.
- Pollock, D.A.; Holmgreen, P.; Lui, L.; and Kirk, M.L. Discrepancies in the reported frequency of cocaine-related deaths, United States, 1983 through 1988. *Journal of the American Medical Association* 266 (16): 2233–2237, 1993.
- Poppy, J. Trauma cases. *Esquire*, October 1990.
- Ravenholt, R.T. Addiction mortality in the United States, 1980: Tobacco, alcohol, and other substances. *Population and Development Review* 10: 697–724, 1984.
- Regier, D., Boyd, J., Burke, J.; Locke B.; Rae, D.; Myers, K.; Kramer, M.; Robins, L.; Blazer, D.; and Karno, M. One-month prevalence of mental disorders in the U.S. based on five epidemiologic catchment area sites. *Archives of General Psychiatry* 45 (11): 977–986, 1988.
- Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set*. Rockville, MD: SAMHSA, 1995.
- Texas Commission on Alcohol and Drug Abuse. *1995 Indicators of Alcohol and Drug Abuse in Texas*, Austin, 1996.
- Thal, E.R., and Rochon, R.B. Inner-city trauma centers: Financial burdens or community saviors? *Surgical Clinics of North America* 71 (2), 1991.
- United States Department of Health and Human Services. *Sixth Special Report to the U.S. Congress on Alcohol and Health*. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1987.
- United States Government Accounting Office. *Trauma Care: Lifesaving System Threatened by Unreimbursed Costs and Other Factors*. Report to the Chairman, Subcommittee on Health for Families and the Uninsured, Committee on Finance, U.S. Senate. Washington, DC: GAO/HRD–91–57, May 17, 1991.
- Wagner, L. Violent, drug-related crime contributes to closures of trauma units. *Modern Healthcare*, May 27, 1991, p. 12.
- Walters, S. Boom or bust in emergency department. *Michigan Hospitals*, May 1990, pp. 5–9.
- Whitfield, C. Outpatient management of alcoholic patient. *Psychiatry Annals* 12: 447–458, 1982.

GLOSSARY

AIDS — Acquired Immunodeficiency Syndrome	DUI — Driving Under the Influence
ARD — AIDS-Related Diseases	ED — Emergency Department
BG — Block Group	FBI — Federal Bureau of Investigation
BJS — Bureau of Justice Statistics	FIPS — Federal Information Processing Standards
BNA — Block Numbering Area	GAO — General Accounting Office
CDC — Centers for Disease Control and Prevention	HIV — Human Immunodeficiency Virus
CDS — Client Data System	ICD — International Classification of Diseases
CEWG — Community Epidemiology Work Group	ICD-9-CM — International Classification of Diseases, 9th Revision
CIDMSP — Criminal Intelligence Division of Maryland State Police	ICPSR — Inter-University Consortium for Political and Social Research
CODAP — Client Oriented Data Acquisition Process	IDU — Injection Drug Users
CSAP — Center for Substance Abuse Prevention	IEWG — International Epidemiology Work Group
CSAT — Center for Substance Abuse Treatment	IVDA — Intravenous Drug Abuse
DAWN — Drug Abuse Warning Network	ME/C — Medical Examiners and Coroners
DEA — Drug Enforcement Administration	MECISP — Medical Examiner and Coroner Information Sharing Program
DHHS — Department of Health and Human Services	MMWR — Morbidity and Mortality Weekly Report
DMP — Domestic Monitor Program	MSA — Metropolitan Statistical Area
DRG — Diagnostic Related Group	MTF — Monitoring the Future Study
DSM-IV — Diagnostic and Statistical Manual of Mental Disorders	NACJD — National Archive of Criminal Justice Data
DUF — Drug Use Forecasting System	NCHS — National Center for Health Statistics

NCJRS — National Criminal Justice Reference Service

NDATUS National Drug and Alcohol Treatment Unit Survey

NHAMCS National Hospital Ambulatory Medical Care Survey

NIAAA — National Institute on Alcoholism and Alcohol Abuse

NIDA — National Institute on Drug Abuse

OAS — Office of Applied Studies

OTC — Over the Counter

PRIDE — Parents Research Institute for Drug Education

SAMHSA Substance Abuse and Mental Health Services Administration

SEWG — State Epidemiology Work Group

SIDS — Sudden Infant Death Syndrome

STD — Sexually Transmitted Disease

TCADA – Texas Commission on Alcohol and Drug Abuse

TEDS — Treatment Episode Data Set

TEFRA — Tax Equity and Fiscal Responsibility Act

UA — Urbanized Area

UCR — Uniform Crime Reports

UFDS — Uniform Facility Data Set

WHO — World Health Organization

Appendix A: National CEWG Members

Mark R. Bencivengo
Coordinating Office for Drug and
Alcohol Abuse Programs
Philadelphia Department of
Public Health
1101 Market Street, 8th floor
Philadelphia, PA 19107
Phone:(215) 592-5404
Fax:(215) 592-5427

Richard F. Calkins
Evaluation and Data Services
Center for Substance Abuse Services
Michigan Department of Public Health
P.O. Box 30195
Lansing, MI 48909
Phone:(517) 335-8858
Fax:(517) 335-8837
E-mail:calkinsr@state.mi.us

Thomas W. Clark
Health and Addictions Research, Inc.
419 Boylston Street, Suite 801
Boston, MA 02116
Phone:(617) 266-9219
Fax:(617) 266-9271
E-mail:twc@world.std.com

Ilene L. Dode, Ph.D.
EMPACT—Suicide Prevention Center, Inc.
1232 East Broadway, Suite 120
Tempe, AZ 85282
Phone:(602) 784-1514
Fax:(602) 967-3528
E-mail:idode@aol.com

Carol L. Falkowski
Hazelden Foundation
P.O. Box 11-CR9
Center City, MN 55012-0011
Phone:(612) 213-4566
Fax:(612) 213-4496
E-mail:cfalkowski@hazelden.org

Blanche Frank, Ph.D.
Bureau of Applied Studies
New York State Office of Alcoholism
and Substance Abuse Services
55 West 125th Street, 10th floor
New York, NY 10027
Phone:(212) 961-8494
Fax:(212) 961-8490

John F. French
Research and Information Services
Data Analysis and Epidemiology
Division of Addiction Services
New Jersey Department of Health
129 East Hanover Street CN 362
Trenton, NJ 08625-0362
Phone:(609) 292-8930
Fax:(609) 292-3816
E-mail:johnf@netaxs.com

Michael Ann Haight
Management Information Services
County Alcohol and Drug Services
P.O. Box 85222
San Diego, CA 92186-5222
Phone:(619) 692-5752
Fax:(619) 692-5604
E-mail:mhaight@aol.com

James N. Hall
UpFront Drug Information
and Education Center
5701 Biscayne Blvd., Suite 9PH
Miami, FL 33137
Phone:(305) 757-2566/(305) 375-8032
Fax: (305) 758-4676
E-mail:uupfrontin@aol.com

Leigh Henderson
3001 Guilford Avenue
Baltimore, MD 21218
Phone:(410) 235-3096
Fax:(410) 235-3096
E-mail:lhenderson@welchlink.elch.jhu.edu

Lee Hoffer
Data Analysis and Evaluation
Colorado Department of Health
ADAD-DAE-A2
4300 Cherry Creek Drive South
Denver, CO 80222-1530
Phone:(303) 294-5270
Fax:(303) 295-3441
E-mail:lee.hoffer@uchsc.edu

Valerie Hoffman, Ph.D.
UCLA Drug Abuse Research Center
University of California, Los Angeles
1100 Glendon Avenue, Suite 763
Los Angeles, CA 90024-3511
Phone:(310) 825-9057
Fax:(310) 794-2802
E-mail: vhoffman@ucla.edu

Heidi Israel
Division of Infectious Diseases
St. Louis University School of Medicine
1200 South Grand
St. Louis, MO 63104
Phone:(314) 268-5448
Fax:(314) 268-5196
E-mail:israelha@sluava.slu.edu

T. Ron Jackson
Evergreen Treatment Services
1250 First Avenue South
Seattle, WA 98134
Phone:(206) 223-3644
Fax:(206) 223-1482
E-mail:ronjack@u.washington.edu

Jane C. Maxwell
Research Department
Texas Commission on Alcohol and Drug Abuse
9001 North IH 35, Suite 105
Austin, TX 78753-5233
Phone:(512) 349-6645
Fax:(512) 349-6802
E-mail:jane_maxwell@tcada.state.tx.us

Marcia Meth
Johnson, Bassin & Shaw, Inc.
8630 Fenton Street, Suite 1200
Silver Spring, MD 20910
Phone:(301) 495-1080
Fax:(301) 587-4352
E-mail:mmeth%nida1@ngmsmtp.samhsa.gov

John A. Newmeyer, Ph.D.
Haight-Ashbury Free Clinics, Inc.
612 Clayton Street
San Francisco, CA 94117
Phone:(415) 931-5420
Fax: (415) 864-6162
E-mail:jnewmeyer@aol.com

Claire Sterk, Ph.D.
Emory University
School of Public Health
Women's and Children's Center
1518 Clifton Road, NE
Atlanta, GA 30322
Phone:(404) 727-9124
Fax: (404) 727-8744
E-mail:sterk@sph.emory.edu

Gail Thornton-Collins
New Orleans Health Department
517 North Rampart Street, 4th floor
New Orleans, LA 70112
Phone:(504) 565-7700
Fax:(504) 565-7886

W. Wayne Wiebel, Ph.D.
School of Public Health
University of Illinois at Chicago
2121 West Taylor Street, Room 552
Chicago, IL 60612
Phone:(312) 996-4870
Fax:(312) 996-1450
E-mail:drugs@uic.edu

D. William Wood, Ph.D., M.P.H.
School of Public Health
University of Hawaii at Manoa
1960 East-West Road, T-102
Honolulu, HI 96822
Phone: (808) 956-8066
Fax:(808) 956-4585

Appendix B: National CEWG Report Format

PATTERNS AND TRENDS OF DRUG ABUSE IN DRUGFREEVILLE: A REPORT THAT FOLLOWS THE CEWG OUTLINE

Daphne Data, Ph.D.
Stanley Statistic, Ph.D.
Alcohol and Drug Abuse Division
Drugfreeville Department of Health

Drugfreeville, Drugless State

The abstracts should be approximately 150 words in length. It should contain a general overall statement, followed by about 1 sentence for each drug category and for AIDS.

INTRODUCTION

1. Area Description

This short section describes factors unique to your city. It can include demographic, geographic, or socioeconomic factors. Include any factors that may be related to the drug abuse problem in the city.

2. Data Sources and Time Periods

This section should contain a series of bulleted items:

- **Source**—Describe the type of data. Explain any limitations and caveats. For each source, define two time periods: the latest reporting period and the comparison reporting period. If you use your State's fiscal years, please define them.

- **Order**—If possible, try to sequence the data sources so they will conform to the following REVISED order:

1. Deaths
2. Emergency room mentions
3. Treatment admissions/ demographics
4. Drug Use Forecasting data (DUF)
5. Arrests/arrestee urinalyses
6. Availability, price, and purity
7. Seizures
8. Trafficking/distribution
9. Ethnographic information
10. Special studies (if available)

The "Data Sources and Time Periods" section might also provide a good opportunity to introduce exhibits; thus, exhibit order would also follow the outline.

DRUG ABUSE TRENDS

This introduction section is optional. If you choose to use it, please write no more than one or two paragraphs. Different authors use this section in different ways: some give data for overall drug use (combined data); some discuss just one major drug category or just one indicator; others describe data caveats or limitations.

1. Cocaine

The first paragraph often opens with an overall one-sentence statement about all the indicators (optional). It then talks about ethnographic data, if available.

Subsequently, each paragraph discusses one indicator. If a paragraph contains lots of data, or more than one source, you may want to split it into two paragraphs.

The order of the paragraphs is as follows: deaths; emergency room mentions; treatment admissions/demographics; DUF; arrests; availability, price, and purity; seizures; trafficking/distribution; ethnographic information special studies (if available).

You can also include paragraphs on special studies.

Don't forget to refer to your exhibits in your discussions.

2. Heroin

The above guidelines apply to all the drug categories in the Drug Abuse Trends section.

3. Other Opiates

For drug categories with fewer relevant data, you can combine several indicator discussions into one or two paragraphs.

4. Marijuana

5. Stimulants

6. Depressants

7. Hallucinogens

SPECIAL STUDIES

This section is optional if such data are available. Alternatively, you may choose to include this information in the

appropriate drug category discussions in the above Drug Abuse Trends section.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS (IDUs)

Please be sure to include the following numbers: Cumulative number of cases (compared to the figure from last report); percentage of cases that are both IDU and heterosexual; percentage of cases that are both IDU and homosexual/ bisexual.

If you give both State and city figures, please differentiate between the two for EVERY figure. Please be clear about whether or not your data include pediatric cases.

EXHIBITS

Please make sure each exhibit is numbered and titled.

- Include a SOURCE line on each exhibit.

- For graphs, please include a printout of your data points. If you are using the same graph as for your last report, **AND IF THE PREVIOUS DATA HAVE NOT CHANGED**, you can include only the data points from the most recent time periods.

Appendix C: Statistical Analysis Centers by State*

Alabama

Alabama Criminal Justice Information Center
770 Washington Avenue, Suite 350
Montgomery, AL 36130
(205) 242-4900

Alaska

The Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508
(907) 786-1810

Arizona

Arizona Criminal Justice Commission
1501 West Washington St.
Suite 207
Phoenix, AZ 85007
(602) 542-1928

Arkansas

Special Services Section
Arkansas Crime Information Center
One Capitol Mall, 4D200
Little Rock, AR 72201
(501) 682-2222

California

Office of Management Evaluation and Training
Law Enforcement Information Center
P.O. Box 903427
Sacramento, CA 94203-4270
(916) 227-3531

Colorado

Colorado Division of Criminal Justice
700 Kipling Street, Suite 1000
Denver, CO 80215
(303) 239-4453

Connecticut

Office of Policy and Management
Policy Development and Planning Division
80 Washington Street
Hartford, CT 06106
(203) 566-3522

Delaware

60 The Plaza
Dover, DE 19901
(302) 739-4846

District of Columbia

University of the District of Columbia
Department of Criminal Justice
4200 Connecticut Avenue NW
Washington, DC 20008
(202) 274-5687

Florida

Florida Department of Law Enforcement
P.O. Box 1489
Tallahassee, FL 32302
(904) 487-4808

Georgia

Statistical Analysis Bureau
Department of Criminal Justice
Georgia State University
P.O. Box 4018
Atlanta, GA 30302-4018
(404) 651-3515

Hawaii

Crime Prevention Division
Department of the Attorney General
City Center Building
810 Richards Street, Suite 701
Honolulu, HI 96813
(808) 586-1416

*SOURCE: Bureau of Justice Statistics, U.S. Department of Justice, Washington, D.C., September 1995.

Idaho

Support Services Bureau
Department of Law Enforcement
P.O. Box 700
Meridian, ID 83680-0700
(208) 884-7044

Illinois

Illinois Criminal Justice Information Authority
120 South Riverside Plaza
Suite 1016
Chicago, IL 60606

Indiana

Indiana Criminal Justice Institute
302 West Washington Street
Room E209
Indianapolis, IN 46204
(317) 232-1233

Iowa

Division of Criminal Justice and Juvenile
Planning
Lucas State Office Building
Des Moines, IA 50319
(515) 242-5816

Kansas

Kansas Criminal Justice Coordinating Council
Jayhawk Tower, Suite 501
700 Southwest Jackson
Topeka, KS 66603
(913) 296-0923

Kentucky

Office of the Attorney General
State Capitol Building
Frankfort, KY 40601
(502) 564-4002

Louisiana

Louisiana Commission on Law Enforcement
1885 Wooddale Boulevard, Suite 708
Baton Rouge, LA 70806
(504) 925-4440

Maine

Maine Criminal Justice Data Center
Department of Corrections
State House Station 111
Augusta, ME 04333
(207) 287-4343

Maryland

Maryland Justice Analysis Center
Institute of Criminal Justice and Criminology
College of Behavioral and Social
Sciences
2220 Samuel J. LeFrak Hall
University of Maryland
College Park, MD 20742-8235
(301) 405-4699

Massachusetts

Massachusetts Committee on Criminal Justice
100 Cambridge Street, Room 2100
Boston, MA 02202
(617) 727-0237

Michigan

Michigan State University
School of Criminal Justice
560 Baker Hall
East Lansing, MI 48824-1118
(517) 355-2197

Minnesota

Minnesota Planning Agency
Centennial Office Building, Room 300
658 Cedar Street
St. Paul, MN 55155
(612) 296-4852

Mississippi

Department of Criminal Justice Planning
301 West Pearl Street
Jackson, MS 39203
(601) 949-2225

Missouri

Information Systems Division
Missouri Highway Patrol
1510 East Elm
Jefferson City, MO 65102
(314) 751-4026

Montana

Board of Crime Control
Montana Department of Justice
303 North Roberts Street
4th Floor
Helena, MT 59620
(406) 444-4298

Nebraska

Commission on Law Enforcement & Criminal
Justice
P.O. Box 94946
Lincoln, NE 68509-4946
(402) 471-2194

Nevada

Nevada Highway Patrol
Records and Identification Services
555 Wright Way
Carson City, NV 89711-0525
(702) 687-5713

New Hampshire

Office of the Attorney General
33 Capitol Street
Concord, NH 03301
(603) 271-3658

New Jersey

Research and Evaluation
Department of Law and Public Safety
Hughes Justice Complex, CN-085
Trenton, NJ 08625
(609) 984-2737

New Mexico

Institute for Social Research
University of New Mexico
2808 Central Avenue SE
Albuquerque, NM 87106
(505) 277-4257

New York

Bureau of Statistical Services
Division of Criminal Justice Services
Executive Park Tower, Eighth Floor
Stuyvesant Plaza
Albany, NY 12203
(518) 457-8381

North Carolina

Criminal Justice Analysis Center
Governor's Crime Commission
3824 Barrett Drive, Suite 100
Raleigh, NC 27609-7220
(919) 571-4736

North Dakota

Information Services Section
Bureau of Criminal Investigation
4205 State Street
Bismarck, ND 58502-1054
(701) 221-5514

Ohio

Research and Statistics
Office of Criminal Justice Services
400 East Town Street, Suite 120
Columbus, OH 43215
(614) 466-0310

Oklahoma

Oklahoma Criminal Justice Resource Center
621 North Robinson, Suite 445
Oklahoma City, OK 73102
(405) 232-3328

Oregon

Criminal Justice Council
Statistical Analysis Center
155 Cottage Street NE
Salem, OR 97310
(503) 378-4123

Pennsylvania

Bureau of Statistics & Policy Research
Pennsylvania Commission on Crime
and Delinquency
P.O. Box 1167
Harrisburg, PA 17108
(717) 787-5152

Rhode Island

Governor's Justice Commission
222 Quaker Lane, Suite 100
Warwick, RI 02886
(401) 277-2620

South Carolina

Office of State and Grant Programs
Department of Public Safety
1205 Pendleton Street
Columbia, SC 29201
(803) 734-0423

South Dakota

Office of the Attorney General
500 East Capitol Avenue
Pierre, SD 57501
(605) 773-6310

Tennessee

Tennessee Bureau of Investigation
1148 Foster Avenue
Nashville, TN 37210-4406
(615) 726-7970

Texas

Criminal Justice Policy Council
P.O. Box 13332
Austin, TX 78711-3332
(512) 463-1810

Utah

Research Division
Commission on Criminal & Juvenile Justice
Room 101, Utah State Capitol
Salt Lake City, UT 84114
(801) 538-1059

Vermont

Vermont Center for Justice Research
33 College Street
Montpelier, VT 05602
(802) 828-8511

Virginia

Department of Criminal Justice Services
805 East Broad Street
Richmond, VA 23219
(804) 786-4000

Washington

Office of Financial Management
P.O. Box 43113
Olympia, WA 98504-3113
(360) 586-2501

West Virginia

Marshall University
Research & Economic Development Center
1050 Fourth Avenue
Huntington, WV 25755-8100
(304) 696-2718

Wisconsin

Office of Justice Assistance
222 State Street, 2nd Floor
Madison, WI 53702
(608) 266-7185

Wyoming

Division of Criminal Investigation
Office of the Attorney General
316 West 22nd Street
Cheyenne, WY 82002
(307) 777-7523

Northern Mariana Islands

Criminal Justice Planning Agency
Commonwealth Northern Mariana Islands
P.O. Box 1133
Saipan, MP 96950
(670) 322-9350

Puerto Rico

Criminal Justice Information System
Office of the Attorney General
P.O. Box 192
San Juan, PR 00902
(809) 729-2445

Virgin Islands

Law Enforcement Planning Commission
8172 Sub Base, Suite Three
St. Thomas, VI 00802-5803
(809) 774-6400

Appendix D: Method for Assessing Hospitalization Related to Drug and Alcohol Misuse by Youth and Young Adults

Juliet VanEenwyk, Ph.D., Steven C. Macdonald, Ph.D., and Lillian S. Bensley, Ph.D.
Office of Epidemiology
Washington State Department of Health

Background

The Washington State Violence Reduction Programs Act of 1994 required the Washington State Department of Health to compile data on behaviors and related risk and protective factors which affect youth and their communities. These behaviors included violent behavior among youth, early pregnancy, dropping out of school, drug and alcohol abuse, suicide, child abuse, and domestic violence. The original data set was compiled in 1995 for defined geographic areas called Public Health and Safety Networks (Networks), which are roughly equivalent to counties or portions of counties. The Networks and Local Health Jurisdictions used the data to determine where to focus prevention efforts. We are currently in the process of updating the data to provide communities with information for ongoing assessment and program evaluation.

To assess the extent of alcohol and drug abuse, we developed community level data from a number of sources, including arrest data for drug and liquor law violations and driving under the influence of drugs or alcohol, alcohol- and drug-related traffic collisions; youth receiving State-sponsored alcohol and drug treatment; and alcohol- and drug-related hospital admissions. For the current update, we plan to use the following methodology to assess hospitalization of youth and young adults related to misuse of drugs and alcohol.

Methods

General considerations

1. Assign youth and young adults to the community based on zip code of residence, not location of hospital.
2. Count hospital discharges, not people. For example, a person who is discharged from the hospital for drug- or alcohol-related diagnoses twice in one year and three times in the following year will be counted twice in the first year and three times in the following year. While counting people is also a valid approach, we have chosen this approach partly because we are unable to unduplicate data we receive for Washington residents hospitalized in Oregon. More importantly, each hospitalization represents an adverse event which we would like to prevent; thus, each hospitalization is an event of public health importance.
3. Count each hospital discharge only once. Thus, a person hospitalized for both alcoholic psychosis and alcohol dependence syndrome will be counted only once for that hospitalization.
4. Count the occurrence of the ICD-9-CM codes in any of the diagnosis fields. From 1994–1996, approximately 37 percent of the alcohol- and drug-related codes specified below appeared as the first diagnosis. The remaining 63 percent appeared in secondary diagnosis fields.

An analysis of the first diagnosis for records where the drug or alcohol code appeared in the 2nd–9th diagnosis field revealed that approximately 85 percent of the first diagnoses were mental disorder codes (51 percent), complications of pregnancy (17 percent), or trauma (16 percent). If a substance abuse code appears with the complication of pregnancy or injury code, it is probably that the substance abuse is related to the hospitalization and, therefore, should be counted. We also want to count youth and young adults with comorbidities of substance abuse and mental disorders, since the substance abuse problem must be treated simultaneously with treatment for the mental disorder. In persons with the dual diagnosis of mental illness and substance abuse, it is also difficult to determine whether underlying mental disorder contributes to substance abuse or vice versa.

For the remaining 15 percent of records where the drug or alcohol diagnosis is in the 2nd to 9th diagnosis field, no group of diagnoses appears as the first diagnosis on more than 2 percent of records. For many of these diagnoses, it is highly likely that the drug or alcohol use contributed to the hospitalization.

Method of identifying records

1. Pull hospitalizations for people age 10 to 24 years at discharge.
2. Exclude all records with codes for suicide (E950–E959).
3. We have developed a 2-tiered approach which assigns each hospitalization with relevant ICD-9-CDM codes to definitely/probably or possibly related to drug and alcohol abuse. The ICD-9-CM codes are 3-digit numbers followed by up to 2 digits to the right of the decimal point. Unless otherwise specified, when we list the 3-digit code, we include any record with the 3-digit code, irrespective of the numbers after the decimal.

Likewise, when we list the code with 1 digit after the decimal, we include those codes with the same 4 numbers irrespective of the number in the 2nd space after the decimal. It is important to pull the records in the stepwise manner indicated so that records with appropriate codes are not excluded.

Codes for definite and probable drug and alcohol misuse

Step 1. Include any record meeting the age and nonsuicide criteria that has the following diagnoses in any of the diagnosis fields:

265.2	Alcoholic pellegra
291	Alcoholic psychoses
303	Alcohol Dependence Syndrome
304	Drug Dependence Syndrome
305.0,.2-9	Non-Dependent Abuse of Drugs
357.5	Alcoholic polyneuropathy
425.5	Alcoholic cardiomyopathy
535.3	Alcoholic gastritis
571.0–571.3	Alcohol-related liver disease
648.3	Drug dependence in pregnancy
790.3	Excess blood alcohol
965.00,.01	Poisoning by opium or heroin
969.6	Poisoning by psychodysleptics (hallucinogens)
980.0	Toxic effect of ethyl alcohol

Step 2. Include remaining records with the following diagnoses in any of the diagnosis fields and no concurrent diagnosis of E930–E949, adverse reactions to drugs, medicinal and biological substances in therapeutic use, properly administered and taken.

292	Drug psychoses
357.6	Polyneuropathy due to drugs

Codes for possible drug and alcohol abuse

Some codes in the series 960–979 (poisoning by drugs, medicinals, and biological substances) can include possible cases of drug

and alcohol misuse. According to the ICD-9-CM rules, this series specifically excludes drug dependence and nondependent abuse. However, for the specific codes in the 960–979 series listed below, we found that approximately 25 percent of the records have a concurrent diagnosis of drug dependence or nondependent abuse. The remaining 75 percent of records with these codes may represent:

- cases of dependence or abuse where the dependence or abuse is not mentioned on the discharge summary and, therefore, not coded as such;
- cases of youth experimenting with drugs, but not meeting the technical definition of dependence or abuse; or
- cases of medicines given or taken in error which have caused an adverse reaction.

We believe the first two types of records are of interest in assessing drug and alcohol misuse among youth, but that cases of medicines given or taken in error are not drug abuse. Since we cannot separate these latter cases, records where the only drug- or alcohol-related code is one of those shown below will be treated as possible cases of drug and alcohol abuse.

If the following codes appear as the only drug- or alcohol-related code, the record is counted as a possible case associated with misuse of drugs and alcohol.

Step 1. Include remaining records meeting the age and nonsuicide criteria that have the following diagnosis in any of the diagnosis fields:

305 Nondependent abuse of drugs
 when 4th digit is not specified

Step 2. Include remaining records meeting

the age and nonsuicide criteria with the following diagnoses in any of the diagnosis fields and no concurrent diagnosis of E930–E949, adverse reactions to drugs, medicinal, and biological substances in therapeutic use, properly administered and taken.

965.02,.09	Poisoning by methadone, other opiates and related narcotics
965.8	Poisoning by other specified analgesics and antipyretics (e.g., Pentazocine)
967	Poisoning by sedatives/hypnotics
968.5	Poisoning by topical anesthetics (cocaine and related compounds)
969	Poisoning by psychotropic agents when 4th digit is not specified
969.0-.5,.7-9	Poisoning by psychotropic agents (nonhallucinogens)
970	Poisoning by CNS stimulants

Use of external cause of poisoning or injury codes

We will not use external causes of poisoning or injury codes (E-codes) for selection of cases. E-codes described the circumstances under which someone is poisoned or injured. Because billing tends to be based on the medical condition and not the cause of the condition, E-codes are not as consistently recorded as other ICD-9-CM codes. (This needs to be remembered when interpreting the data, if codes have been specified as exclusion criteria.)

For most of the E-codes which might capture drug and alcohol abuse, we cannot distinguish poisonings related to abuse from those related to wrong drugs given or taken in error, accidents in the use of drugs during medical or surgical procedures, or accidental inhalation or ingestion.

E850.0 (accidental poisoning by heroin) and E860.0 (accidental poisoning by ethyl alcohol) may be exceptions. However, between 1994 and 1996 in the State of Washington data set, there were no records with E850.0 and only one record with E860.0 which did not also have one of the ICD-9-CM codes specified above. Therefore, omitting these E-codes does not substantively change hospitalization rates for drug and alcohol abuse. Between 1994 and 1996, there were 36 records with E-codes that might be related to drug and alcohol misuse among youth and young adults that were not identified using the rules specified above. This represents less than one-half of 1 percent of all hospitalizations captured using those rules.

Appendix E: State Contacts for Uniform Crime Reports*

Alabama

Alabama Criminal Justice Information
Center
Suite 350
770 Washington Avenue
Montgomery, Alabama 36130
(334) 242-4900

Alaska

Uniform Crime Reporting Section
Department of Public Safety Information
System
5700 East Tudor Road
Anchorage, Alaska 99507
(907) 269-5708

American Samoa

Department of Public Safety
Post Office Box 1086
Pago Pago
American Samoa 96799
(684) 633-1111

Arizona

Uniform Crime Reporting
Arizona Department of Public Safety
Post Office Box 6638
Phoenix, Arizona 85005
(602) 223-2263

Arkansas

Arkansas Crime Information Center
One Capitol Mall, 4D-200
Little Rock, Arkansas 72201
(501) 682-2222

California

Criminal Justice Statistics Center
Department of Justice
Post Office Box 903427
Sacramento, California 94203-4270
(916) 227-3470

Colorado

Uniform Crime Reporting
Colorado Bureau of Investigation
690 Kipling Street
Denver, Colorado 80215
(303) 239-4300

Connecticut

Uniform Crime Reporting Program
1111 Country Club Road
Post Office Box 2794
Middletown, Connecticut 06457-9294
(203) 685-8030

Delaware

State Bureau of Identification
Post Office Box 430
Dover, Delaware 19903
(302) 739-5875

District of Columbia

Information Services Division
Metropolitan Police Department
Room 5054
300 Indiana Avenue, Northwest
Washington, D.C. 20001
(202) 727-4301

Florida

Uniform Crime Reports Section
Florida Crime Information Center Bureau
Post Office Box 1489
Tallahassee, Florida 32302-1489
(904) 487-1179

Georgia

Georgia Crime Information Center
Georgia Bureau of Investigation
Post Office Box 370748
Decatur, Georgia 30037
(404) 244-2840

*Bureau of Justice Statistics, U.S. Department of Justice, Washington, D.C., September 1995.

Guam

Guam Police Department
Planning, Research and Development
Pedro's Plaza
287 West O'Brien Drive
Agana, Guam 96910
(671) 472-8911 x418

Hawaii

Chief of Research and Statistics
Crime Prevention Division
Department of the Attorney General
Suite 701
810 Richards Street
Honolulu, Hawaii 96813
(808) 586-1416

Idaho

Criminal Identification Bureau
Department of Law Enforcement
Post Office Box 700
Meridian, Idaho 83680
(208) 884-7156

Illinois

Uniform Crime Reporting Program
Illinois State Police
100 Illes Park Place
Post Office Box 3677
Springfield, Illinois 62704
(217) 782-5791

Iowa

Iowa Department of Public Safety
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-8494

Kansas

Kansas Bureau of Investigation
1620 Southwest Tyler Street
Topeka, Kansas 66612
(913) 296-8200

Kentucky

Information Services Branch
Kentucky State Police
1250 Louisville Road
Frankfort, Kentucky 40601
(502) 227-8783

Louisiana

Louisiana Commission on Law Enforcement
7th Floor
1885 Wooddale Boulevard
Baton Rouge, Louisiana 70806
(504) 925-4847
(504) 925-7730

Maine

Uniform Crime Reporting Division
Maine State Police
Station #42
36 Hospital Street
Augusta, Maine 04333
(207) 624-7003

Maryland

Central Records Division
Maryland State Police Department
1711 Belmont Avenue
Baltimore, Maryland 21244
(410) 298-3883

Massachusetts

Crime Reporting Unit
Massachusetts State Police
470 Worcester Road
Framingham, Massachusetts 01701
(508) 820-2110
(508) 820-2115

Michigan

Uniform Crime Reporting Section
Michigan State Police
7150 Harris Drive
Lansing, Michigan 48913
(517) 322-1150

Minnesota

Bureau of Criminal Apprehension
Minnesota Department of Public Safety
Suite 100-H, Town Square
1246 University Avenue
St. Paul, Minnesota 55104
(612) 642-0670
(612) 642-0610

Montana

Management Analyst
Montana Board of Crime Control
303 North Roberts
Helena, Montana 59620
(406) 444-2077

Nebraska

Uniform Crime Reporting Section
The Nebraska Commission on Law
Enforcement and Criminal Justice
Post Office Box 94946
Lincoln, Nebraska 68509
(402) 471-3982

Nevada

Criminal Information Services
Nevada Highway Patrol
555 Wright Way
Carson City, Nevada 89711
(702) 687-5713

New Hampshire

Uniform Crime Report
Division of State Police
10 Hazen Drive
Concord, New Hampshire 03305
(603) 271-2509

New Jersey

Uniform Crime Reporting
Division of State Police
Post Office Box 7068
West Trenton, New Jersey 08628-0068
(609) 882-2000 x2392

New York

Statistical Services
New York State Division of Criminal
Justice Services
8th Floor, Mail Room
Executive Park Tower Building
Stuyvesant Plaza
Albany, New York 12203
(518) 457-8381

North Carolina

Crime Reporting and Field Services
Division of Criminal Information
State Bureau of Investigation
407 North Blount Street
Raleigh, North Carolina 27601
(919) 733-3171

North Dakota

Information Services Section
Bureau of Criminal Investigation
Attorney General's Office
Post Office Box 1054
Bismarck, North Dakota 58502
(701) 328-5500

Oklahoma

Uniform Crime Reporting Section
Oklahoma State Bureau of Investigation
Suite 300
6600 North Harvey
Oklahoma City, Oklahoma 73116
(405) 879-2531

Oregon

Law Enforcement Data Systems Division
Oregon Department of State Police
400 Public Service Building
Salem, Oregon 97310
(503) 378-3057

Pennsylvania

Bureau of Research and Development
Pennsylvania State Police
1800 Elmerton Avenue
Harrisburg, Pennsylvania 17110
(717) 783-5536

Puerto Rico

Director of Statistics
Puerto Rico Police
Roosevelt Avenue 101
San Juan, Puerto Rico 00936
1-(787) 793-1234 ext. 3113

Rhode Island

Rhode Island State Police
311 Danielson Pike Post Office Box 185
North Scituate, Rhode Island 02857
(401) 444-1121

South Carolina

South Carolina Law Enforcement Division
Post Office Box 21398
Columbia, South Carolina 29221-1398
(803) 896-7022

South Dakota

South Dakota Statistical Analysis Center
500 East Capitol Avenue
Pierre, South Dakota 57501
(605) 773-6310

Texas

Uniform Crime Reporting Bureau
Crime Information Bureau
Texas Department of Public Safety
Post Office Box 4143
Austin, Texas 78765-4143
(512) 424-2091

Utah

Uniform Crime Reporting
Bureau of Criminal Investigation
Utah Department of Public Safety
4501 South 2700 West
Salt Lake City, Utah 84119
(801) 965-4445

Vermont

Vermont Crime Information Center
Post Office Box 189
Waterbury, Vermont 05676
(802) 244-8786

Virginia

Records Management Division
Department of State Police
Post Office Box 27472
Richmond, Virginia 23261-7472
(804) 674-2023

Virgin Islands

Records Bureau
Department of Public Safety
Post Office Box 210
Charlotte Amalie
Saint Thomas, Virgin Islands 00801
(809) 774-2211

Washington

Uniform Crime Reporting Program
Washington Association of Sheriffs and
Police Chiefs
Post Office Box 826
Olympia, Washington 98507
(360) 586-3221

West Virginia

Uniform Crime Reporting Program
West Virginia State Police
725 Jefferson Road
South Charleston, West Virginia 25309
(304) 746-2259

Wisconsin

Office of Justice Assistance
2nd Floor
222 State Street
Madison, Wisconsin 53703
(608) 266-3323

Wyoming

Uniform Crime Reporting
Criminal Records Section
Division of Criminal Investigation
316 West 22nd Street
Cheyenne, Wyoming 82002
(307) 777-7625

Appendix F-1: 1994 Drug-Related Arrests of Persons Over Age 17 by Age, Gender, and Race/Ethnicity—State of Maryland

	Gender	Age														Total	Race			
		18	19	20	21	22	23	24	25	30	35	40-44	45-49	50-54	55 & over		White	Black	Indian	Asian
Drug Abuse Laws	M	2,027	1,992	1,654	1,533	1,425	1,365	1,266	5,128	4,544	3,093	1,764	769	306	167	27,033	10,534	21,163	24	65
	F	165	175	173	161	179	187	218	1,087	1,073	787	352	124	40	32	4,753				
Drug Sales-Total	M	869	850	720	682	603	599	540	2,017	1,575	1,027	561	260	120	85	10,508	2,424	9,712	7	22
	F	53	64	64	71	77	66	80	402	353	236	114	41	14	22	1,657				
Opium or Cocaine and Derivatives	M	713	669	597	562	497	509	456	1,716	1,325	855	481	216	130	71	8,800	1,239	8,750	6	11
	F	37	41	33	50	59	49	61	307	262	169	84	31	8	15	1,206				
Marijuana	M	125	129	98	100	88	78	59	209	182	119	46	32	10	5	1,280	836	712	1	11
	F	12	20	26	15	15	10	14	57	45	35	19	5	5	2	280				
Synthetic Narcotics (Methadone, Demerol)	M	13	7	14	10	8	4	12	51	30	27	8	3	2	1	190	208	47		
	F	2	2	2	2	2	2	0	20	21	10	1	1	0	0	65	0	0		
Other Dangerous Non-Narcotic Drugs	M	18	15	11	10	10	8	13	41	28	26	26	9	5	8	238	141	203		
	F	2	1	3	4	1	5	5	18	25	22	10	4	1	5	106	0	0		
Drug Possession-Total	M	1,158	1,142	934	851	822	766	726	3,111	3,111	2,066	1,203	509	186	82	16,525	8,110	11,451	17	43
	F	112	111	109	90	102	121	138	685	685	551	238	83	26	10	3,096				
Opium or Cocaine and Derivatives	M	308	331	293	272	338	320	343	1,678	1,312	798	346	131	52	8,313	2,862	7,308	11	9	
	F	30	28	37	45	48	71	78	446	446	379	167	49	16	5	1,877				
Marijuana	M	703	665	506	445	374	341	282	1,015	1,015	496	256	114	42	22	6,079	4,438	2,520	6	33
	F	77	70	69	41	43	44	39	177	177	117	47	23	7	2	918				
Synthetic Narcotics (Methadone, Demerol)	M	10	12	11	20	6	12	15	67	67	53	21	7	0	0	317	365	48		1
	F	3	3	0	0	4	2	7	21	21	22	3	3	0	0	97				
Other Dangerous Non-Narcotic Drugs	M	137	134	124	114	104	93	86	351	351	205	128	42	13	8	1,816	445	1,575		
	F	2	10	3	4	7	4	14	41	41	33	21	8	3	3	204				

SOURCE: Maryland State Police, 1996.

Appendix F-2: 1994 Drug-Related Arrests of Persons Under Age 18 by Age, Gender, and Race/ Ethnicity—State of Maryland

	Gender	09 and under	10-12	13-14	15	16	17	Total under 18	White	Black	Asian
Drug Abuse Laws	M	3	60	882	1,153	1,566	2,031	5,695	2,051	4,201	16
	F		15	92	114	146	206	573			
Drug Sales-Total	M	3	32	437	529	696	855	2,552	337	2,352	3
	F		3	22	25	31	59	140			
Opium or Cocaine and Derivatives	M	2	27	383	460	620	718	2,210	140	2,162	
	F		1	15	16	24	36	92			
Marijuana	M		5	46	60	61	112	284	144	172	2
	F		1	4	8	5	16	34			
Synthetic Narcotics (Methadone, Demorol)	M			6	4	12	10	32	21	15	1
	F			1	1	2	1	5			
Other Dangerous Non-Narcotic drugs	M	1		2	5	3	15	26	32	3	
	F		1	2			6	9			
Drug Possession-Total	M		28	445	624	870	1,176	3,143	1,714	1,849	13
	F		12	70	89	115	147	433			
Opium or Cocaine and Derivatives	M		11	180	227	293	367	1,078	162	992	1
	F		4	14	13	18	28	77			
Marijuana	M		17	226	373	544	773	1,933	1,410	831	12
	F		8	48	66	88	110	320			
Synthetic Narcotics (Methadone, Demorol)	M			4	7	7	4	22	35	2	
	F			3	2	4	6	15			
Other Dangerous Non-Narcotic drugs	M			35	17	26	32	110	107	24	
	F			5	8	5	3	21			

SOURCE: Maryland State Police, 1996.

Appendix G: DEA Division Offices

Aviation Operations Center

2300 Horizon Road
Ft. Worth, TX 76177-5300
(817) 837-2000

DEA Atlanta Division

75 Spring Street, S.W., Room 740
Atlanta, GA 30303
(404) 331-4407

DEA New England Division

50 Staniford Street, Suite 200
Boston, MA 02114
(617) 557-2100

DEA Carribbean Division

2434 Loiza Street
Santurce, PR 00913
(809) 253-4200

DEA Chicago Division

2300 S. Dearborn Street, Suite 1200
Chicago, IL 60604
(312) 353-7875

DEA Dallas Division

1880 Regal Row
Dallas, TX 75235
(214) 767-7151

DEA Detroit Division

431 Howard Street
Detroit, MI 48226
(313)234-4000

EPIC

11339 SSG Sims Street
El Paso, TX 79908-2033
(915) 564-2033

DEA Houston Division

333 West Loop North, Suite 300
Houston, TX 77024
(700) 527-9000

DEA Los Angeles Division

255 East Temple Street, 20th Floor
Los Angeles, CA 90012
(213) 894-2650

DEA Miami Division

8400 N.W. 53rd Street
Miami, FL 33166
(305)590-4870

DEA New Orleans Division

3 Lakeway Center
3838 N. Causeway Blvd., Suite 1800
Metairie, LA 70002
(504) 840-1100

DEA New York Division

99 Tenth Avenue
New York, NY 10011
(212) 337-3900

DEA Newark Division

970 Broad Street, Room 806
Newark, NJ 07102
(201) 645-6060

DEA Philadelphia Division

600 Arch Street, Room 10224
Philadelphia, PA 19106
(215) 597-9530

DEA Phoenix Division

3010 North 2nd Street, Suite 301
Phoenix, AS 85012
(602) 64-5600

DEA Rocky Mountain Division

115 Inverness Drive, East
Englewood, CO 80112-5116
(303) 784-6300

DEA San Diego Division

402 West 35th Street
National City, CA 91950
(619) 585-4200

DEA San Francisco Division

450 Golden Gate Ave.
San Francisco, CA 94102
(415) 556-6771

DEA Seattle Division

220 West Mercer, Suite 300
Seattle, WA 98119
(206) 553-5443

DEA St. Louis Division

7911 Forsythe Boulevard, Suite 500
St. Louis, MO 63105
(314) 425-3241

DEA Washington, D.C.

Division 400 Sixth Street, S.W., Room 2558
Washington, D.C. 20024
(202) 401-7834

Appendix H-1: Excerpts from 1995 Drug Prospectus Report, Criminal Intelligence Division, Maryland State Police

Cocaine

In the eastern region of the United States, a system for cocaine distribution exists, with New York City at the center of a "hub and spoke" distribution design. Cocaine destined for New York City arrives from all directions, including shipments moving to New York through Maryland.

Cocaine dealers from Maryland's larger cities travel to New York City to buy multi-ounce or pound quantities at the best possible prices. In the northern part of the State, lower level drug traffickers will obtain smaller quantities of cocaine in Philadelphia and Wilmington, Delaware. Likewise, dealers in the southern part of Maryland obtain cocaine from sources in Miami and Los Angeles.

Once back in Maryland, these dealers distribute ounce and multi-gram quantities of cocaine to smaller municipalities via the major highways: Interstate 95 from Baltimore, Route 13 from Salisbury, Routes 50 and 301 from Cambridge, Interstate 70 from Frederick and Hagerstown, and Route 68 from Cumberland. Recent drug arrests, however, indicate that traffickers may be switching to alternate, less traveled routes to avoid heavy law enforcement interdiction efforts on the major highways.

Prospective traffickers from New York also come to Maryland to sell cocaine and learn the trafficking trade. In this way, they can gather funding, establish supply contacts, and hone their business skills in a less ferocious dealing environment than New York City. If, in time, they have the opportunity to become dealers in the overcrowded New York drug market as well, they can easily extend the range of their already established and functioning trafficking networks northward.

The problem of New Yorkers venturing into Maryland to sell drugs has been mentioned in several law enforcement reports. The Criminal Intelligence Section of the Baltimore City Police Department noted in a report in fall 1992 that the agency first observed New Yorkers in a 1987 Baltimore cocaine trafficking investigation involving the Charles "Chucky" Pierce organization. In December 1991, a questionnaire circulated to all Baltimore patrol districts showed four of the nine districts exhibiting a significant influx of New Yorkers. The highest level quoted was in the southwestern district, where 45 to 50 percent of the drug activity at that time could be directly attributed to New York dealers. The northwestern, southeastern, and southern districts also reported the impact of New Yorkers. Both the northwestern and southeastern districts reported that 16 to 20 percent of their drug-dealing activity could be ascribed directly to New Yorkers, while the southern district reported that 6 to 10 percent of drug activity came from New Yorkers. It was also noted that, while the percentage of drug arrests involving New Yorkers stayed constant at about 2 percent of the total Baltimore drug arrests from 1986 to 1991, the actual number of New Yorkers (not including locals working for New Yorkers) arrested each year during that time span had increased nearly 200 percent. At that time, cocaine was the primary drug sold by New Yorkers, making up 54 percent of the cases, while heroin (22 percent of the cases) and marijuana (18 percent of the cases) dealing trailed.

In 1992, a report by the Wicomico County Narcotics Task Force in Salisbury, Maryland, indicated that, since 1988, the county had been inundated by New York dealers traveling to their area to sell drugs, primarily crack cocaine.

This migration of New York dealers purportedly supplanted and displaced the Haitian/Jamaican cocaine-dealing organizations that had dominated the market before that time, reducing these Caribbean traffickers to dealing on the outskirts of the drug community.

Finally, in 1992, the Maryland State Police (MSP) Criminal Intelligence Division issued a report noting the influence of New York drug dealers on a number of localities within the State. Data emerging from Frederick City were of particular interest. Of the 1,096 persons arrested for drug violations in 1990 and 1991, 48 gave New York residence addresses while another 140 listed New York as their place of birth. Of the 188 drug arrests with New York references, 124 of the arrestees, almost 66 percent of the total, were 30 years old or less at the time of arrest.

Much of the information about wholesale prices, payments to underlings, and other ancillary expenses attached to facilitating cocaine dealing is derived from anecdotal data acquired from apprehended individuals. Like all underground enterprises, the cocaine trafficking trade does not freely reveal its profit margins, expenses, and methods of operation. Thus, arrestees exaggerate their success, inflate their earnings, and magnify their images as master hustlers and street entrepreneurs. Despite the lack of credibility of some of these sources, one can gain some insight into the profitability of the drug business. One hears how a 19-year-old ex-street dealer made \$5,000 in one day selling drugs in the Lexington Terrace Housing Project in Baltimore. In another example, a kilogram of cocaine purchased wholesale in 1991 for \$18,000 in New York City generated \$50,000 in street sales in Baltimore. In 1991, 40 percent of the gross sales gained from vending that kilogram of cocaine in Baltimore went to street salesmen, leaving the dealer a profit of about \$10,000. Using this store of anecdotal information with the most recent average user/dealer prices, it is possible to surmise costs and profits for present-day cocaine dealers and street salesmen in Baltimore as trafficking operations expand.

Heroin

On the East Coast, New York City is recognized as the principal debarkation point for heroin into the country. The majority of heroin coming to Baltimore appears to be from New York City, with Philadelphia as the second most frequent point of shipment. Virginia may be an intermediate transshipment point for New York heroin destined for Maryland. The Drug Price and Purity Reports covering a 2-1/2 year period (issued by the MSP Criminal Intelligence Division, Analytical Services Unit) show that the Northern Virginia area has had substantially higher heroin purity levels compared to Maryland. In addition, heroin purity changes between the two areas were found to move in concert. Purity increases/decreases in Maryland mirrored changes in Northern Virginia. This was corroborated by intelligence information revealing that traffickers were transporting heroin to Virginia by train, then sending it to Baltimore by bus.

Maryland's heroin supply certainly does not come from just New York and Philadelphia. In April 1993, three Maryland women were arrested with 13.2 pounds of heroin at the U.S. Customs station in Otay Mesa, California. A controlled delivery was initiated, and the women were allowed to complete the transaction at a Laurel, Maryland, apartment complex. In that incident, the suspects traveled from Dallas, Texas, to Amsterdam, Holland, then to Lagos, Nigeria, where the original heroin was allegedly purchased. Then they traveled to Mexico City, Mexico, and finally, journeyed to the Otay Mesa, California, checkpoint.

The following heroin demographic information for 1994 was extracted from the MSP Criminal Intelligence Division, Analytical Services Unit, database:

In 1994, 82 percent of the people investigated for heroin were males. Racial breakdowns revealed that 59 percent were African American, 37 percent were Anglo, 3 percent were Hispanic, and 1 percent were described as "other race." By

age category, 25 percent were 18 to 25, 19 percent were 26 to 30, 17 percent were 31 to 35, and 39 percent were 36 and over.

High-purity heroin (inhalation quality heroin generally at least 20 percent pure) averaged between 50 to 55 percent purity in 1994. This represents an increase from 44 percent purity found in 1993. In 1994, a 1-gram purchase of low-purity heroin averaged around \$67, while the same 1-gram purchase of high-purity heroin commanded about \$272.

High-purity heroin may account for the dramatic rise in the Baltimore metropolitan area Drug Abuse Warning Network (DAWN) statistics for emergency room admissions. In the first half of 1990, the estimated rate of heroin-related emergency room episodes in Baltimore was 30.1 per 100,000 population. By the end of 1993 this rate had increased to 133.1 per 100,000 population. The problem may be rooted in the mentality of the user who injects heroin. An addict is principally concerned with his or her next fix. If only high-purity, snortable quality heroin is available, the intravenous drug user will probably inject it, regardless of the consequences.

Street-level dealers may find it less time-consuming and possibly even safer to sell heroin versus crack cocaine. Crack is a quick acting drug with a high that may last as little as 30 minutes, while the effects of heroin last for hours. This means the crack dealer must be available to meet the constant demand for the drug while the heroin dealer can sell his product, leave an area, and engage in other activities. By limiting the time on the street, the dealer lessens his risk of arrest. Since crack addicts are typically more violent than heroin addicts, dealing heroin offers less physical risk to the dealer. The same is true for competing dealers. Crack dealers have been associated with the rampant violence that has occurred in many U.S. cities, while heroin dealing has been less violent.

Anecdotal information indicates that some cocaine dealers require a heroin purchase with a

cocaine purchase. It has not yet been established whether this marketing method is being used to hook new heroin users, or if it is related to the user population that "speedballs" (injects cocaine and heroin mixed together). One trend that appears to be on the rise is that of the drug user who smokes crack and then snorts heroin to lessen the crash resulting from the cocaine high.

It is also important to understand the nature of heroin addiction. While cocaine abuse causes user burn out in a relatively short period of time, heroin addiction can span years or even decades, thus ensuring long-term customers.

Marijuana

Marijuana cultivation is a lucrative enterprise, and Maryland's geographic location and climate are conducive to growing the illicit crop. Indoor and outdoor grows can be found throughout the State. To counter this problem, the State with the support of the Bureau of Justice Assistance and DEA, has established a Marijuana Eradication Program that involves the combined efforts of State, county, and local police agencies and the Maryland National Guard. These eradication efforts are conducted through aerial and ground operations and result in a sizeable number of arrests and large marijuana seizures. The 1991 Marijuana Eradication Program set a record for marijuana plant seizures, a total of 11,210 plants. Plant seizures in subsequent years have shown a decline; however, this downturn may be accentuated because of the extremely successful 1991 eradication campaign.

In 1994, outdoor plant seizures declined because of several factors. First, a 20 percent decrease in helicopter flight time resulted in fewer plants being located by air. Secondly, a heat wave in early spring and a lack of rain killed many seedlings; consequently, eradication team members encountered many empty gardens. In addition to the plant seizures, 23.2 pounds of bulk processed marijuana were seized at outdoor grows in 1994, a significant decrease from 1993, when 75 pounds of processed marijuana were seized.

Although relatively small in number, seizures from indoor marijuana grows in Maryland have increased steadily since 1990. Seizures of bulk processed marijuana at these indoor growing operations have also increased significantly. In 1994, 88.3 pounds of processed marijuana were seized, versus 24.5 pounds in 1993. Officers making these indoor seizures frequently encounter sophisticated equipment used to raise the delta-9-tetrahydrocannabinol (THC) levels in the plants and increase the volume of marijuana produced per plant.

Occasionally, officers discover an indoor marijuana grow that is so small that it is deemed for personal use. However, the vast majority of indoor grows found in Maryland are large enough to supply high-grade marijuana for commercial sale. Statistics for indoor seizures in Maryland revealed an average of 39 marijuana plants per grow. The wholesale price of commercial-grade marijuana averages approximately \$1,800 per pound, while high-quality sinsemilla can sell for almost twice that amount. Currently, yield studies indicate that each marijuana plant is capable of producing 1 pound of marketable marijuana, so a modest 10-plant grow could generate at least \$18,000 in sales. Thus, an indoor grow as small as 10 plants still affords the opportunity to make substantial profits when production yield and quality are optimized.

Although an extended decline in marijuana use has been evident, marijuana has never vanished from the drug scene. Other more exotic or currently newsworthy drugs have simply overshadowed it. Now the negative social image of cocaine may be contributing to a resurgence in the popularity of marijuana. The constant publicity, education, and exposure regarding the dangers of cocaine addiction may have influenced some users to seek a "softer" alternative. Moreover, the much stiffer legal penalties attached to crack and cocaine trafficking may well be an impetus for some drug traffickers/dealers to switch to marijuana sales.

According to information extracted from the MSP Criminal Intelligence Division, Analytical

Services Unit data base, casual use of marijuana appears to be on the rise. In Maryland between 1993 and 1994, there was a 27 percent increase in persons arrested for user quantities of marijuana (1,553 in 1993 and 1,969 in 1994). Males comprised 85 percent of these arrests. By race, 74 percent of these individuals were Anglo, 25 percent were African American, and 1 percent were of another race. By age category, 14 percent of these marijuana users were under 18, 43 percent were between 18 and 25, 16 percent were between 26 and 30, 13 percent were between 31 and 35, and 14 percent were 36 or older.

Young people are becoming more inclined to view marijuana as harmless. Contributing to this perception is the overt promotion of the drug by rock, hip-hop, and heavy metal musical groups. These groups advocate marijuana use through their music and frequently use their popularity and media exposure to express pro-use/legalization views. Organizations advocating marijuana legalization use music concerts as a venue to solicit support, setting up booths and distributing propaganda on the benefits of the drug and the rights of the user. For example, promoters for a New Year's Eve "rave party" in Baltimore County used an advertisement with Uncle Sam displaying a marijuana leaf in his lapel.

Contributing to the resurgence of marijuana in the Baltimore-Washington area is the use of "blunts." A blunt is an inexpensive cigar, typically a "Philly Blunts" brand cigar, that has been split open and emptied of tobacco. Marijuana is substituted for the removed tobacco, and the exterior tobacco leaf of each cigar is used to rewrap the new contents. Use of blunts began in New York or Philadelphia and spread south, first to the Washington metropolitan area and then to Baltimore City. Reflections of this trend can be noted on clothing such as hats, T-shirts, and sweatshirts with characters who wear dreadlock hairstyles and declare their preference for blunts. In 1992, a feature article in *High Times* magazine described the assembly of blunts; an article in 1993 highlighted the history of the trend.

Drug use is cyclical in nature, and marijuana use appears to have reached the bottom of its most recent ebb in usage. Statistics and anecdotal information suggest that fads and marijuana use as an alternative to other drugs may be refueling a resurgence. Although law enforcement wins frequent battles against marijuana organizations, the massive number of smugglers involved and the diversified systems used to manufacture and distribute marijuana overwhelm law enforcement's efforts. With no foreseeable major interruption in supply and a predicted rise in the number of users, the status of marijuana as the most abused drug will probably rise.

Appendix H-2: Additional Drugs of Abuse Reported by Criminal Intelligence Division, Maryland Department of State Police

PCP

The availability and use of phencyclidine (PCP) appears to be stable. The bulk of PCP arrests are made in southern Maryland. Highway interdictions involving PCP in 1994 were common in Prince George's, Anne Arundel, and Charles Counties. Historically, Prince George's County is known as a vending site for PCP, with most of the drug entering the county from Washington, DC.

U.S. Drug Enforcement Agency (DEA) intelligence reports that PCP is generally transported from southern California to the Washington, DC, area in gallon and 3-gallon quantities in luggage via bus or airplane.

Average PCP prices in Maryland have fluctuated over the past 3 years. In 1992, an ounce of liquid PCP sold for about \$365 and declined to \$320 in 1993. In 1994, an ounce of liquid PCP sold for between \$350 and \$400. The decrease in price for PCP may have been the result of larger amounts of this drug reaching the streets.

One liquid ounce of PCP can produce 4 street ounces of treated parsley flakes. Each street ounce of parsley can be divided into 8 film canisters. A single film canister is the usual user purchase amount and sells for \$50 on the street. Therefore, after an initial investment of \$300, the dealer can realize up to \$1,300 profit from sales of PCP-treated parsley.

Dealers in Washington, DC, predominately African American males, continue to control the wholesale market for PCP. However, over 80

percent of individuals encountered in Maryland highway interdictions and investigations involving PCP in 1994 were Anglo. Anglo Marylanders travel to Washington, DC, to purchase liquid PCP from African American wholesalers, and return to Maryland to resell the drug locally in street-level quantities.

PCP is usually marketed in two ways. The drug is sprayed on parsley flakes ("greens") or marijuana ("love boat") and is sold in film canisters containing roughly 2.5 grams each. The treated parsley or marijuana is then smoked. In another use method, liquid ounces of PCP are sold in vanilla extract bottles, and tobacco or marijuana cigarettes are dipped into the liquid. These treated cigarettes, called "dippers," "sherman sticks," or "illies," can be purchased for approximately \$20 each.

No other new sales trends for PCP have been reported in Maryland. However, reports from Washington, DC, indicate that, in street jargon, PCP is known as "water." Another trend is PCP laced with gasoline. Called "octane," this variety of PCP is also being used for "dippers" and for treating parsley.

LSD

Lysergic acid diethylamide (LSD) continues to be a popular drug among high school and college-aged individuals. Circulated in high schools, on college campuses, at nightclubs, or teen and young adult parties, this hallucinogen appeals to the younger market because it is easy to obtain, cheap to purchase, and produces a high lasting up to 12 hours.

According to DEA intelligence information, LSD, or "acid," can be found in virtually every State in the nation. LSD is sold in a variety of forms at the retail level, including blotter paper, gelatin squares ("windowpanes"), sugar cubes, and small pills ("microdots"). In Maryland, blotter paper is the most common form of LSD.

Both retail and wholesale LSD prices have increased minimally over the past few years. State and local undercover agents usually purchase LSD at retail levels in quantities of 100 dosage units or less.

Maryland State Police Statewide LSD Prices
LSD prices have increased for street-level dealer quantities of 50 to 100 dosage units. However, prices for user quantities (1 to 5 dosage units) have remained stable over the past 3 years.

In January 1993, a new form of LSD was purchased during an undercover operation by the Maryland State Police (MSP), Drug Enforcement Division, in southern Maryland. This LSD was in the most common form for LSD in Maryland, blotter paper. However, the perforated doses, or "hits," measured twice the normal size, approximately 1/4 inch square. A picture of a cartoon pig dressed in overalls was imprinted on each hit. This was the first appearance of this type of LSD in Maryland.

Recently, another type of blotter acid has become popular in central Maryland. The blotter paper containing the LSD is orange in color and is imprinted with a picture of a sun with a human face covering each four square blocks of paper. The street name of this LSD is "orange sunshine" (not to be confused with the microdot form of "orange sunshine" LSD popular in the 1960s). In October 1993, the MSP Metropolitan Area Drug Task Force seized over 1,400 dosage units of "orange sunshine" in College Park, Maryland. "Orange sunshine" has also been sold in Baltimore County and Baltimore City.

Methamphetamine

Methamphetamine, known as "meth," "speed," and "crank" on the street, is a synthetic stimulant. Methamphetamine powder, often packaged in capsules or zip lock baggies, can be swallowed, snorted, or dissolved in water and injected. A very pure and potent form of methamphetamine, known as "ice," can be smoked.

Historically, methamphetamine has been associated with outlaw motorcycle gangs. Meth has not been prevalent in Maryland because of a decline in the activity of this major trafficking group in the State. However, recent information suggests that methamphetamine may be gaining in popularity among new and younger users in Maryland. Reportedly, the crystalline powder form of methamphetamine is readily available at rave parties and all-night dance parties frequented by juveniles and young adults, and can be purchased for \$20 a hit.

Several national indicators are also showing that methamphetamine use is on the rise. The DEA reports that, during the early part of 1995, the number of methamphetamine seizures as a result of highway interdictions has increased significantly around the country. Law enforcement agencies indicate that California is usually the source of methamphetamine being shipped to distribution/user markets throughout the United States.

According to Drug Abuse Warning Network (DAWN) Emergency Room data, between 1988 and 1991 the number of methamphetamine-related emergency room episodes decreased nationally. However, between 1991 and 1993, methamphetamine episodes increased 106 percent (from 4,900 to 10,100).

Methcathinone

Methcathinone, or "cat," first appeared on the illicit drug market near Marquette, Michigan, in January 1991. Since then, "cat" has spread

throughout the upper peninsula of Michigan and to other parts of Michigan and Wisconsin. Isolated reports of cat in Florida, Virginia, and Washington have been noted. In Maryland, there have been reports that persons have attempted to manufacture and market "cat" in Frederick County, but confirmation is lacking.

Methcathinone, a strong amphetamine-like substance, is known to be more potent than methamphetamine. "Cat" is easy to make and its precursor chemicals are readily available. As such, the manufacture of "cat" could become attractive to drug entrepreneurs. The DEA permanently listed methcathinone as a Schedule I Controlled Dangerous Substance (CDS) on October 15, 1993.

Maryland does not have a strong existing user population for methamphetamine or similar drugs, so "cat" may be slow to find a market here. However, law enforcement and legislators should be aware of this drug and the threat it poses if it starts to appear with any regularity in Maryland.

MDMA

MDMA (3, 4-methylenedioxymethamphetamine) is a hallucinogenic amphetamine. Also known as "ecstasy," "XTC," "X," and "Adam," it is not a prominent drug in Maryland. Popular among rave party attendees, it is sold in pill, capsule, or powder form and can be taken orally or snorted. One hit of the drug sells for between \$25 to \$45. MDMA seizures or undercover purchases have been made in Frederick County, Howard County, and Baltimore City. In two instances the drug was in tablet form and concealed inside Tic-Tac and Tylenol containers. Anecdotal information suggests that MDMA is finding its way to different areas of the State. It is believed that teenagers and young adults purchase small quantities of the drug at rave parties and return to their homes to sell the MDMA to friends and associates.

Sources in nearby Fairfax County, Virginia, reveal that MDMA is available and has been purchased from an Asian male. The MDMA was sold in capsule form at \$35 per capsule. The source of the MDMA has not been determined.

The Clarksburg, West Virginia, DEA office was involved in the arrest of four individuals connected with an MDMA clandestine lab operation. When seized, the lab contained about 4,000 ml of MDMA solution. Reportedly, the "cooker" of this solution has a bachelor's degree in chemistry.

Ketamine

Ketamine, or ketamine hydrochloride, is a legal tranquilizer used in veterinary medicine. Chemically related to phencyclidine (PCP), it is sold as an injectable under the brand names Ketacet and Ketajet. For human consumption, ketamine is marketed under the name Ketalar. Ketalar is a rapid-acting general anesthetic that is mostly used for diagnostic and short surgical procedures.

Ketamine has been diverted into the illicit market from veterinary sources and is called "Special K" or "cat Valium" on the street. Normally found in injectable form, it is converted into a powder and repackaged in small zip-lock baggies or capsules. Sold for \$20 a dosage unit or "hit," ketamine is generally snorted. While ketamine acts as a tranquilizer in animals, it has hallucinogenic effects on humans. Ketamine can cause convulsions, especially when taken in large dosages. Some users experience vomiting when mixing it with alcohol. The drug can cause a depressed person to become suicidal or an agitated person to become violent.

Ketamine has been common in the New York night club scene for many years. In the Baltimore metropolitan area "Special K" is readily available at rave parties.

According to the American Veterinary Medical Association, ketamine can only be obtained by licensed veterinary clinics and research institutes. Last summer, the Virginia Veterinary Medical Association reported a scam to obtain ketamine. A person would call a veterinary hospital or clinic, saying they were from another doctor's office. They then stated that they had run out of ketamine and wanted to borrow a bottle until their order came in. This scheme was reported in Virginia, Maryland, and North Carolina. Heightened awareness among veterinary clinics has resulted in tighter controls on ketamine supplies and, as a result, traffickers are resorting to more drastic measures to obtain the substance. In February 1995, three subjects committed an armed robbery at a Carroll County veterinary hospital and stole bottles of ketamine. In June 1995, a veterinary clinic in St. Mary's County was broken into and 33 bottles of ketamine were stolen.

In some States, ketamine is controlled, but in most States it is only restricted. Because of the drug's high potential for abuse, it is under consideration for an official controlled substance classification, based on police and medical information.

Drugs Used at Raves

Rave parties, also known as underground or after-hour parties, are all-night dance parties held at night clubs, warehouses, and parks. Disc jockeys from New York, Philadelphia, Baltimore, and Washington, DC, travel up and down the eastern seaboard to play the "techno music" heard at these gatherings. The music, accompanied by laser and strobe light shows, is loud and characterized by a fast, pulsating beat. Large rave parties are considered to be special events and are very popular and well-attended by young people. It is not uncommon for people to travel 4 or 5 hours to attend one of these parties.

Most rave party goers are high school and college students ranging in age from their late teens to early twenties. Ravers in the Baltimore-Washington area are predominantly Anglo; however, some rave parties are described as melting pots for young people from different economic and racial backgrounds. The clothing styles are mostly retro 60s and 70s psychedelic colors, bell-bottoms, platform shoes, and bizarre hats but loose-fitting shirts, shorts and pants, and baseball hats worn backwards are also popular. Raves are a forum for the "X" generation, a place to release frustrations and be rebellious.

The promoters of rave parties advertise via flyers (usually index card sized with psychedelic designs), private mailing lists, e-mail, and by word of mouth. There is security at all rave parties, and the clubs that hold parties check identification at the door. A person must be 18 or over to attend a rave, but it is easy enough for high school students to acquire false identification to gain admittance. Some rave parties claim to be alcohol-free, others serve alcohol, and still others let participants bring their own. All sell non-alcohol drinks, especially sodas and "smart drinks," fruit juice drinks with vitamins, amino acids, and caffeine.

There are also smaller, private rave parties held at a variety of different locations. Alcohol is generally not served at these functions, and consequently, identification is not checked. Admission is by invitation only.

The most prevalent drugs at rave parties are LSD, MDMA ("ecstasy"), marijuana, cocaine, methamphetamine, ketamine ("Special K"), and nitrous oxide. It is difficult for law enforcement to mingle with the drug-users at rave parties because they generally hang out in cliques or tight-knit groups and are suspicious of outsiders.

Rave parties are distinguished from "house parties," which have a predominately African

American crowd. The popular drug at these club and social gatherings is marijuana "reefer" joints and "blunts," inexpensive cigars, especially "Philly Blunts," that are split open, emptied of tobacco, and filled with marijuana.

Prescription Drugs

Drug diversion is the act of obtaining legal prescription drugs for illicit purposes. Such drugs are diverted into the illicit market by prescription forgery and phone-in prescription fraud, by falsifying symptoms in order to obtain prescriptions ("doctor shopping"), and by unscrupulous practices of professionals such as doctors, nurses, dentists, and pharmacists. Hospitals and pharmacies are also the target of thefts by burglars and by employees themselves.

Diverted pharmaceutical drugs are popular for a variety of reasons. First and foremost, quality control is employed during drug manufacture and the user knows that each dose will be consistent and the effects will be the same. Easily recognizable, prescription drugs are usually imprinted with a drug name or a drug company symbol. These drugs are also relatively cheap and easy to obtain. Unlike illicit drugs, they can be purchased through prescription plans, Medicare, or medical assistance. Finally, the abuse of prescription drugs generally goes undetected because police either have few resources to tackle the problem or are not well informed about drug diversion. Prescription drugs in Maryland continue to be trafficked primarily by Anglos in their early 20s to late 40s. The following are the commonly diverted drugs:

- Dilaudid (hydromorphone, Schedule II), a narcotic analgesic
- Percocet/Percodan (oxycodone, Schedule II), a narcotic analgesic
- Xanax (alprazolam, Schedule IV), a tranquilizer
- Valium (diazepam, Schedule IV), a tranquilizer

Vicodin, Lorcet, Lortab, Anexsia (hydrocodone, Schedule III), narcotic analgesics and antitussives

Doriden (glutethimide, Schedule II), a depressant

Tylenol with Codeine Tylenol 3 or 4 (codeine phosphate, Schedule III), an analgesic.

DEA drug diversion units in the Baltimore-Washington area also report that clonidine (brand name Catapres), a non-controlled drug used to manage hypertension, is being used as a booster with narcotics, narcotic analgesics, and sedatives such as heroin, methadone, Darvocet, Valium, and Xanax.

A DEA system that tracks the wholesale movement of pharmaceuticals shows that, in 1993, Maryland ranked number one per capita in the nation in shipments of oxycodone. In 1992 Maryland ranked third. An increase was also seen with Doriden, a depressant, which ranked eighth in 1992 and rose to second in 1993. Although there is a large heroin population in Baltimore, Maryland, dropped from seventh place in 1992 to thirteenth in 1993 for hydromorphone (Dilaudid), a narcotic analgesic. These three drugs are readily available on the street in Maryland.

The DAWN emergency room sample for the Baltimore metropolitan area showed significant decreases between the first two quarters of 1992 and the first two quarters of 1993 for the following prescription drugs reported by participating hospitals: alprazolam (Xanax, a tranquilizer), diazepam (Valium, a tranquilizer), d-propoxphene (Darvon, a narcotic analgesic), fluoxetine (Prozac, an antidepressant), cyclobenzaprine (Flexeril, muscle relaxant), and naproxen (Naprosyn, an analgesic).

Approximately 5 percent of admissions to Maryland treatment facilities in FY 94 reported a prescription drug or an over-the-counter drug as

a substance of abuse. Among those admitted, pharmaceutical drugs (non-prescription methadone, barbiturates, sedatives, amphetamines, tranquilizers, and over-the-counter drugs) increased slightly from 2,843 in FY 93 to 3,011 in FY 94. Because treatment centers report only the top three substances cited as substances of abuse by each client, it is possible that prescription drug abuse by Maryland residents is underestimated in persons using multiple illicit drugs.

Inhalants

The term "inhalants" refers to a wide array of chemicals, including solvents, aerosols, gases, and volatile nitrites, which, when drawn into the lungs, induce a temporary euphoric state. The majority of these chemicals are legal to purchase and possess. In fact, many are contained in common household items such as cleaning fluids, glue, nail polish remover, spray paint, lighter fluid, and gasoline.

Inhalants are inhaled, or "huffed." Some of the more common ways to huff are directly from the container, from a soaked rag, or after the substance has been transferred into another container such as a soda can or plastic bag. Many are not aware of the potential dangers of this form of abuse. Inhalants can cause physical changes such as double vision, dizziness, loss of coordination, and blackouts. These effects are usually temporary; however the misuse of these substances can damage the heart, lungs, brain, liver, and kidneys. High concentrations of these substances can also cause death by suffocation or cardiac collapse from shock.

Inhalant abuse has been popular among school-aged children for many years, and recent reports indicate that the frequency of abuse is on the rise. The 1993 Monitoring the Future Survey reported that, after alcohol and tobacco, inhalants are the most abused substances among eighth-graders. According to the survey, almost one in

five eighth graders has used inhalants. The 1992 National Household Survey on Drug Abuse indicates that, for lifetime use, gasoline and glue are the most abused inhalants among 12- to 17-year-olds, while amyl nitrites (poppers or snappers) and nitrous oxide are most frequently used by adults age 18 or over.

Law enforcement can offer little deterrence because most of these products are readily available and can be purchased by anyone. Moreover, the charge for illegally selling inhalants is usually a misdemeanor. It is not surprising, then, that incidents of inhalant abuse are becoming more common.

In Maryland and elsewhere, there is a growing problem in the sale and abuse of nitrous oxide gas. Nitrous oxide is a colorless, sweet-smelling gas that has a variety of uses. In the medical profession, nitrous oxide, known as "laughing gas," is most commonly used for minor oral surgery and dental work. This gas also has a number of industrial uses. It is used as a propellant in aerosol food cans and is sold commercially in small canisters or cartridges called "whip-its," which are marketed under various brand names such as Whippets and EZ Whip and used to make whipped cream. Nitrous oxide is also sold in cylinders or tanks for medical and dental use. Nitrous oxide with hydrogen sulphide or another gas added is used as a fuel enhancement in race cars.

There has been a growing concern by many in the medical profession, government, and industry about an increase in the abuse of nitrous oxide. Theft of cylinders from suppliers and medical sources and the deliberate purchase of tanks from distributors who are oblivious to its misuse has made nitrous oxide available to many persons. Some are entrepreneurs who seek to profit from its misuse while others are juveniles or young adults looking for a cheap high. At concerts, people will openly sell a dose of nitrous

oxide, known as "hippie crack" or simply "nitrous," for approximately \$2 to \$5. The gas is generally dispensed from a large nitrous oxide tank into a balloon. The captured gas is then sucked through the mouth in the same manner as some draw in helium to make their voices change.

Concert goers, however, are not the only ones lured into taking part in this activity. In the summer of 1992, police officers from the Wilkens precinct of the Baltimore County Police Department arrested two young men on separate occasions for allegedly selling balloons of nitrous oxide for \$2 to \$3 each to kids on the street.

Not just a local phenomenon, there are numerous news accounts of nitrous oxide-related incidents across the country. Some news reports describe motor vehicle accidents where not only drivers under the influence of nitrous oxide were injured or killed, but also pedestrians. Other articles recount the deaths of juveniles that were not aware of the hazards of inhaling this potentially lethal substance. Special dangers include using the gas in a closed environment, such as a car, where all the oxygen is expelled, or where an

anesthesiological mask is used that stays attached to the face even if the user passes out, or explosion of the tank.

Many who abuse nitrous oxide believe that it is a "safe" (harmless, nonaddictive and undetectable) drug. However, taken in combination with prescription or over-the-counter medicines or any street drugs, anesthetics such as nitrous oxide can have serious side effects or can be fatal. In addition, the doses or "hits" of nitrous oxide purchased on the street may not be medical grade laughing gas, but rather an industrial grade of the gas used in race cars, with many harmful impurities such as sulphuric acid, ammonia and nitric oxide.

According to law enforcement, there is a huge profit motive for selling nitrous oxide. One large compressed gas cylinder contains between 14,000 to 16,000 liters of nitrous oxide. A typical street sale involves a 2- to 3-liter balloon of nitrous oxide, which sells for anywhere between \$2 and \$5. One 14,000 liter tank could inflate approximately 4,700 balloons. Even at the more conservative price of \$3 per balloon, the profit potential from one large cylinder is \$14,100.

Appendix I: Ethnographic Studies

Atlanta

An ethnographer in Atlanta developed a short-term ethnographic project to determine why female crack users were increasingly being arrested but were not being treated in hospital emergency rooms or admitted to drug abuse treatment programs. This was an important question because the indicator data from all three sources (police, hospitals, and drug abuse treatment programs) were being used to assess the nature and extent of drug abuse problems.

The ethnographic team in Atlanta already had substantial experience in the city. In addition to interviews, they did participant observation in neighborhoods in which they had previously worked. They quickly learned about women in the crack scene.

Female crack users had previously been portrayed primarily as women who offer sexual services in return for small amounts of the drug. The ethnographers learned that most of the female crack users in Atlanta were not happy with this arrangement, and looked for other ways to support their habits in a more independent, less demeaning way. The solution for many of these users was to become crack dealers. In fact, some had moved into higher level positions in the crack distribution network.

As women entered the crack-dealing business, they became more visible to law enforcement which, in turn, resulted in an increase in arrests. Once they were arrested and known as dealers, their arrests tended to repeat. This shift in positions in the crack scene thus resulted in increase of women in the arrest statistics.

But why were these women not being seen in drug abuse treatment programs and hospital emergency rooms? First, they criticized local drug treatment programs for their "male" orientation. One issue was the lack of child care.

Many refused to consider drug abuse treatment because they would have to leave their children for extended periods of time. A more diffuse issue had to do with what they called "male" treatment styles.

The crack-using females talked about why they avoided the emergency room as well. The issue of child care came up here, but more importantly, women felt that if they went to an emergency room, they would be labeled as "drug addicts" and the label would increase their chances of being arrested once they were back on the streets. They wanted to avoid this label, especially since the police were increasing efforts to arrest crack users and dealers.

Conducting a short-term ethnography, the Atlanta researchers were only able to tap the surface of this issue, but they did obtain some useful information to help understand the differences that were being seen in the indicator data. The epidemiologic indicators turned out not to be a puzzle at all. Instead, the indicators reflected a shift in behaviors. More and more, the women were turning to drug dealing and feeling negatively about treatment facilities.

Philadelphia

With the support and interest of the city health services, an ethnographer in Philadelphia conducted a study of the city's Puerto Rican community. The question was, "Why don't more Puerto Rican heroin addicts use treatment services?" Arrest data showed that a relatively high percentage of Hispanic arrestees had used illicit drugs.

The Philadelphia ethnographer, who was already well known for her work with needle exchange, went into the community to interview and observe. In a relatively short period of time, she learned why Puerto Rican heroin addicts were less likely than addicts in other racial/

ethnic groups to use treatment services. First, an obvious language problem existed. Many of the interviewees could speak English well, but experienced difficulty expressing emotional problems and needs. In a fast-paced therapeutic environment, many felt that there was no point in seeking treatment where communication was so difficult.

A second issue had to do with the boundary between the streets and treatment. It was learned that entering and leaving treatment was more of a social than an individual act. Among interviewees, the ethnographers found greater treatment success when an addict had family support in physically entering a treatment program and then when leaving it and returning to the community. In the Anglo-American model, the individual shows up, and once treatment is finished returns to the community and starts a new life. This lack of social support in the transitions was often mentioned by Puerto Ricans as problematic.

A third issue related to sources of information about different programs. The city used a variety of methods to market treatment services, but the most important source of information from the addicts' point of view was what they learned within their drug-using networks and in places where drug addicts congregate, like shooting galleries.

Many other issues were identified by the ethnographer, but these three language, social support during transition into and out of treatment, and source of program information exemplify the reasons Puerto Rican addicts were not taking advantage of treatment resources and not well represented in the treatment data set.

San Francisco

An ethnographer in San Francisco assessed risk factors for HIV transmission among needle-using addicts. The ethnographic team observed and interviewed a group of homeless men who lived under a freeway overpass in the city. One of their first conclusions was how often and how routinely users put themselves at risk for HIV. It

was quickly learned that there was one simple economic reason. The average cost for a street unit of heroin in that city is \$20. Seldom does an individual have that much money, so typically two to three addicts pool their resources. The primary type of heroin in San Francisco is Mexican Black Tar, which has to be dissolved before it can be divided. This means that, at the time of use, shares must be apportioned, and the measuring out process involves common implements or shared water and cotton. The economics of heroin, then, established conditions of HIV risk most of the time that the men used.

San Antonio

In San Antonio, an ethnographic team assessed the transmission and prevention of drug-use patterns in the family context among the Mexican-Americans in that city. Chicano addicts often explain use and relapse with the Spanish phrase *la presion*, the "pressure" in English. *La presion* is so taken for granted that community members have difficulty explaining what it means. Indeed, some ethnography consists of making such taken-for-granted aspects of life explicit in all their complexity. *La presion* signals a host of external events that can occur, often unpredictably, usually out of the person's control, that impact them and their lives in a negative way. Many of the problems that result are a function of poverty, since the Chicano addicts usually lead lives with no margin for such mistakes to occur.

Baltimore

In Baltimore, there was an interest in determining the relationship between (un)employment and drug abuse. An ethnographer in Baltimore conducted ethnographic interviews and spent time in the neighborhood around a homeless shelter. He found that some men, who had histories of casual and controlled drug use, had found work difficult to locate in Baltimore because of economic decline. The loss of employment had a deteriorating effect on family life, and drug use increased.

For most of the sample, the story was more complicated. Most of the men "juggled" different

identities and had done so for years. They worked, had families, and used drugs and alcohol in more or less serious ways. They had lived for years like this, pushing different work, family, and drug identities to the edge, then coming back to maintain the balance. For these men, employment mattered in a different way. With the economic downturn in Baltimore, it was not easy to find jobs anymore. Once an addict pushed a little too far over the edge in one job and lost it, others were difficult to find. But the problem was also the structure of the

Baltimore drug markets. With vertical integration and a shift to crack cocaine, the old neighborhood-based markets for heroin disappeared. The men lost their sources of supply and the new sources were more violent and impersonal than what they had known before. With the loss of jobs and the shift in the market, they found themselves in a world that no longer allowed them to use their experience to manage two kinds of identities work and drugs. They became homeless and turned up in the shelter.

Appendix J: Sample Format for State Reports

DRUG ABUSE PATTERNS AND TRENDS IN ALEXANDRIA/RAPIDES PARISH

Regional Office
State Office of Alcohol and Drug Abuse

Alexandria, Rapides Parish

Cocaine/crack and marijuana are the most serious illicit drug abuse problems in Rapides Parish and the City of Alexandria. In the period from January 1, 1996 through August 31, 1997, 59 percent (n=783) of the clients admitted to treatment programs for illicit drug use in Rapides Parish were primary cocaine/crack abusers; almost 63 percent were African-American (compared with 36 percent whites), 67 percent were male, and almost three-quarters (73.7 percent) were 30 years of age or over. Primary marijuana abusers accounted for almost 27 percent of the illicit drug abusers admitted to treatment. More than half (59 percent) were white (40 percent were African-American), 62 percent were male, and 73 percent were under 30 years of age. Twenty-nine people were admitted for primary methamphetamine abuse and only 9 for primary heroin abuse. Most of the methamphetamine abusers were white (55 percent) and male (62 percent). The 1996 Alexandria City Police Arrest Report provides further evidence of the cocaine/crack and marijuana problems. Of the 398 adult arrests for drug possession, 57 percent involved marijuana and 41 percent involved cocaine (including crack). Most of the adult marijuana (83 percent) and cocaine (83 percent) possession arrests were African-American. There also were 31 adult arrests for the sale or manufacturing of illicit drugs; 58 percent involved marijuana and 35 percent involved cocaine and 81 percent of those arrested were African-American. In addition, 82 juveniles were arrested for drug-related violations by the Alexandria police: 73 for drug possession and 9 for selling or manufacturing drugs. Most (93 percent) were African-American. Over two-thirds of possession arrests of juveniles involved marijuana; 27 percent involved cocaine.

INTRODUCTION

1. Area Description

Alexandria is located in central Louisiana. The population of the city is approximately 50,000 residents. About half the population is African-American and half is white. According to the 1990 census, 54 percent of the population are females. Because the city is located in the center of the State, treatment programs draw people from other areas of the State.

2. Sources of Data

- **Treatment Data**—Rapides Parish Drug Abuse Treatment Admissions Data were provided by the State Office of Alcohol and Drug Abuse for the period from January 1, 1996 through August 31, 1997.
- **Rapides Parish Coroner's Office**—Coroner's reports provided information

on deaths with positive tests for alcohol and/or drugs.

- **Rapides Regional Medical Center**— This facility reported emergency department drug-related incidents but could not provide information about the specific drugs used.
- **Marshal's Office, City of Alexandria**— The Marshal's Office provided data on substance-abuse related arrests and convictions for motivation (disturbing the peace), possession of drug paraphernalia, and possession of marijuana.
- **Metro Narcotics Task Force**— This task force provides data on drug-related arrests by race/ethnicity.
- **Alexandria City Police (FBI Arrest Report)**— This report covers arrests for drug violations including the manufacturing/sale and possession of different drugs by ethnicity.
- **Louisiana Adult Household Survey**— Alexandria was included with Shreveport in this Statewide survey.
- **1996–1997 Adolescent Survey on Pathological Gambling and Substance Abuse**— Data from this survey represent 417 youth in Rapides Parish. (Sample sizes for different questions vary because of branching patterns in the questionnaire.)

DRUG ABUSE PATTERNS AND TRENDS

1. Treatment Data

Cocaine/crack accounted for 31.1 percent of all treatment admissions in Rapides Parish during the period from January 1, 1996–August 31, 1997, and for 59.3 percent of admissions for primary abuse of an illicit drug. Almost two-thirds of the primary cocaine/crack admissions were men, 62.8 percent were African-American, and 73.7 percent were age 30 or older (exhibit 1).

Marijuana accounted for 14 percent of all admissions, and for 26.6 percent of admissions for primary abuse of an illicit drug. Nearly three-fourths of the (primary) marijuana abusers were male, 59.4 percent were white, and 73.5 percent were age 29 or

younger, with 38.9 percent being under 20 years of age.

Nine admissions were for primary abuse of heroin; the majority were male, white, and age 30 or older. There also were 29 admissions for primary abuse of methamphetamine; the majority were male, white, and age 30 or older, although 12 (41.4 percent) were under age 30.

2. Drug-Related Emergency Department Admissions

The Rapides Regional Medical Center reported 150 drug-related emergency department admissions in 1996. Data on the specific drugs were not available.

3. Drug-Related Deaths

The Rapides Parish Coroner's Office reported 11 alcohol-related and 2 drug abuse-related deaths in 1997. The types of drugs used were reported as "unknown." One drug-related death involved an accident, the other a homicide.

4. Drug-Related Arrests

- **Marshal's Office, City of Alexandria**

The Marshal's Office reported 157 arrests and 140 convictions for the possession of drug paraphernalia in 1996. In addition, there were 221 arrests and 205 convictions for marijuana possession (exhibit 2).

- **Metro Narcotics Task Force**

In 1996, the Narcotics Task Force reported 229 drug-related arrests (exhibit 3). Of those arrested, 77.3 percent were African-American, and 21.4 percent were white (1.3 percent were of other ethnic backgrounds). Of the African-Americans, 83 percent were males. Of the white arrestees, 59 percent were male and 41 percent female.

- **Alexandria City Police**

The Alexandria Police Department reported 429 arrests of adults for drug-related violations in 1996. The vast majority were male (89.3 percent) and African-American (82.7 percent). There were 163 arrests for possession of cocaine and 11 for the manufacture/sale of cocaine, as well as 227 arrests for marijuana possession and 18 for the manufacture/sale of marijuana. Relatively few of the 1996 arrests involved other drugs. There were five arrests for the possession of synthetic narcotics and one for the manufacture/sale of

synthetic narcotics. There were three arrests for the possession of other non-narcotic drugs and one arrest for the sale/manufacturing of these drugs (exhibit 4).

Partial data reported for the January 1 through August 31 period showed that marijuana and cocaine continued to be the most serious drug problems among adult arrestees. There were 95 arrests for marijuana possession and 23 for cocaine possession (exhibit 4).

In 1996, 82 juveniles were arrested for drug violations; most of the juveniles (92.7 percent) were African-American. Fifty youngsters (48 boys and 2 girls) were arrested for marijuana possession; two boys were arrested for the manufacture/sale of marijuana. In addition, 20 (18 boys and 2 girls) were arrested for cocaine possession, and 7 (African-American males) for the manufacture/sale of cocaine (exhibit 5).

The data for the first 10 months of 1997 showed similar arrest patterns. There were 19 arrests of juveniles for marijuana possession and 3 marijuana manufacture/sale arrests; all were male. There were eight arrests for cocaine possession (7 were male and 7 were African-American; see exhibit 5).

5. 1996 Louisiana Adult Household Survey

As noted earlier, Alexandria and Shreveport were included together in a region in this survey. This area had the highest rate of heavy alcohol use (10.2 percent of the respondents) and the lowest rate of core illicit drug use (4.7 percent) during the year prior to the survey. ("Core" drugs are marijuana/hashish, hallucinogens, cocaine/crack, and heroin/opiates.)

6. 1996–1997 Statewide Adolescent Survey

A total of 417 adolescents from Rapides Parish were included in the survey. Almost 66 percent were female, 69 percent white; the mean age of the youth was 14.30. Most (61 percent) had consumed a full drink of alcohol and 47 percent had, reportedly, been drunk. Almost 25 percent had been drunk monthly, weekly, or daily in the last 12 months. The drugs reported as ever used by the youth included marijuana (26.9 percent), narcotics other than heroin (11.5 percent), inhalants

(12.9 percent), hallucinogens (8.6 percent), amphetamines (6 percent), cocaine/crack (4.8 percent), and heroin (3.1 percent; see exhibit 6).

7. Field Data

There is some evidence that youngsters are injecting crack. Intravenous crack use has been reported, each week, by two to three people entering detoxification in Alexandria. A few years ago, field reports indicated that youngsters were mixing crack with lemon juice to melt the crack) and injecting it.

EXHIBIT 1

TREATMENT ADMISSIONS BY PRIMARY DRUG OF ABUSE, AGE AT ADMISSION, RACE/ETHNICITY AND PERCENTAGE—RAPIDES PARISH

Drug Variable	Cocaine/ Crack	Heroin	Marijuana/ Hashish	Methamphetamine	Alcohol	Other Drugs/ No Data*
Number	(783)	(9)	(352)	(29)	(1,199)	(148)
Primary Drug	31.1	0.3	14.0	1.1	47.6	5.9
Age at Admission						
<20	2.7	0.0	38.9	20.7	6.7	12.8
20-29	23.7	12.5	34.6	20.7	23.2	37.9
30-39	50.7	50.0	21.7	34.5	37.4	33.1
40+	23.0	37.5	4.9	24.1	32.6	16.2
Race/Ethnicity						
Caucasian	36.4	66.7	59.4	55.2	61.9	90.0
African-American	62.8	33.3	40.3	44.8	37.6	9.4
Other	0.8	0.0	0.3	0.0	0.5	0.6
Gender						
Male	66.7	66.7	75.3	62.1	74.1	47.3
Female	33.3	33.3	24.7	37.9	25.9	52.7

N=2,520

* No Data=33

SOURCE: Louisiana State Office of Alcohol and Drug Abuse, January 1, 1996–August 31, 1997

EXHIBIT 2

NUMBER OF DRUG-RELATED ARRESTS AND CONVICTIONS—
CITY OF ALEXANDRIA, MARSHAL'S OFFICE, 1996

Charge	Arrested	Convicted
Disturbing the peace by intoxication	347	331
Possession of drug paraphernalia	157	140
Possession of marijuana	221	205
Total Number	725	676

SOURCE: City of Alexandria, Marshal's Office

EXHIBIT 3

GENDER AND RACE/ETHNICITY OF PERSONS ARRESTED
FOR DRUG-RELATED OFFENSES BY THE METRO
NARCOTICS TASK FORCE, 1996

Gender	Race/Ethnicity			
	African-American	Caucasian	Other	Total
(Number)	(177)	(49)	(3)	(229)
Male	64.2	12.7	0.9	77.7
Female	13.1	8.7	0.4	22.3

SOURCE: Metro Narcotics Task Force

EXHIBIT 4

DRUG-RELATED* ADULT ARRESTS BY TYPE OF ARREST, GENDER, AND RACE/ETHNICITY—
ALEXANDRIA CITY, 1996–1997**

Type of Arrest	Males		Females		African-American		White/Other	
	1996	1997	1996	1997	1996	1997	1996	1997
(Total Violations)	(383)	(108)	(46)	(16)	(355)	(81)	(74)	(43)
Sale/Manufacture								
Cocaine	11	0	0	0	10	0	1	0
Marijuana	17	0	1	0	15	0	3	0
Synthetic Narcotics	1	0	0	0	0	0	1	0
Other Non-Narcotics	0	0	1	0	0	0	1	0
Possession								
Cocaine	142	18	21	5	135	15	28	8
Marijuana	205	85	22	10	188	62	39	33
Synthetic Narcotics	5	3	0	0	5	3	0	0
Other Non-Narcotics	2	2	1	1	2	1	1	2

*Excludes alcohol-related arrests: 320 in 1996, 185 in 1997; 97 percent were DWI in 1996. All were DWI in 1997

**January 1–August 31, 1997

***“Other” includes only 2 persons charged with possession (1 cocaine, 1 marijuana) in 1996

SOURCE: Alexandria City Police FBI Arrest Report

EXHIBIT 5

NUMBER OF DRUG-RELATED* JUVENILE ARRESTS BY TYPE OF ARREST, GENDER, AND RACE/ETHNICITY—ALEXANDRIA CITY, 1996–1997**

Type of Arrest	Males		Females		African-American		White	
	1996	1997	1996	1997	1996	1997	1996	1997
(Total Violations)	(78)	(31)	(4)	(1)	(76)	(27)	(6)	(5)
Sale/Manufacture								
Cocaine	7	0	0	0	7	0	0	0
Marijuana	2	3	0	0	2	3	0	0
Possession								
Cocaine	18	7	2	1	19	7	1	1
Marijuana	48	19	2	0	46	17	4	2
Synthetic Narcotics	0	1	0	0	0	0	0	1
Other Non-Narcotics	3	1	0	0	2	0	1	1

*Excludes 8 alcohol-related arrests in 1996; 7 were DWI arrests

**January 1–August 31, 1997

SOURCE: Alexandria City Police FBI Arrest Report

EXHIBIT 6

SUBSTANCE USE AMONG ADOLESCENTS SURVEYED—RAPIDES PARISH

“Ever Tried”	Percent “Yes” (Rounded)
Marijuana	26.9
(Drugs other than marijuana)	(29.5)
Cocaine/Crack	4.8
Heroin	3.1
Other Narcotics	11.5
Tranquilizers	5.8
Hallucinogens	8.6
Amphetamines	6.0
Barbiturates	2.9
Over-the counter drugs	21.6
Someone else=s prescribed drug	12.7
Alcohol (a “full drink”)	61.4
Tobacco products	57.3
“Huffing” (sniffing drugs)	12.9
Ever Been Drunk	
Drunk in last 12 months	47.0
Monthly or more often	24.9
Mean	
Age first tried marijuana	13.55
Age at first drink (alcohol)	10.93
Age first drunk	12.50

N=147 full sample; 398–411 on substance abuse questions

SOURCE: Statewide Adolescent Survey on Pathological Gambling and Substance Abuse (6th through 12th grades) School Year 1996–97



<http://nihlibrary.nih.gov>

10 Center Drive
Bethesda, MD 20892-1150
301-496-1080

NIH LIBRARY

3 1496 00775 3000

NIDA
NATIONAL INSTITUTE
ON DRUG ABUSE

NIH Publication No. 98-3614
Printed 1998