

**Proceedings
May 1994 Meeting**



MARYLAND

Statewide Epidemiology Work Group

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**Center for Substance Abuse Research
University of Maryland, College Park**

Funded by the Governor's Drug and Alcohol Abuse Commission

155890

PROCEEDINGS

MARYLAND STATEWIDE EPIDEMIOLOGY WORK GROUP

MAY 1994 MEETING

NCJRS

AUG 80 1995

ACQUISITION

Prepared by

**The CESAR Staff
and Sharon Stout,
MD/SEWG Coordinator**

155890

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FROM THE DIRECTOR

With the strong support of Floyd Pond, Executive Director of Governor Schaefer's Drug and Alcohol Abuse Commission, his staff, and staff from the National Institute on Drug Abuse, CESAR convened a group of local and state agency representatives in January 1992 to determine their interest in sharing information on local and state drug use trends. That meeting provided much encouragement to start the project, while at the same time cautioning us to expect a long and arduous process.

The Maryland Statewide Epidemiology Work Group (MD/SEWG) is now in its third year. Five full SEWG meetings have been held, and participation by both local and state agencies has remained high. Additional jurisdictions are requesting participation.

I want to acknowledge the support of the local participants and state agencies who have helped to sustain the MD/SEWG. Acknowledgment is also in order for CESAR staff who have worked hard to sustain the project: Sharon Stout, the MD/SEWG Coordinator; Clare Mundell, who represents the Washington Metropolitan Area in the national Community Epidemiology Work Group (CEWG); Maggie Hsu, manager of the CESAR Compendium of Drug Abuse Indicators; Bernadine Douglas, CESAR's dedicated CESAR BOARD operator and report technician; Jean Shirhall, CESAR's editor and librarian; Fran Martinez-Scott, CESAR's library assistant; and Trinette Fletcher, research assistant.

We welcome your reactions to this report and suggestions for future proceedings.

Eric D. Wish, Ph.D.
CESAR
Director

CONTENTS
PROCEEDINGS
MAY 1994 MEETING

	Page
From the Director	iii
Introduction	1
Agenda	3
Presentations	
• Maryland Statewide Drug Trends - Maggie Hsu	5
• Maryland Telephone Surveys of Alcohol and Other Drug Abuse - Ken Petronis	25
• The Forthcoming Maryland State Department of Education 1994 Maryland Adolescent Survey: Overview and Discussion - Gary Huang and Chou-lin Chen	29
• A Comprehensive Program to Treat Drug Use During Pregnancy - Michael Fuller	31
• General Trends in Drug Use in Washington, D.C., Spring 1994 - Clare Mundell	35
• The Washington, D.C. Metropolitan Area Drug Study: Methodology and Preliminary Findings - Elizabeth Lambert	39
• Panel Discussion: Issues and Strategies for a Comprehensive Community Program to Combat Drugs and Crime in Baltimore - Tony Whitehead (Moderator), Lt. Col. Marcellus Boles, Thelma Millard, Kevin Jordan, Curtis Price, Shirley Stokes	53
MD/SEWG Membership List	61
List of Attendees	63
Appendix: Results of the May 1994 Participant Survey	

INTRODUCTION

On January 12, 1992, the Center for Substance Abuse Research (CESAR), with the support of the Governor's Drug and Alcohol Abuse Commission, formed a Statewide Epidemiology Work Group (SEWG). The Maryland SEWG (MD/SEWG) is modeled after the national Community Epidemiology Work Group developed and supported by the National Institute on Drug Abuse.

MD/SEWG Scope and Purpose

The mission of the MD/SEWG is to track, monitor, and analyze trends and patterns of use for legal and illegal substances throughout Maryland, with detailed focus on member counties and Baltimore City. Specific objectives of the work group are to (1) provide accurate and timely assessment of local alcohol and drug abuse trends; (2) identify emerging drugs of abuse; (3) determine at-risk populations and environments for program interventions; (4) identify measures for program evaluation and resource allocation; and (5) develop baselines for local program initiatives.

The MD/SEWG meets twice annually, providing a unique forum for mutual exchange among representatives from local jurisdictions (counties and municipalities) and key state agencies. Representatives of participating jurisdictions are responsible for forming Drug Epidemiology Networks (DENs). Each DEN draws on representatives from local law enforcement, treatment, prevention, education, and public health agencies, and meets regularly to analyze local indicators for patterns and trends in the local drug problem. The DEN representative then reports these data at the semiannual SEWG meeting.

Structure of This Report

This report contains the Proceedings of the fifth meeting of the Maryland SEWG, held on May 6, 1994, at the University of Maryland, College Park. This meeting continued to address the question: To what extent can program practitioners--law enforcement, treatment, and prevention professionals--report and interpret social indicator data in a way that is useful both to their local agencies and to state drug policy and program officials?

The meeting included (1) presentations describing the nature and extent of the drug problem in Maryland; (2) discussions of initiatives to collect additional data on the drug problem; (3) descriptions of programs addressing specific problems identified using social indicators; and (4) a panel discussion on the issues of drug use and violence in Baltimore.

The Proceedings have been published in a single volume. The volume contains a summary of each presentation made at the May 1994 MD/SEWG meeting. It also includes an SEWG membership list, the agenda for the meeting, a list of attendees, and a summary of the evaluations of the meeting.

**Maryland Statewide Epidemiology Work Group (MD/SEWG)
Spring Meeting
May 6, 1994**

AGENDA

- 8:30 Registration and Continental Breakfast
- 9:00 Welcome, Participant Introductions, and MD/SEWG Update
Eric Wish and Sharon Stout
- 9:15 Maryland Drug Trends
Maggie Hsu, CESAR
Ken Petronis, CESAR
- 9:45 The Forthcoming Maryland Adolescent Survey: Overview and Discussion
Gary Huang and Chou-lin Chen, Maryland State Department of Education
- 10:30 Break
- 10:40 A Comprehensive Program to Treat Drug Use During Pregnancy
Michael Fuller, Prince George's County Health Department
- 11:10 The Washington, D.C. Metropolitan Area Drug Study (DC*MADS): Methodology and Preliminary Findings
Elizabeth Lambert, Division of Epidemiology and Prevention Research, NIDA
Introduction by Clare Mundell, CESAR
- 12:00 Lunch
- 1:00 Panel Discussion: Strategies and Issues for a Comprehensive Community Program to Combat Drugs and Violence
- Lt. Col. Marcellus Boles, Baltimore City Police Department
 - Kevin Jordan, Citizen's Planning and Housing Association
 - Thelma Millard, Division of Family Support Services, Housing Authority of Baltimore City
 - Curtis Price, Street Voice
 - Shirley Stokes, Baltimore City Health Department
 - Tony Whitehead, moderator, Dept. of Anthropology, University of Maryland

Maryland Statewide Epidemiology Work Group (MD/SEWG)
Spring Meeting
May 6, 1994

AGENDA (Page 2 of 2)

- 3:00 Break
- 3:15 Developing Community Action Plans: The Experiences of the Grantees of the Robert Wood Johnson "Fighting Back" Program
Michael Klitzner, Klitzner and Associates*
- 4:15 Open Discussion and Planning for November, 1994 Meeting
- 4:30 Adjourn

*Dr. Klitzner was unable to attend.

Maryland Statewide Drug Trends

Maggie Hsu
Center for Substance Abuse Research
University of Maryland at College Park

Introduction

At the last planning meeting for the MD/SEWG, several representatives of the local DENs requested that CESAR present data on statewide trends in substance abuse. This presentation is in response to that request.

Trends and patterns emerging from analysis of the indicator data CESAR collects have implications for those engaged in substance abuse prevention, treatment, and law enforcement.

- Alcohol is clearly the most abused substance in Maryland among both the juvenile and adult populations.
- Patterns of illicit drug use vary. In general, marijuana use among juveniles appears to be increasing. Cocaine use appears to be stabilizing. Data on heroin use are conflicting, but the more time-sensitive indicators (such as the number of drug abuse deaths) show an increase in heroin use.
- Patterns of illicit drug use among juveniles and adults appear to be distinctively different.
- Different regions of Maryland show different patterns of drug use.

Economic and Societal Costs of Substance Abuse

Although it probably is not news to anyone that alcohol presents the greatest substance abuse problem in Maryland, alcohol abuse is often overshadowed by concerns about illicit drug use. We need to consider the societal costs of licit as well as illicit drug use in Maryland.

According to Dorothy Rice's 1990 estimate of the economic and societal costs of substance abuse to the nation, alcohol was the most costly abused substance, followed by cigarettes and then illicit drugs.

- Alcohol abuse was associated with total costs of \$98.6 billion in 1990.

- Smoking cost \$72 billion.
- Illicit drug use cost \$66.9 billion.

Each substance has a different impact on society:

- The costs of alcohol abuse are attributable primarily to lost productivity due to illness and death.
- The costs of smoking are due to losses associated with premature death.
- The costs of illicit drugs are attributable primarily to crime.

Statewide Trends and Patterns

Specific indicators used at the statewide level are discussed below. First, however, some basic demographic information may help in interpreting trends and patterns. The 1990 Census of Population and Housing indicates that approximately 4.8 million people live in Maryland. Of these, 71 percent are white, 24.9 percent are black, and 4.1 percent belong to other races (including Native American, Eskimo, or Aleut; Asian or Pacific Islander). The median age is 33. About one-quarter of the population are under age 18; 65 percent are between the ages of 18 and 64; and 11 percent are over age 65.

The Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is based on a telephone survey of a random sample of Maryland adults. The BRFSS is intended to provide state-level estimates of the prevalence of selected health-risk behaviors. The results can be used to estimate the number of adults who currently use cigarettes, binge drink, chronically drink, or drink and drive. These results are based on self-reported responses, and thus should be considered conservative estimates, as people may underreport.

- As shown in Figure 1, in 1992 Maryland ranked below the national median on all risk factors.
- The 2.9 percent of Maryland adults who reported that they chronically drink represent about 119,500 people.
- The 0.8 percent who reported that they drink and drive represent about 38,200 Maryland adults.

- Approximately 1 in 5 Maryland adults (about 956,000 people) reported that they regularly smoke cigarettes.

Drinking and Driving

The 1992 Maryland Adolescent Survey (MAS) included questions on drinking and driving and marijuana use and driving.

- Nineteen percent of high school seniors (7,762) reported driving at least once in the past year after consuming five or more alcoholic drinks.
- Thirty-six percent (14,553) reported driving after consuming between one and four drinks.
- Eighteen percent (7,317) reported driving at least once in the past year after smoking marijuana.
- Sixty percent reported riding as a passenger in a car with a driver who had consumed alcohol or other drugs.

The MAS results, combined with the BRFSS results, suggest that a minimum of 46,000 Marylanders engaged in drinking and driving behavior in 1992.

These results suggest that other indicators on drinking and driving should be interpreted cautiously. As shown in Figure 2, the number of crashes in which alcohol and/or other drugs (AOD) are involved has been declining in Maryland. However, the number of AOD-related crashes depends on police reporting of accidents, which is influenced by the extent of serious damage or injury. As cars become equipped with more safety features (e.g., airbags) and people increase their use of seat belts, one might expect that more accidents would go unreported. The number of severe AOD-related accidents, which are more likely to be reported, may be a better indicator of drinking and driving behavior.

- Both the number of total AOD-related accidents and the number of severe AOD-related accidents have declined over time.
- Severe AOD-related accidents declined less (4 percent) than total accidents (5 percent).
- In 1992, there were approximately 8,468 recorded AOD-related accidents--when at least 46,000 Marylanders engaged in drinking and driving.

Arrests for driving under the influence (DUI) are also declining (16 percent from 1991 to 1992). However, there were still 26,187 DUI arrests in 1992. These numbers are also influenced by the level of enforcement activity.

Crime Data

Figure 3 provides Uniform Crime Report (UCR) data on the number of drug abuse arrests in Maryland for 1988-1992. Because only the most serious offenses are recorded by the UCR system, many AOD-related arrests may not be reflected in these data. Again, enforcement priorities may influence the number of arrests and direction of year-to-year trends.

- One area of concern is that Maryland ranked third in the nation in 1992 on the rate of drug abuse arrests (593 per 100,000 residents).
- In 1992, juvenile arrests increased 9 percent, while adult arrests increased 6 percent.

Treatment Admissions

On admission to treatment for substance abuse, each client is asked to report the substances he or she is abusing. Up to three substances may be recorded each time someone is admitted to treatment. For people who abuse more than one drug (polydrug users), three drugs, at most, are recorded.

Figure 4 shows the percentage of all treatment admissions (FY89-FY93) in which a drug user mentioned alcohol, cocaine, marijuana, or heroin.

- Alcohol was the greatest problem among those admitted to treatment: Roughly three-fourths of treatment admissions were of people mentioning alcohol.
- Cocaine abuse appears to have been relatively stable over the FY89-FY93 period. About 41 percent of treatment admissions involved cocaine.
- Marijuana was reported more frequently at the beginning of the period than at the end, but it increased slightly (2 percent) from FY92 to FY93.
- Heroin mentions were at a somewhat higher level in FY93 than in FY89, but dropped between FY92 and FY93.

Although the number of treatment admissions provides insight into patterns of drug use in Maryland, admissions statistics confound the need for treatment and treatment capacity. Between FY92 and FY93, capacity decreased due to budget cuts.

Treatment admissions reflect patterns of use among those who seek or are assisted in finding treatment, but they may not reflect the drug usage of those who are not in treatment.

In particular, admissions data may not reflect emerging drugs of abuse, because it may take time before users recognize that they need treatment, seek it, and are admitted. For example:

- Among FY93 admissions, the average number of years between first use and admission for treatment was 14 years, for those mentioning alcohol.
- Between first use of marijuana and treatment, there was a lag of 10 years.
- Between first use of heroin and treatment, 9 years elapsed, on average.
- Finally, admissions data suggest that cocaine abuse has adverse effects on users more rapidly than other drugs do: The gap between first use and treatment was 7 years.

Drug Use Among Youth

The 1992 Maryland Adolescent Survey provides the most recent statewide data on the patterns of use of substances among young people. These data reflect rather conservative estimates of use because students may underreport their drug use in a school setting. In addition, school dropouts and absent students--youths who are at risk of drug use and abuse--are underrepresented in this survey.

Figure 5 compares the percentage of students reporting use of different substances within the year prior to the survey. The figure shows that,

- Once again, alcohol is the most abused drug, followed by cigarettes and then either marijuana (among 10th and 12th graders) or inhalants (among 6th and 8th graders).
- In general, drug use increases with age. However, use of inhalants appears to decline with age--reflecting either decreased use among older students or increased dropouts among older users.

Comparing reported current use (within the past month) in 1992 with previous surveys (see Figure 6) shows that,

- Between 1990 and 1992, alcohol use declined among 8th and 10th graders, remained stable among 12th graders, but increased slightly among 6th graders.
- Between 1988 and 1992, cigarette use increased slightly among students for most grade levels.

- Between 1990 and 1992, inhalant use fell, but marijuana use increased among 10th and 12th graders.

In 1992, more Maryland 12th graders than a national sample of 12th graders reported current use of alcohol, cigarettes, marijuana, LSD, and inhalants.

Schools keep records on the number of students suspended for drug use and the type of drug. These data may be used to gauge general patterns of drug use, but policies may be enforced differently across schools. Nevertheless, suspensions for marijuana use have not only dominated those for other drugs since the 1989-90 school year, but they increased markedly in 1992-93.

Juvenile Treatment Admissions

The pattern of drug use reflected by juvenile admissions differs from that for adults. Juveniles admitted to treatment mention somewhat different drugs and rank them differently: Compared with the four mentioned by adults, youths mention alcohol, marijuana, cocaine, and hallucinogens (which replaces heroin among adults). In addition, the time lags reported between first use of a drug and entry into treatment may be affected by different factors than is the case for adults. For instance, parental concerns may bring children into treatment earlier than if the decision was left to the children. As shown in Figure 7,

- Alcohol abuse was most commonly mentioned, but it declined 11 percentage points between FY92 and FY93.
- Marijuana mentions declined from FY90 to FY92, but increased slightly from FY92 to FY93.
- Between FY90 and FY93, both cocaine and hallucinogen mentions declined.

Treatment admissions for juveniles, however, have not been declining. Because the trends above represent decreasing shares of drug mentions (which are limited to three per admission), they may reflect decreased polydrug use among this population--or increases in other drugs not ranked among the top four.

Drug Testing of Youths in Juvenile Detention Centers

A study of youths tested for drug use at Waxter Children's Center in Laurel and Noyes Children's Center in Rockville found the following:

- Alcohol is the most widely used drug among this population.

- Regional differences appear. Waxter youths (drawn from Baltimore City) had lower rates of alcohol, marijuana, and LSD use than did youths at Noyes (drawn from a suburban population).
- Substance abuse rates increased with age.

Deaths Caused by Drug Abuse

The number of deaths attributable to or caused by illicit drug use offers another perspective on changing patterns of drug use. The Office of the Chief Medical Examiner performs autopsies on almost all the unexpected deaths (e.g., those from accidents, homicides, overdoses) in Maryland. Figure 8 shows the total number of drug abuse deaths and the number of deaths associated with heroin/morphine and cocaine for the period 1986-1993.

- Although the number of drug abuse deaths in Maryland fluctuated over the period, there has been an increasing trend in drug abuse deaths since 1990. Between 1992 and 1993, drug abuse deaths increased 43 percent.
- Heroin has consistently accounted for the great majority of drug abuse deaths, and in 1992, it accounted for a record high of 88 percent of drug abuse deaths. The percentage of drug abuse deaths associated with cocaine is declining.
- The increase in deaths due to heroin may be associated with the increasing availability of high-purity heroin. The Maryland State Police report that high-purity heroin (60 percent purity) has been available in the state since 1990.

Regional Patterns of Substance Abuse in Maryland

Maryland may be considered as comprising six regions: Western Maryland, Baltimore Metropolitan, Upper Shore, Lower Shore, Southern Maryland, and District of Columbia Metropolitan. The jurisdictions included in each region are identified in Figure 9.

Roughly 80 percent of the Maryland population lives in the Baltimore and D.C. Metro areas. Between 25 and 31 percent of the people in these two areas, and in the Lower Shore, are nonwhite. Significantly fewer minorities live in the Upper Shore, Southern, and Western Maryland regions.

The age distributions across the regions tend to be similar, but Southern Maryland has the youngest population. It has been suggested that Baltimore City has a greater substance abuse problem because it has a higher proportion of young people. If true, that fact is masked in the aggregation with the other jurisdictions in this region.

As discussed below, patterns of drug use vary by region, possibly reflecting differences in the demand and supply of different substances in rural and urban areas, as well as proximity to the District of Columbia and Baltimore, which have distinctly different drug trends and patterns.

Treatment Admissions by Region

As shown in Figure 10, treatment admissions for FY93 reflect some combination of the differing patterns of drug use--and demand for and availability of different kinds of treatment.

- For all regions, alcohol remains the most frequently mentioned substance of abuse.
- After alcohol, cocaine is the second greatest problem in the two metropolitan regions. Marijuana is the second greatest problem in the rural areas.
- The Baltimore region had the lowest percentage of mentions of alcohol (63 percent), but the highest percentage of heroin mentions (34 percent).
- The Upper Shore had the highest percentage of alcohol and marijuana mentions.

The Maryland Automated Hotline Reporting System (MAHRS)

The patterns of use evident in the treatment data are reflected in the Maryland Automated Hotline Reporting System (MAHRS) data reported by CESAR (see Figure 11). Alcohol- and drug-related calls made to six Maryland crisis hotlines were tallied by region. Although all hotlines handle AOD related calls, some are better known for this service. Thus, rather than report the percentage of calls that were AOD related, Figure 11 shows the number of calls mentioning a particular substance per 100 AOD-related calls.

- Alcohol was the most frequently mentioned substance in all regions.
- Baltimore area callers were more likely to mention heroin (12 mentions out of each 100 AOD-related calls) and less likely to mention alcohol than were callers in other regions.
- The highest rates of crack mentions were in the Lower Shore and Southern Maryland regions--exceeding the rate for calls in the Baltimore area.

- The highest rate of marijuana mentions was in Western Maryland (22 of every 100 AOD-related calls), closely followed by the Upper Shore (19 of every 100).

Conclusion

Substance abuse trends and patterns in Maryland include the following:

- Alcohol is clearly the most abused substance in the state among both the juvenile and adult populations.
- Trends in illicit drug use vary, depending on the substance.
- Patterns of illicit drug use among juveniles and adults appear to be distinctively different.
- Patterns of drug use vary by region of the state.

For additional information, see:

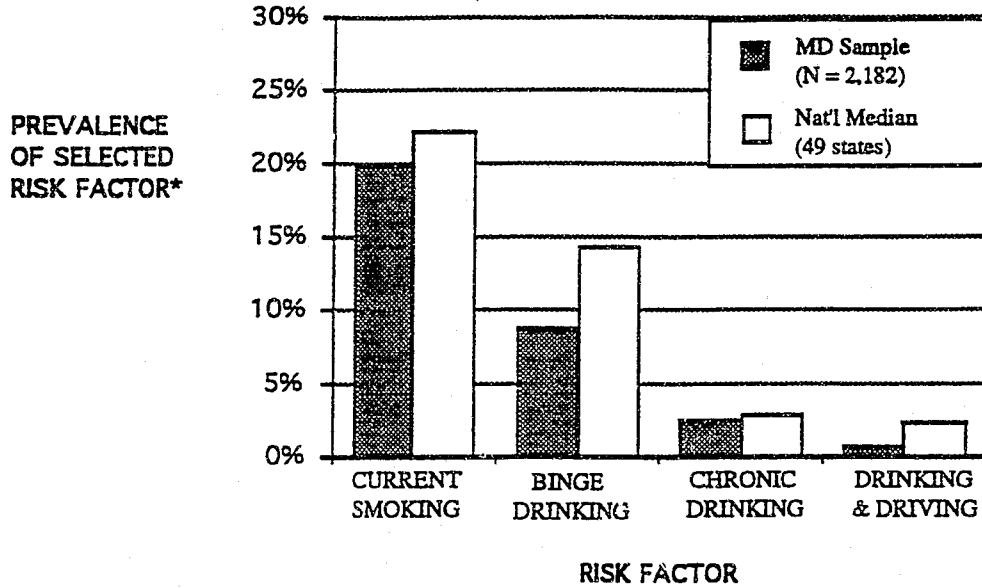
Substance Abuse: The Nation's Number One Health Problem. Key Indicators for Policy. 1993. Institute for Health Policy, Brandeis University. Princeton, N.J.: Robert Wood Johnson Foundation.

Cost estimates for 1990 from Dorothy P. Rice, Institute for Health and Aging, University of California at San Francisco. In *Substance Abuse: The Nation's Number One Health Problem. Key Indicators for Policy.*

"The Nature and Extent of the Drug Abuse Problem in Maryland," in *Maryland's Drug and Alcohol Abuse Control Plan*, November 1993. Governor's Drug and Alcohol Abuse Commission. Reprints of the "Nature and Extent" are also available from CESAR. Request Report 93-4, CESAR Special Topics on Drug Abuse series.

Figure 1

Prevalence of Smoking and Drinking Among
Maryland and U.S. Residents Aged 18 Years and Over, 1992



* Risk Factor Definitions:

Current Smoking = current use of cigarettes by someone who has smoked at least 100 cigarettes in his/her lifetime.

Binge Drinking = consumption of 5 or more alcoholic drinks on at least one occasion during the past month.

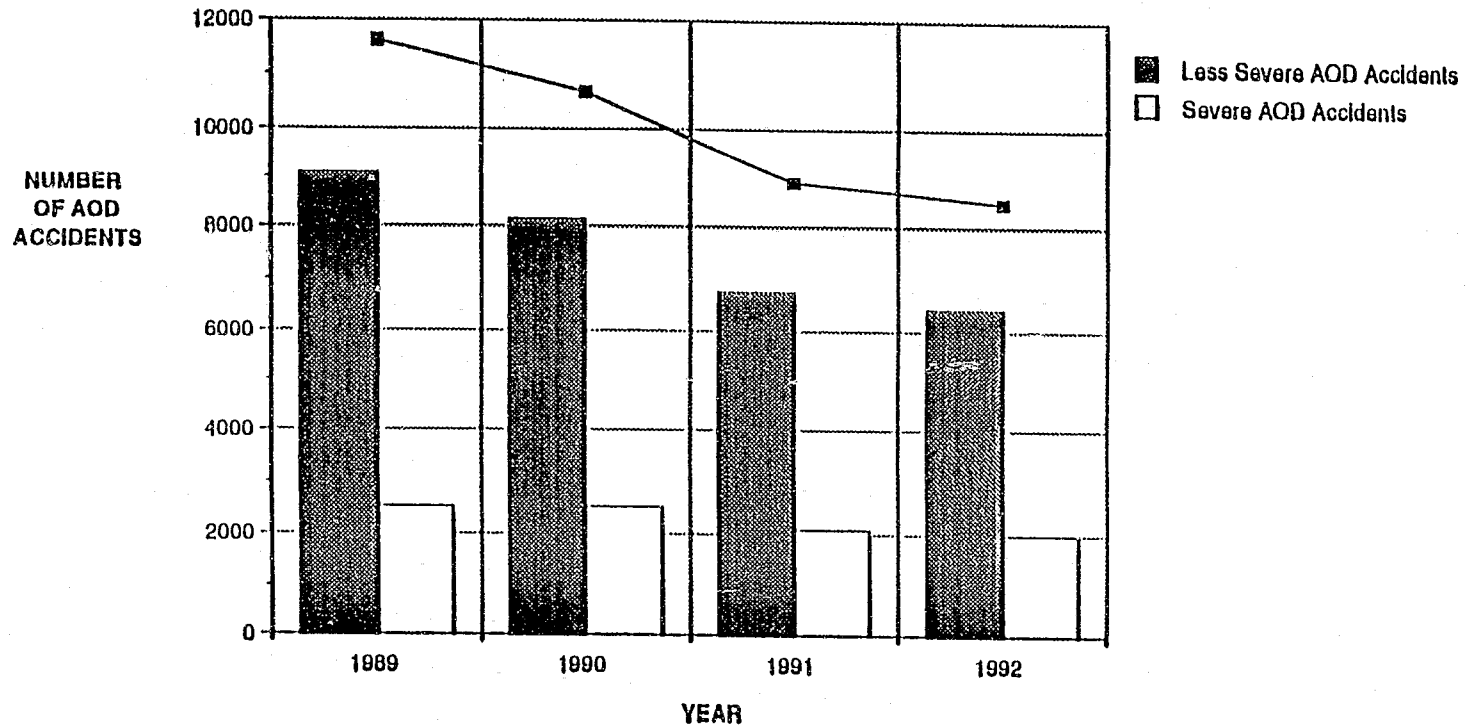
Chronic Drinking = having an average of 60 or more alcoholic drinks a month.

Drinking and Driving = operation of a motor vehicle after drinking too much alcohol at least once in the past month.

SOURCE: Adapted by CESAR from the Behavioral Risk Factor Surveillance System (BRFSS), Maryland Department of Health and Mental Hygiene.

Figure 2

**Total Number of Alcohol and/or Other Drug-Related (AOD) Accidents in Maryland
And Number of AOD Accidents, by Severity Level,* 1989 through 1992**

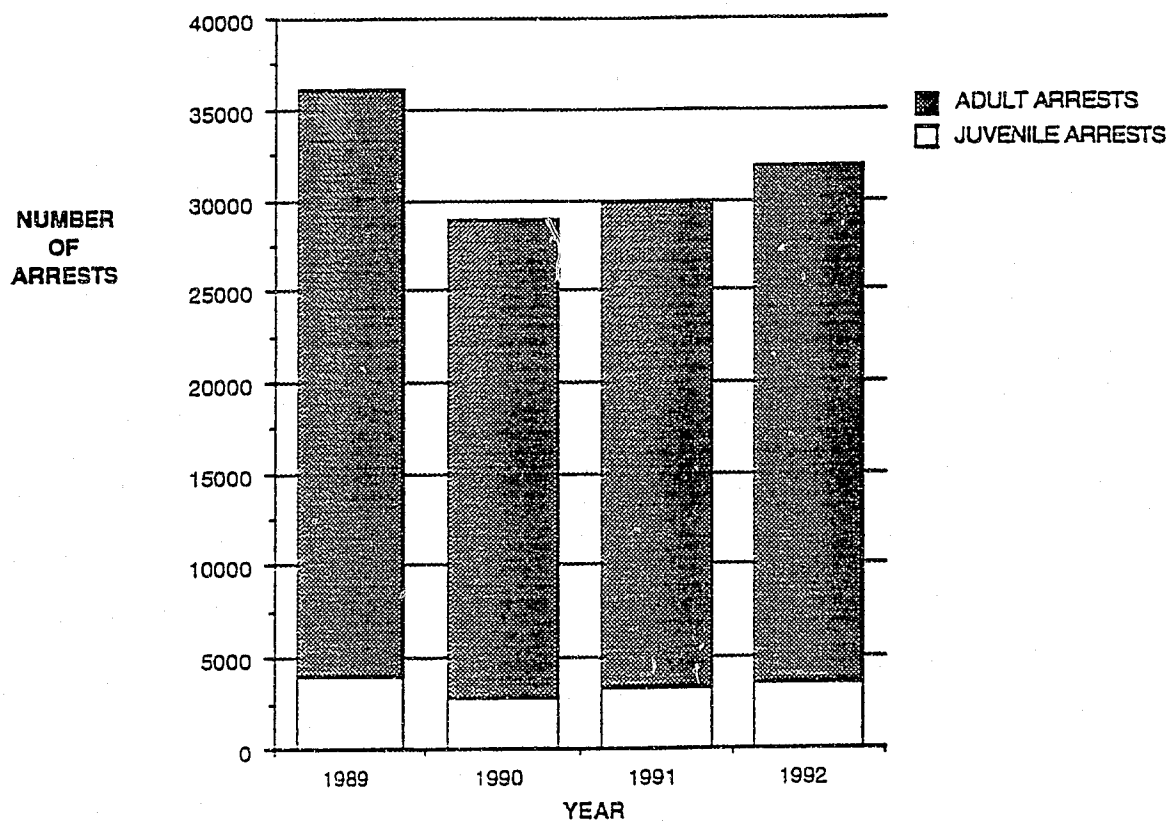


* Severity Level: Less Severe = accidents involving property damage, possible injury, and non-incapacitating injury.
Severe = accidents involving incapacitating injury or fatal injury.

SOURCE: Adapted by CESAR from data from the Maryland Department of Transportation, State Highway Administration.

Figure 3

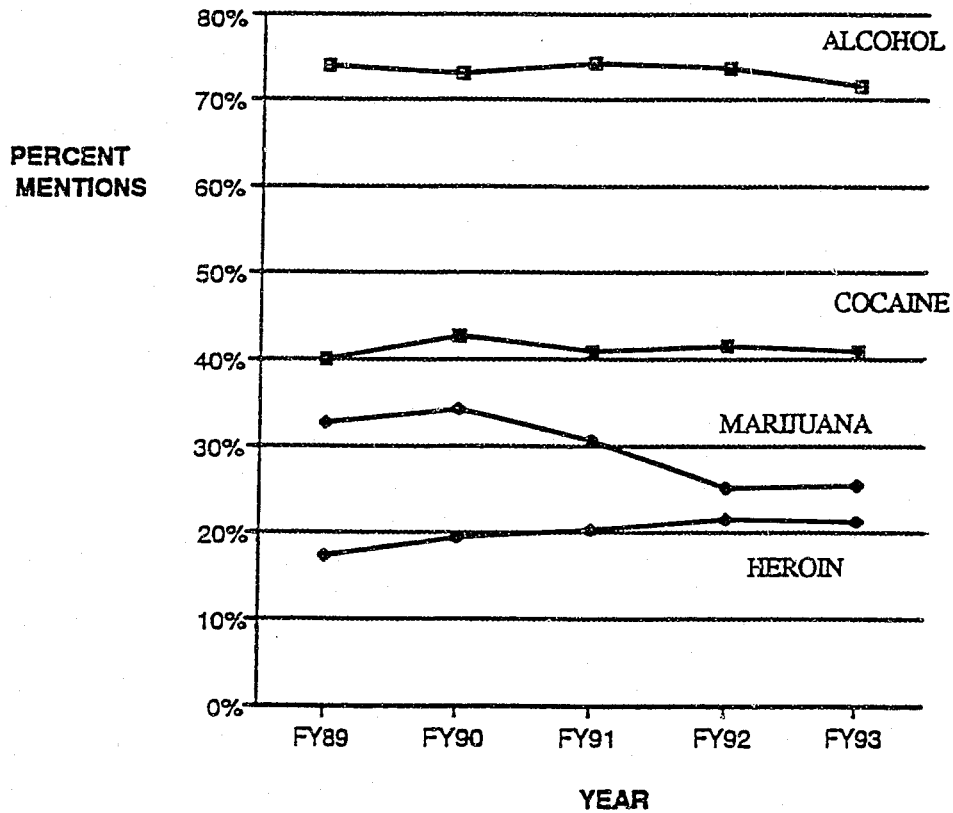
Number of Drug Abuse Arrests in Maryland
By Age, 1989 through 1992



SOURCE: Adapted by CESAR from data from the Uniform Crime Reports (UCR) Program, Maryland State Police (MSP).

Figure 4

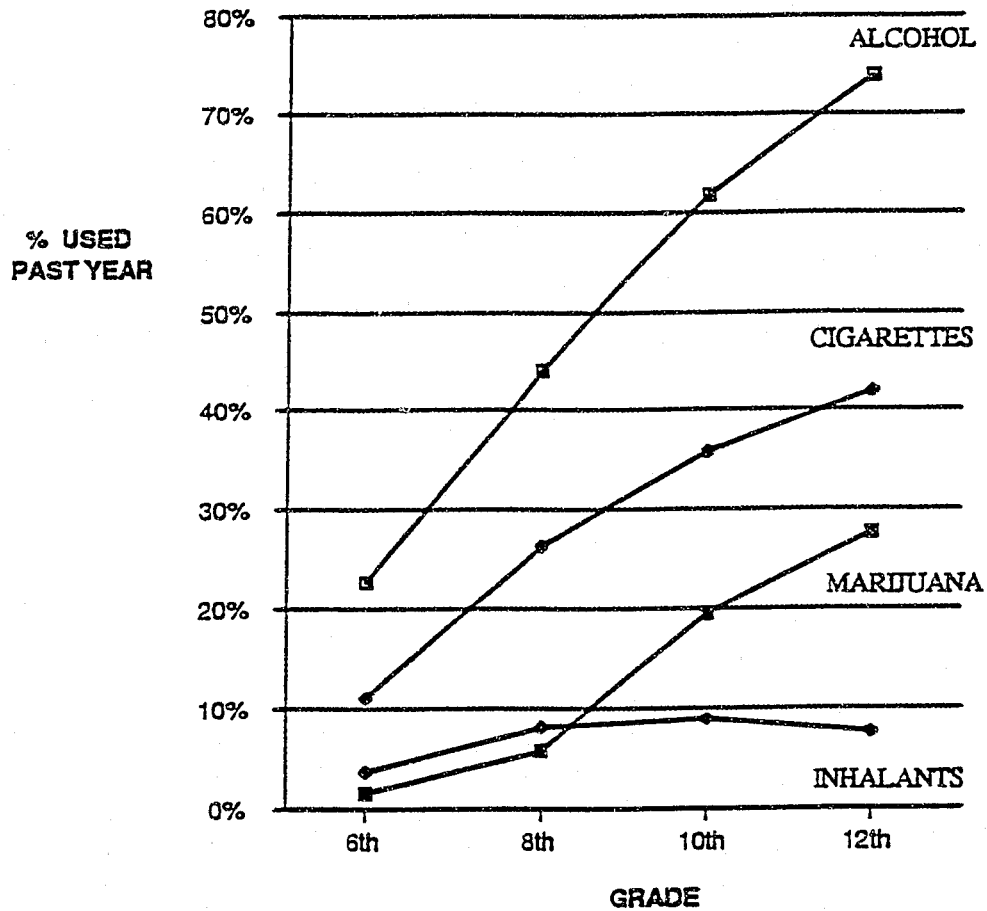
Percentage of Treatment Admissions Mentioning Alcohol, Cocaine, Marijuana, or Heroin as a Substance of Abuse, Fiscal Years 1989 through 1993



SOURCE: Adapted by CESAR from data from the Substance Abuse Management Information System (SAMIS), Maryland Alcohol and Drug Abuse Administration (ADAA).

Figure 5

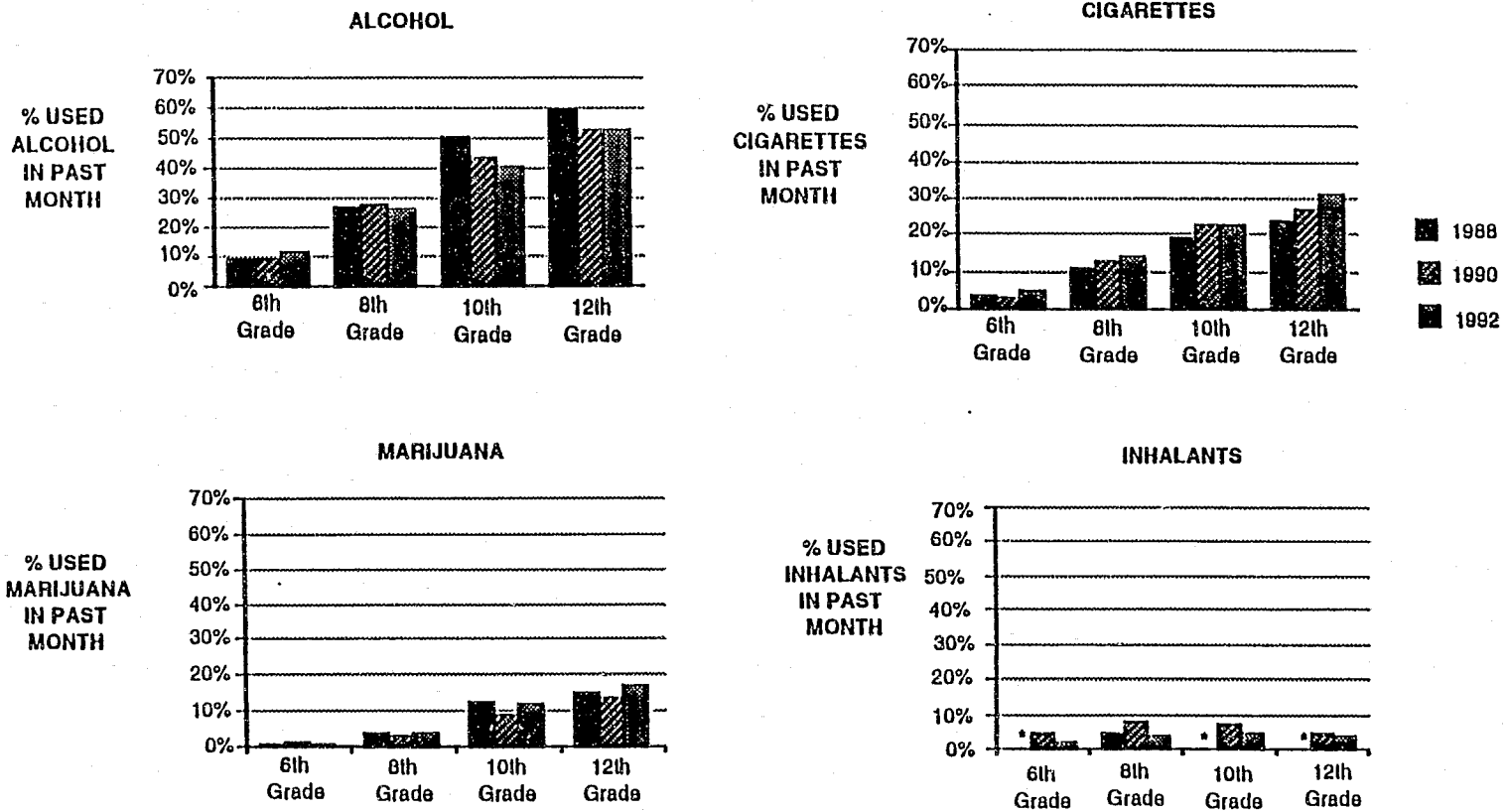
Percentage of Maryland Students Reporting
Past Year Use of Selected Substances, by Grade,
School Year 1992-93



SOURCE: Adapted by CESAR from data from the 1992 Maryland Adolescent Survey (MAS),
Maryland State Department of Education (MSDE).

Figure 6

Trends in Current Use*** of Alcohol, Cigarettes, Marijuana, and Inhalants
By Grade Level, School Years 1988-89 to 1992-93, Maryland



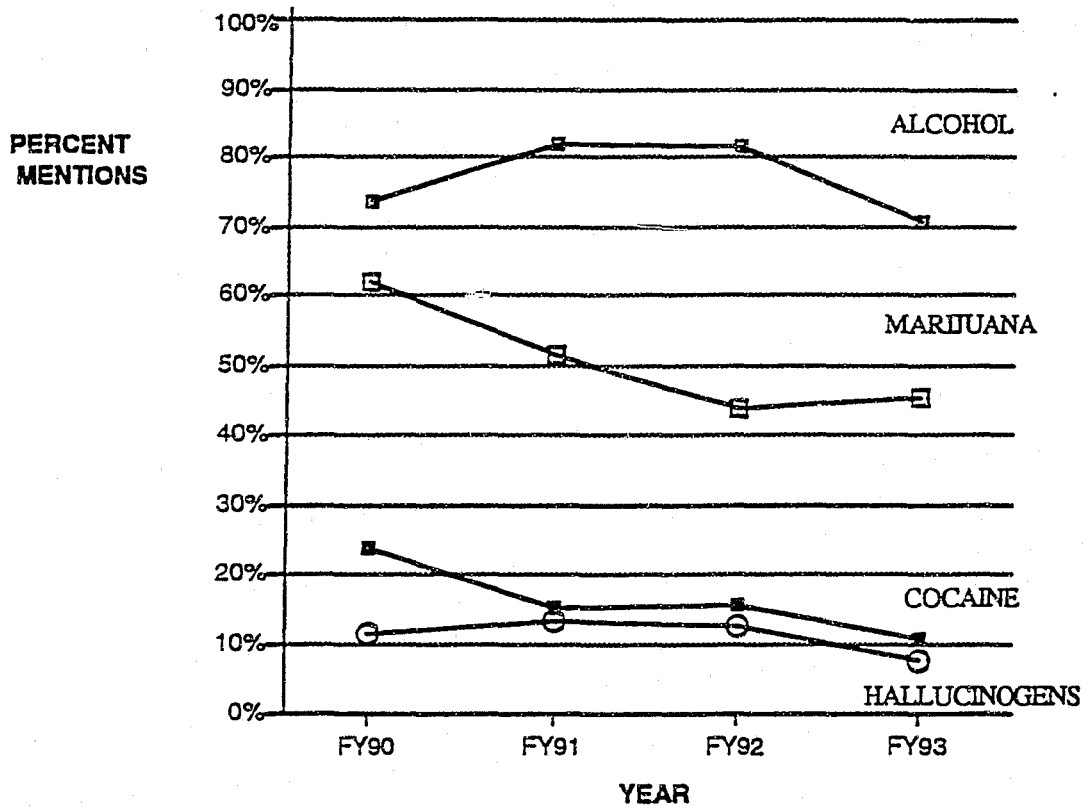
* Missing Data for 6th, 10th, and 12th grade inhalant use in school year 1988.

** Current use refers to use of substance in the 30 days prior to administration of the survey.

SOURCE: Adapted by CESAR from the 1992 Maryland Adolescent Survey (MAS), Maryland State Dept. of Education (MSDE).

Figure 7

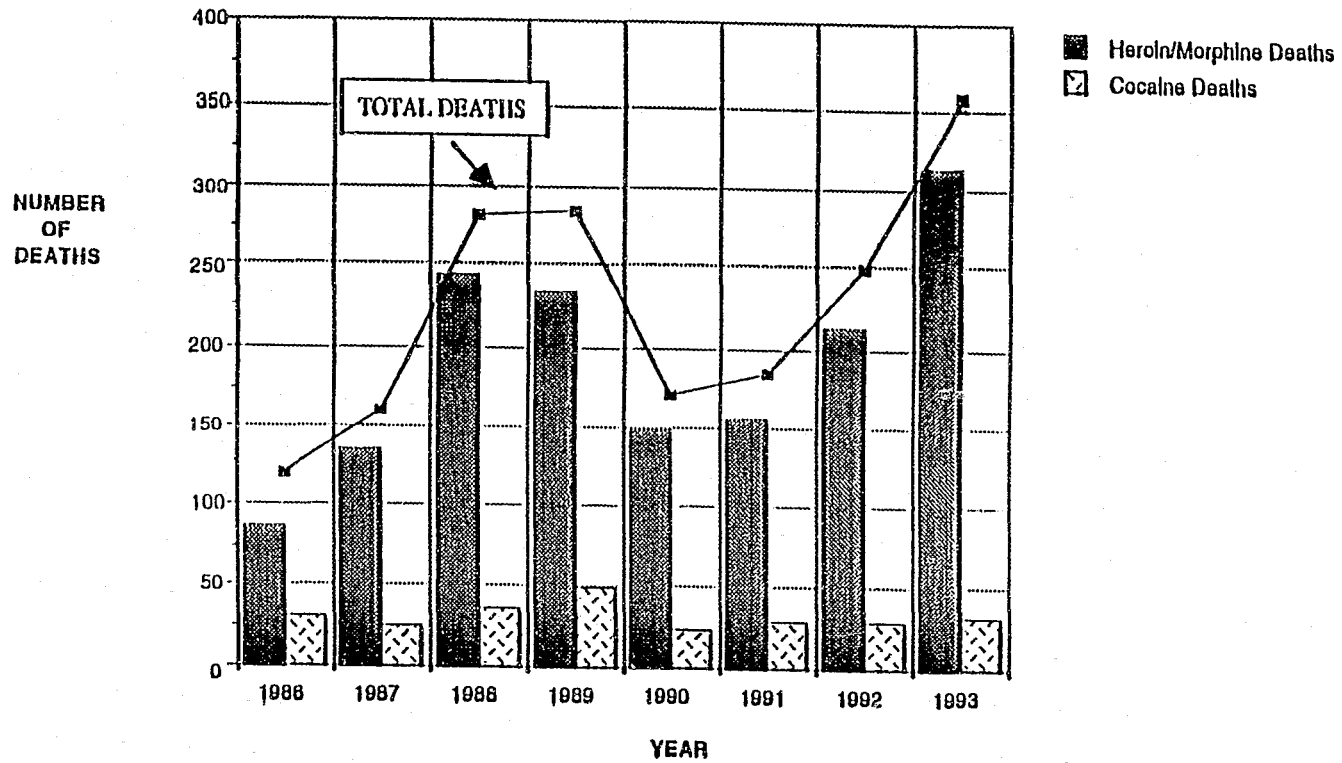
Percentage of Juvenile (Under Age 18) Treatment Admissions Mentioning Alcohol, Marijuana, Cocaine, or Hallucinogens as a Substance of Abuse, Fiscal Years 1990 through 1993



SOURCE: Adapted by CESAR from data from the Substance Abuse Management Information System (SAMIS), Maryland Alcohol and Drug Abuse Administration (ADAA).

Figure 8

Total Number of Drug Abuse Deaths and Number of Heroin/Morphine and Cocaine Deaths in Maryland, 1986 through 1993



SOURCE: Adapted by CESAR from data from the State of Maryland's Office of the Chief Medical Examiner (OCME).

Figure 9

Regional Map of Maryland

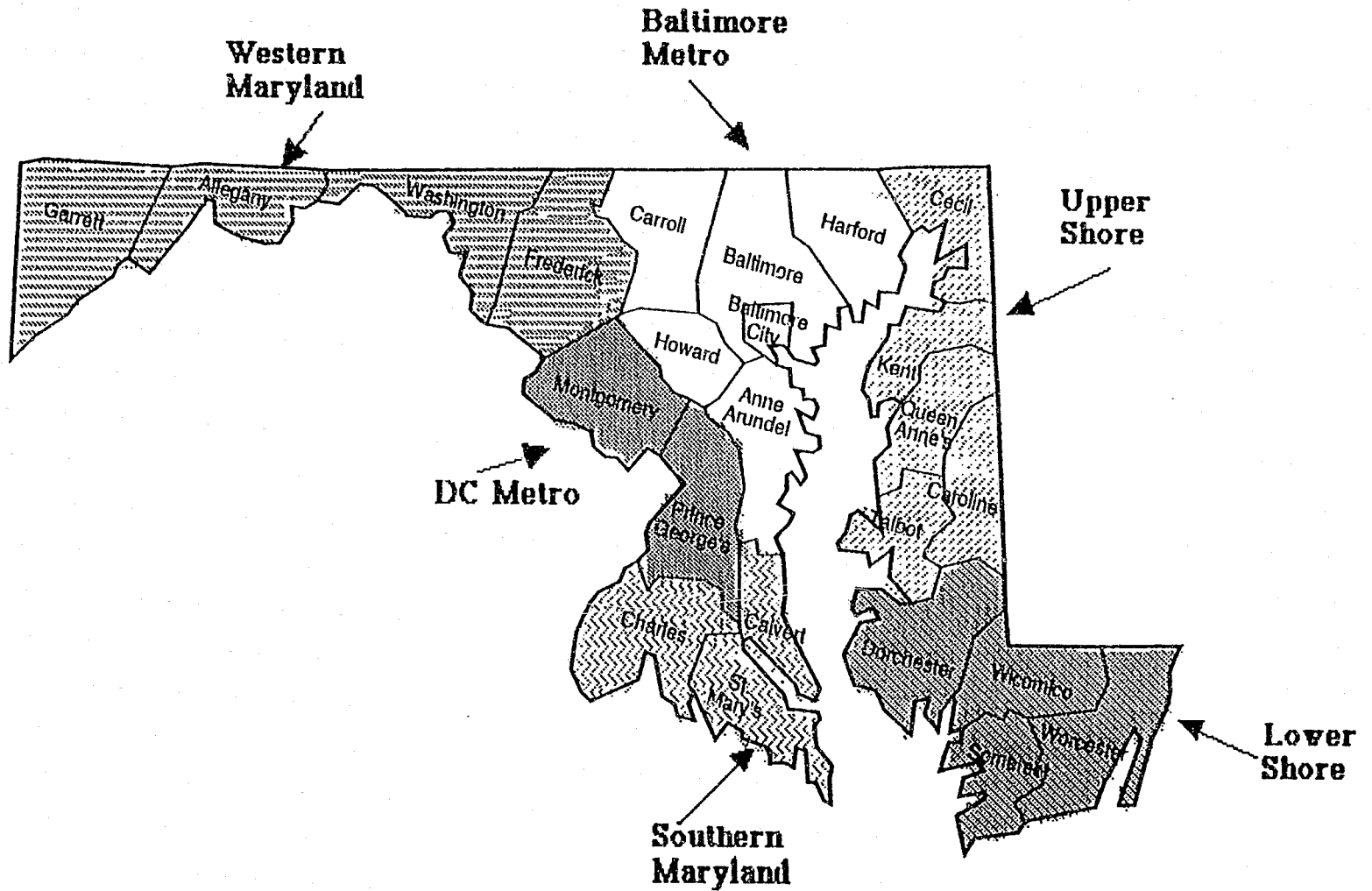
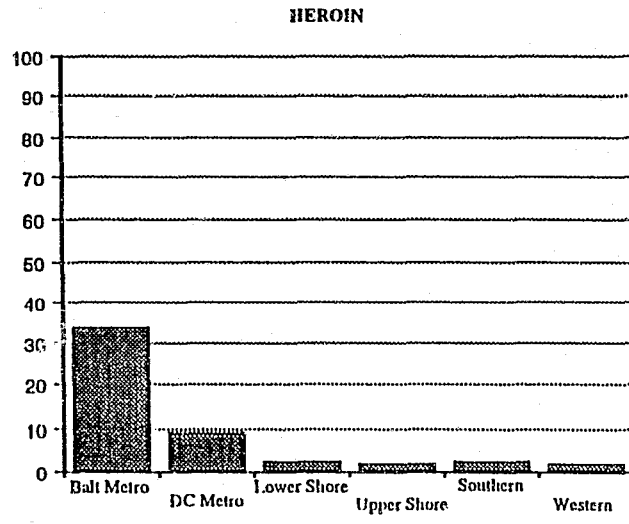
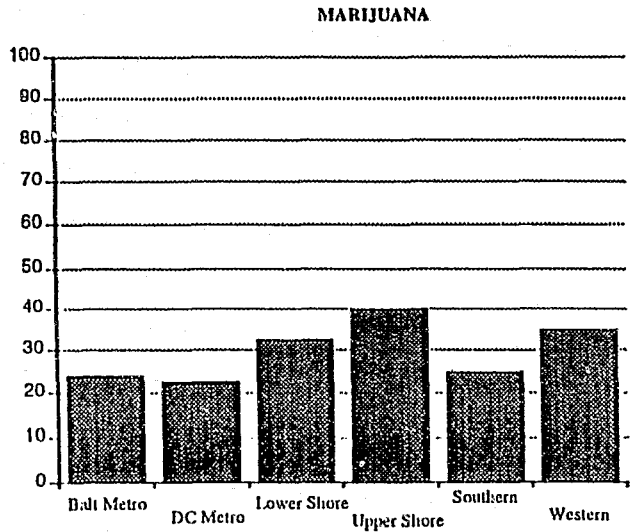
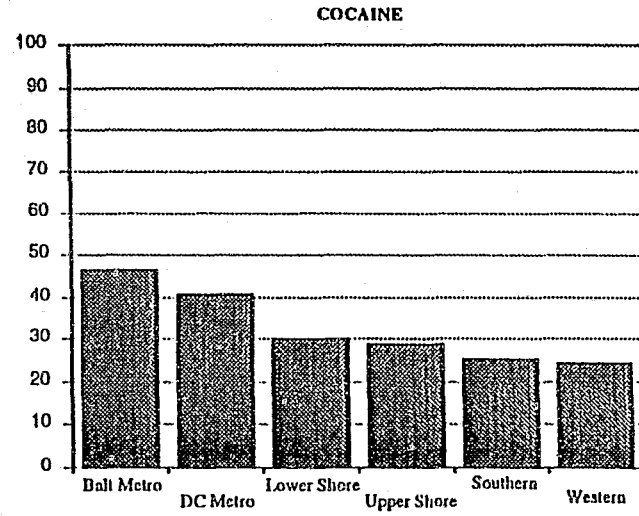
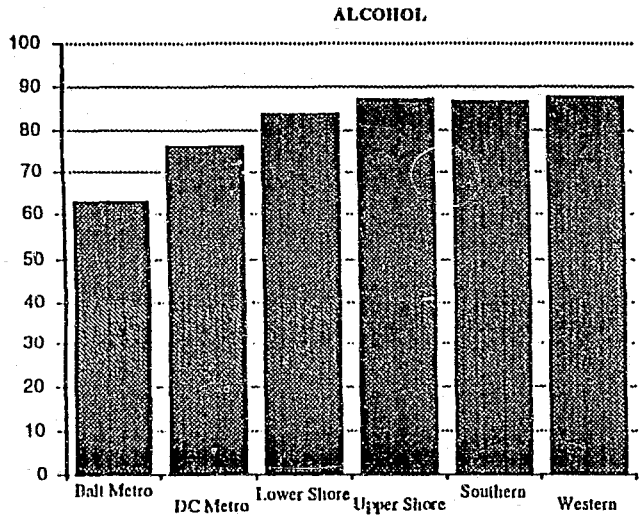


Figure 10

Percentage of Treatment Admissions Mentioning Alcohol, Cocaine, Marijuana, or Heroin As a Substance of Abuse, by Maryland Region, FY 1993

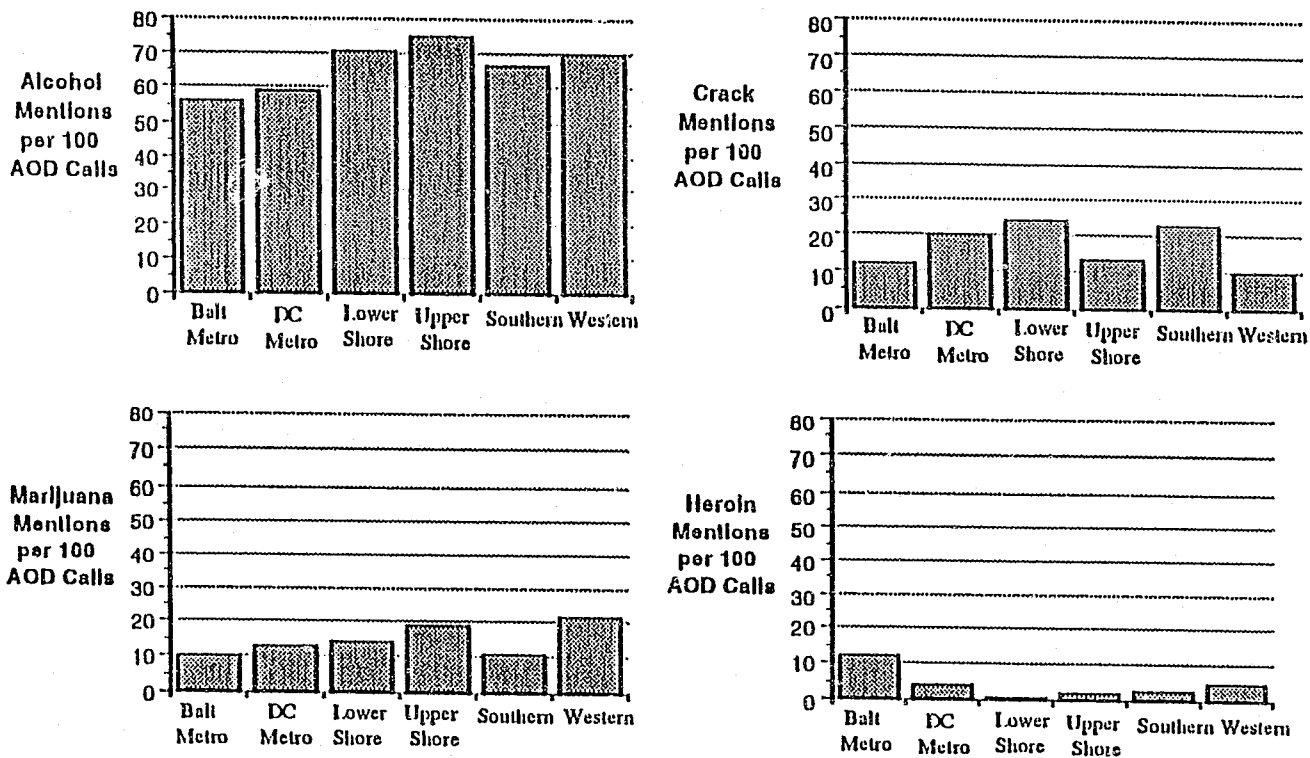
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SOURCE: Adapted by CBSAR from data from the Substance Abuse Management Information System (SAMIS), Maryland Alcohol and Drug Abuse Administration (ADAA).

Figure 11

Alcohol, Crack, Marijuana, and Heroin Mentions, by Maryland Region,** March 1993 through July 1993
(Rates per 100 AOD calls)



SOURCE: Elliot Levine, Michael Wagner, and Eric Wish, "The Maryland Automated Hotline Reporting System (MAHRS): Background and Early Findings." CESAR, University of Maryland at College Park.

Maryland Telephone Surveys Of Alcohol and Other Drug Abuse

**Ken Petronis
Center for Substance Abuse Research
University of Maryland at College Park**

Introduction

Maryland is one of many states that have been funded by the Center for Substance Abuse Treatment (CSAT) to conduct statewide treatment needs assessment studies. Through a subcontract from the Alcohol and Drug Abuse Administration, CESAR is conducting the CSAT needs assessment studies for the state of Maryland. One of these studies consists of two telephone surveys of alcohol and drug abuse among the general population. These surveys are described below.

Data Collection

Data collection for the first telephone survey was conducted by the Survey Research Center at the University of Maryland at College Park and was completed in February 1994.

In order to obtain a representative sample of Maryland residents, residential telephone numbers in the state were randomly selected and dialed. Only Maryland residents 18 years of age or older were interviewed.

Seventy-seven percent of the adults randomly selected to be interviewed completed an interview. This produced a total sample size of just over 2,500 adult residents of the state of Maryland. Within the statewide sample, three areas were oversampled in order to obtain representative samples of those areas--Baltimore City, Prince George's County, and Washington County--each of the oversamples contains about 650 respondents.

The second survey will begin at the end of 1994. It will use the same questionnaire as the first survey and will have approximately the same total sample size--about 2,500 residents. The combined surveys will cover approximately 5,000 Maryland residents.

Purpose of the Surveys

The surveys will provide information on the rate of drug use during the 12 months preceding each survey, similar to the National Household Survey on Drug Abuse conducted by the National Institute on Drug Abuse. However, the main purpose of the Maryland

telephone surveys is to estimate the need for treatment in the state as a whole and in the selected sub-state areas.

Need for Treatment Estimated by Percentage Diagnosed as Dependent

The need for treatment for abuse of a substance is determined by estimating the number of people who are dependent on that substance. The guiding principle here is that if someone is dependent on a substance, that person is considered to need treatment for that substance.

The Maryland surveys ask questions about use of alcohol, marijuana, hallucinogens, cocaine, and opiates. For each survey respondent, therefore, the survey questions can be used to determine if a diagnosable dependence exists on each of these substances.

How Dependence Is Diagnosed

To estimate the number of persons dependent on each substance, the survey questionnaire includes questions from the alcohol and drug dependence modules of the Diagnostic Interview Schedule, better known as the DIS. Only those respondents whose answers to a set of screening questions indicate a potential need for treatment are asked the DIS questions.

The DIS is a structured interview used to diagnose alcohol and drug dependence, as well as mental disorders. To permit diagnoses, the DIS operationalizes the nine criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) developed by the American Psychiatric Association.

For each of the following DSM-III-R criteria, the DIS asks multiple questions in order to determine if the subject has experienced symptoms related to any of the criteria:

DSM-III-R CRITERIA FOR DIAGNOSIS OF SUBSTANCE DEPENDENCE

- (1) Use larger amounts or for a longer period than intended.
- (2) Persistent desire for or unable to cut down on use.
- (3) Considerable time spent using or obtaining the substance.
- (4) Frequent intoxication or withdrawal symptoms when expected to fulfill major obligations at work, school, or home.

- (5) Reduced social, work, recreational activities due to use.
- (6) Continued use despite knowing a persistent social, psychological or physical problem has developed from use.
- (7) Tolerance--need more to achieve same effect.
- (8) Characteristic withdrawal symptoms.
- (9) Substance often taken to relieve withdrawal symptoms.

If a subject answers in a way that indicates he or she had symptoms related to three or more of the nine criteria during the preceding year, the subject is considered to have had a diagnosable dependence on the respective substance during that year, according to DSM-III-R criteria.

Making Statewide Estimates

Since the survey sample is representative of the state of Maryland, the percentage of the sample that is diagnosed as dependent on a substance will be considered the percentage of the Maryland population in need of treatment for that substance.

Because the first survey sampled the entire state and oversampled three areas, it will estimate need for treatment in the entire state and separately for Baltimore City, Prince George's County, and Washington County. The second survey will also estimate the need for treatment in the entire state and selected sub-state areas.

Persons Asked Diagnostic Questions

At this point in the data preparation, we do not know how many of the people interviewed qualify for a diagnosis of dependence on each of the substances. However, as shown on the next page, we do know how many of the people interviewed reported a level of use that qualified them to be asked the more intensive diagnostic questions.

Sample Subjects Asked Diagnostic Questions

(N = 2,553)

	<u>Number</u>	<u>Percent</u>
Alcohol	702	27.5
Marijuana	96	3.8
Cocaine	32	1.3
Hallucinogens	8	0.3
Opiates	11	0.4

(NOTE: These are NOT the number diagnosed as dependent.)

For example, in the state as a whole, 27.5 percent of the respondents used alcohol at a level high enough to be asked in-depth questions about their alcohol use. The responses to the in-depth questions will be used to determine what portion of the 27.5 percent were actually dependent on alcohol. The same explanation applies to each of the other drugs listed.

Note that the 27.5 percent figure represents the maximum percentage of the population that could possibly be diagnosed as dependent on alcohol. Previous national surveys have indicated that about 6.8 percent of the U.S. population is diagnosable as dependent on alcohol in a one-year period.

Conclusion

CESAR will soon begin analyzing the data from the first telephone survey. Actual one-year diagnostic rates of substance dependence will be presented at the November 1994 SEWG meeting.

**The Forthcoming Maryland State Department of Education
1994 Maryland Adolescent Survey:
Overview and Discussion**

**Gary Huang
Chou-lin Chen
Maryland State Department of Education**

The presentation provided an overview of the planning for the 1994 Maryland Adolescent Survey (MAS). The purpose of the MAS is to assess students' attitudes toward drug use and to estimate the prevalence of drug use among students in Maryland.

The tentative timetable for the 1994 MAS has been established. The pre-test is currently under way, and the survey questionnaire will be finalized in June 1994. Local coordinators will meet in September, and schools will be contacted regarding participation. The survey will be administered December 6, 1994. Results from the survey will be first reported at the statewide Drug Free School conference in May 1995.

The sampling plan for the 1994 survey differs from that for previous years. The population consists of students in grades 6, 8, 10, and 12 in all schools, except home and hospital schools, non-home vocational schools, and special education centers. Youths in juvenile detention centers and private schools are excluded, as well.

The sampling design calls for a stratified two-stage cluster sampling plan. The design is stratified by local education agency (LEA) and by grade. The first step is to sample schools. Then, sample classrooms will be chosen from the selected schools. All students present in the selected classrooms will be surveyed.

In the 1992 survey, the sample was designed to be representative of the student population at the state level. The sample was then apportioned to each LEA by size. However, the 1992 estimates by LEA were not designed to be representative of the LEA. In 1994, the sampling will be done at the LEA level, so that ideally the estimates will be representative.

Following the presentation, there was extensive discussion of ways to include additional youths, particularly those in juvenile detention centers, in the survey. Discussion also focused on the accuracy of estimates based on self-reported drug use and on whether high-risk students might be more inclined to intentionally miss school the day of the survey.

**A Comprehensive Program to Treat Drug Use During Pregnancy:
The Center for Addictions and Pregnancy**

**Michael Fuller
Division of Addictions
Prince George's County Health Department**

Prince George's County is opening a new program, the Center for Addictions and Pregnancy (CAP) to treat substance abuse during pregnancy. We began the CAP program after we observed that we received virtually no referrals from maternal health clinics. Yet we know that we have a problem with cocaine use among pregnant women and that we have a small percentage of PCP- or heroin-involved pregnant women in the county.

To a large degree, the program is modeled after the Key Hospital program in Baltimore City. Based on the experience at Key Hospital, we expect that reducing drug use among pregnant women will lead to significant savings on neonatal intensive care. At Key Hospital, neonatal intensive care for drug-affected infants costs between \$1,600 and \$1,700 per day. They are seeing significant savings with their program.

The CAP program is community based and located within the Health Department, which allows for close coordination of services. The program's mission is to provide comprehensive mental health, substance abuse, case management, and other public health and delivery services to women who use alcohol and/or other drugs during pregnancy; coordinate the provision of services under one roof; reduce costs associated with drug-affected newborns; and improve the lives of mother and babies.

The program is targeted to pregnant women who use alcohol and other drugs (cocaine, PCP, heroin) during their pregnancy, and it has three objectives:

- Reduce drug use during pregnancy and the subsequent need for neonatal intensive care;
- Begin a long-term recovery program for substance-abusing women; and
- Encourage family planning to prevent unplanned pregnancies.

Drug use during pregnancy is not a reportable disease, and so we do not know how many pregnant women in Prince George's County use drugs. However, we used a number of indicators to estimate need:

- The total number of deliveries to Prince George's County residents each year

is about 12,000. As many as 55 to 60 percent of deliveries to county residents occur outside the county--making tracking clients and their drug use difficult.

- As reported by the Rutgers Center of Alcohol Studies, Ira Chasnoff has estimated that nationally 10 to 15 percent of pregnant women use drugs during their pregnancies. Interestingly, he reported that private-pay patients had higher rates of drug use.
- Estimates of the number of pregnant women who walk into county hospital emergency departments each year having had no prenatal care have fluctuated. In the Prince George's County Medical Center, these numbers range from 300 to 500 per year. We estimate that the overwhelming majority of these women are also using alcohol and/or other drugs.
- Data provided by the Health Department's Maternal Care Clinics on the results of urine tests indicate that 11 percent of clients are using illicit drugs at their first contact with the clinics. Often, clients are in their second trimester at this time.
- The Infant-at-Risk program gets 1,200 referrals per year. Of these, 35 percent are referred for maternal drug use; another 35 percent are referred because they have had no prenatal care.
- Pediatric AIDs cases increased from 5 cases in 1992 to 25 cases in 1993. These numbers now appear to be leveling off.

CAP program services are provided by the Division of Addictions, other divisions within the Health Department, or paid providers. Services provided by Addictions include the following:

- Outreach and transportation. Because it is hard to reach out to this population and get them into services, we funded outreach positions.
- Psychiatric evaluation and treatment.
- Alcohol and other drug evaluation and treatment.
- Tobacco control initiatives. We are trying to discourage use of tobacco products. However, nicotine patches are not approved for this population.
- Nutrition and health.
- Parent effectiveness training.

- Assertiveness and self-esteem training.
- Evaluation and placement into educational and occupational programs.
- Orientation to Narcotics Anonymous, Cocaine Anonymous, and Alcohol Anonymous.
- Drug testing. For drug testing, we are working with CESAR to use hair testing. To safeguard the health of our obstetrics patients, we need to know what drugs they are using when they come in for treatment. Hair testing provides a 90-day window on drug use, compared with 2 or 3 days for urine testing. Although we would like to expand hair testing to other populations, the cost of the test is not yet competitive with urine testing. We also want to use hair testing at discharge, to determine how effective the program has been.
- Onsite preschool day care for dependent children.
- Substance abuse aftercare.

CAP services provided by other divisions within the Health Department include:

- Medical assistance eligibility.
- Women, infants, and children (WIC) services.
- Outreach and referral.
- Ambulatory obstetrics.
- TB, HIV, and STD services.
- Family planning.
- Mental health aftercare.

CAP program services provided through cooperative agreements include:

- Residential substance abuse treatment. We use the residential treatment program at admission. If clients relapse, we consider readmitting them to the residential program.
- Delivery and neonatal care.

- Ambulatory pediatrics.
- Food services.
- Medical and dental services.

How can other jurisdictions afford to set up programs such as this one? We suggest that the mental health and addictions services join forces. We licensed the CAP program under mental health outpatient and community rehabilitation services. We then bill medical assistance at \$84 and \$54, respectively, for a combined rate of \$138 per day. These billing levels are comparable to those for a partially reimbursed hospital-based program. We believe that we will be able to demonstrate the savings on neonatal intensive care costs.

For additional information, see:

Rutgers Center of Alcohol Studies. 1993. *Socioeconomic Evaluations of Addictions Treatment: Executive Summary*. Prepared for the President's Commission on Model State Drug Laws. New Brunswick, N.J.

**General Trends in Drug Use in Washington, D.C.
Spring 1994**

**Clare Mundell
Center for Substance Abuse Research
University of Maryland, College Park**

As a brief update to describe the general trends in drug use in Washington, D.C., I would like to underscore the following four points:

- Marijuana use, especially "blunts," is soaring.
- "Recreational" drug use is increasing among youths.
- PCP is making a comeback.
- High-purity heroin is appearing in the District.

Marijuana use among adolescents is soaring. Blunts appear to be the method of choice and are used by all ethnic groups. Shipments into the District of large cigars (including blunts) rose from 1.3 million in 1988 to 6.2 million in 1992. As shown in Figure 1, the percentage of juvenile arrestees testing positive for marijuana continues to climb, with a record high in March 1994 of 55 percent.

Marijuana use requires attention, because marijuana is a gateway drug: Frequent use of marijuana is associated with use of other drugs. The blunt form of marijuana use may also serve as a means of introducing use of other drugs: Blunts are sometimes dipped in PCP, or crack is inserted into the blunt.

The use of PCP also appears to be rising--as reflected by a number of indicators and qualitative information. Juvenile arrestees are more likely to test positive for PCP than are adult arrestees; this is a new pattern. Among juvenile arrestees the percentage testing positive for PCP dropped from 27 percent in 1987 to 9 percent in early 1989, to 1 percent in 1990 and 1991, and then rose to 3 percent in 1992, 10 percent in 1993, and 16 percent in March 1994 (Figure 2).

Heroin purity is increasing. In the District, purity at the 1/4-gram level rose from 7-11 percent in early 1990 to 15-22 percent in first quarter 1994. The kilogram purity has been rising since early 1990 and reached 80-98 percent pure in first quarter 1994. Qualitative data suggest that heroin is being snorted by adolescents and young adults.

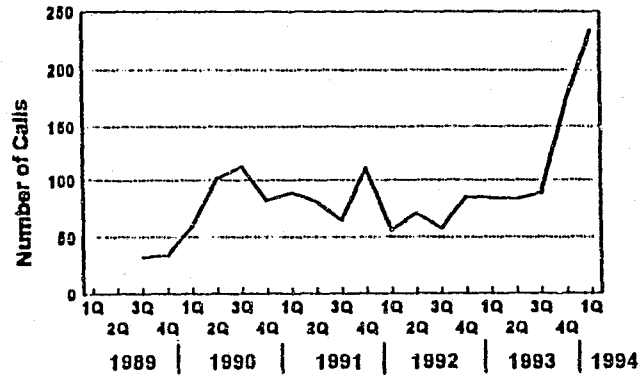
For additional information, see:

Clare E. Mundell, "Patterns and Trends in Drug Abuse in Washington, D.C.," forthcoming in National Institute on Drug Abuse, *Epidemiologic Trends in Drug Abuse*, proceedings of the June 1994 meeting of the Community Epidemiology Work Group. Rockville, Md.

Figure 1

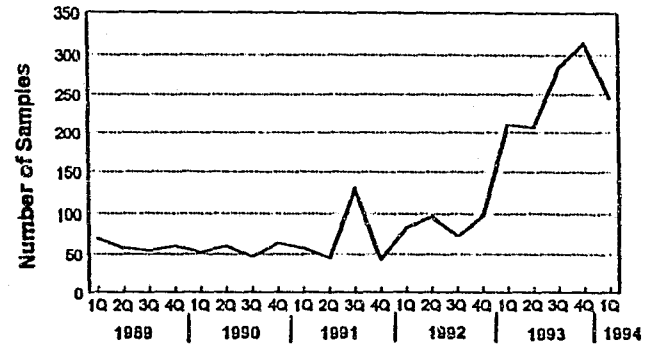
Trends in Selected Indicators of Marijuana Use in Washington, D.C.

Washington, D.C. Area Drug Abuse Hotline Calls for Marijuana



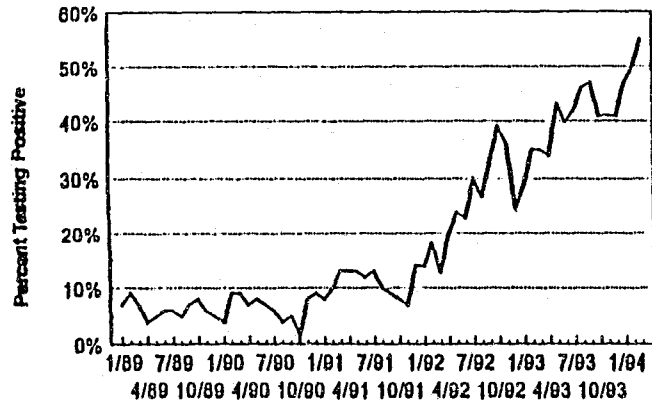
Source: Washington Area Council on Alcoholism and Drug Abuse.

Number of Removed Samples of Marijuana Submitted to DEA for Analysis Washington, D.C.



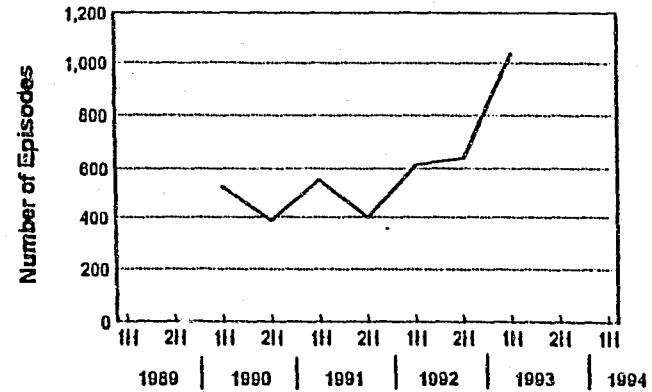
Source: DEA, Planning and Statistical Analysis.

Juvenile Arrestee Drug Test Results, Marijuana Washington, D.C.



Source: D.C. Pretrial Services Agency.

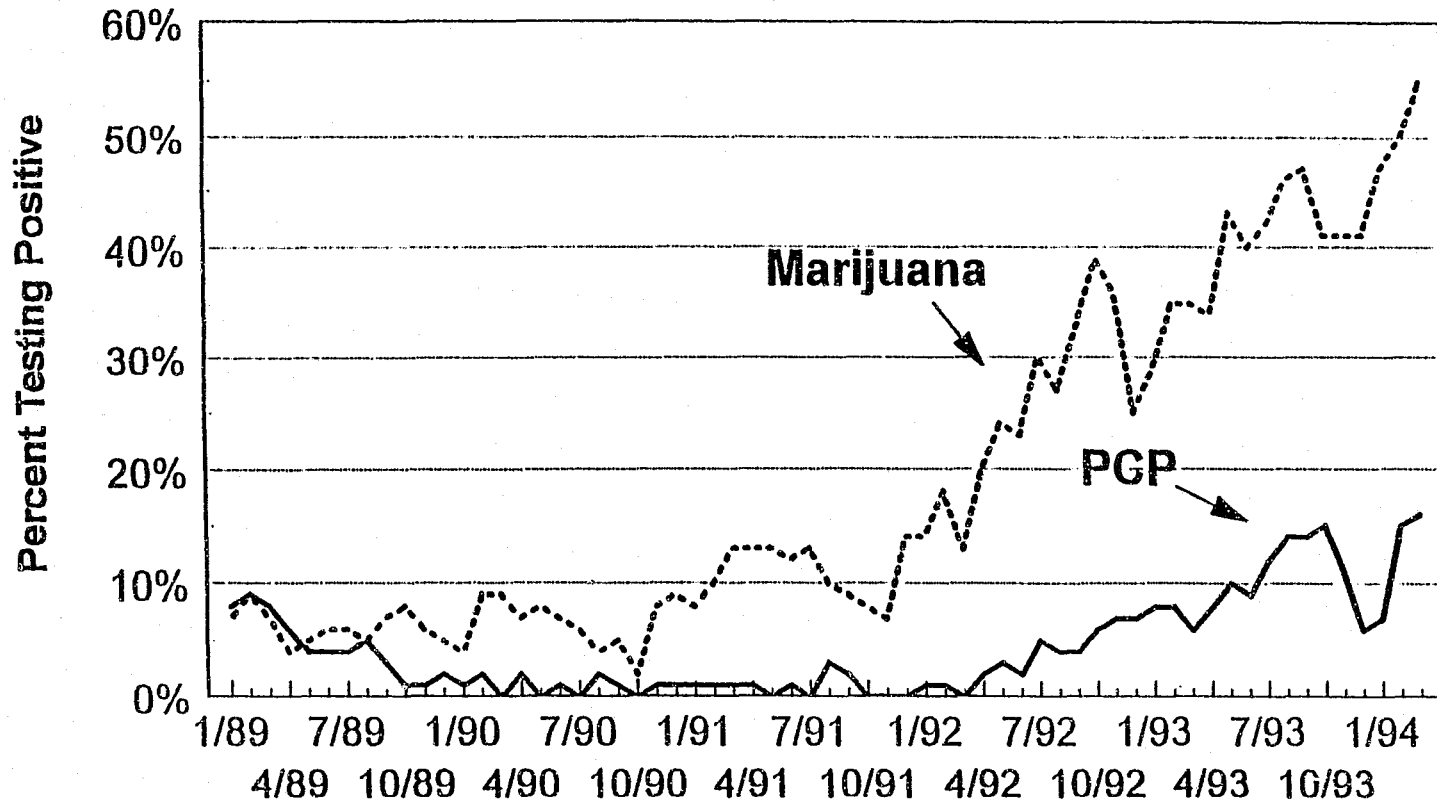
Emergency Room Marijuana-Related Episodes Washington, D.C. Metropolitan Area



Source: Drug Abuse Warning Network, October 1993 data files.

Figure 2

Juvenile Arrestee Drug Test Results,
Marijuana and PCP
Washington, D.C.



Source: D.C. Pretrial Services Agency.

The Washington, D.C. Metropolitan Area Drug Study: Methodology and Preliminary Findings

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National Institute on Drug Abuse

Introduction

The National Institute on Drug Abuse (NIDA) began the Washington, D.C. Metropolitan Area Drug Study (DC*MADS) in 1989 in response to the 1988 Anti-Drug Abuse Act, which recognized the need to supplement the National Household Survey on Drug Abuse (NHSDA) with information on underrepresented populations. The DC*MADS project was designed to examine drug abuse among population subgroups residing in a single Metropolitan Statistical Area (MSA) during the same period in time. The main objectives of DC*MADS are to:

- Estimate the prevalence, correlates, and consequences of drug abuse among the diverse populations residing in the metropolitan area, and
- Develop a methodological model for similar data collection about drug abuse in other major metropolitan areas.

DC*MADS consists of numerous individual studies that focus either on population subgroups (e.g., homeless people, institutionalized individuals) that are underrepresented or unrepresented in traditional surveys or on different aspects of the drug abuse problem (e.g., adverse consequences of drug abuse). (A list of the study reports currently available is included at the end of this section.) Interviewers administered questionnaires designed to be similar to those used in the NHSDA. Respondents were asked about their sociodemographic characteristics, drug abuse, alcohol use, psychological and physiological health, income and health insurance, and drug treatment and criminal histories. Respondents were given a \$10 incentive payment at the end of the interview (sometimes food coupons were given), and they were assured that the interviews were confidential.

As shown in Figure 1, the D.C. MSA covers a large multijurisdictional region. It is very diverse and includes urban, suburban, and semirural areas.

Homeless and Transient Population Study

This report (Technical Report #2) examines the prevalence of illicit drug use and related problems among members of the homeless and transient population, aged 12 and older. Questions were asked about alcohol use, criminal activity, physical health, mental health, employment, receipt of services, and entitlement participation among homeless people.

In-person interviews were conducted anonymously with 908 people chosen from four overlapping sampling frames: 477 residents in 93 shelters; 224 patrons of 31 soup kitchens and food banks; 143 literally homeless people from 18 major clusters of encampments; and 64 literally homeless people from an area probability sample of 432 census blocks in the MSA. The response rate for shelters and soup kitchens was 83 percent. The response rate across the four frames was 86 percent.

The sampling plan was designed to provide unbiased estimates for an "average" day in the D.C. MSA from February through June 1991. From 9,031 to 11,743 people are homeless or transient in the D.C. MSA on an average day. Homeless and transient people in the D.C. MSA tend to be male, over 26 years of age, black, single, located in D.C. (rather than Virginia or Maryland), unemployed, and not high school graduates.

Primary findings of the study include the following:

- An estimated 97 percent of the homeless population fell into one or more of the special groups identified in the Stewart B. McKinney Homeless Assistance Act of 1987: Seventy percent had experienced one or more major illnesses; 54 percent were currently unemployed; 34 percent had problems with drug use; 28 percent were heavy alcohol users; 28 percent had histories of mental treatment; 23 percent were the head of a family; 22 percent were veterans; and 5 percent were youths. About 58 percent had one or more problems with alcohol, drug use, or mental illness.
- Rates of any illicit drug use among homeless people were 80 percent over their lifetime, 58 percent in the past year, and 34 percent in the past month. These rates were influenced most by cocaine and then by marijuana. The rates of cocaine use were 65 percent in their lifetime, 48 in the past year, and 28 in the past month.
- Rates of alcohol use among this population were 93 percent in their lifetime, 86 percent in the past year, and 70 percent in the past month. Twenty-eight percent of the homeless drank heavily (five or more drinks on five or more days in the prior month) while homeless during the prior month.

- Adding homeless people to the NHSDA population of past year injection drug users in the D.C. MSA would increase the latter from 0.2 percent to 0.25 percent of the total population. This difference does not change prevalence estimates noticeably, but it results in a 25 percent increase in the population estimates used by providers to estimate the number of people in need of treatment. While the addition of injection drug users (1,402 in the past year) is small relative to the total household population (3,174,498 people in the MSA), it is large relative to the size of the treatment population.
- More than 70 percent of the homeless people had at least one major medical problem in the past year, and 7 percent had four or more. Twelve percent (20 percent of current drug users) reported having been diagnosed with one or more drug-related illnesses such as the acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), tuberculosis, or hepatitis.
- Twenty-five percent of the homeless population had visited a hospital and 37 percent an emergency room in the past year, but only 36 percent had any public or private health insurance.

Institutionalized Population Study

This report (Technical Report #4) examines the prevalence of substance abuse and related problems among residents of institutions and group homes. Questions were asked about alcohol and illicit drug use, mental and physical health problems, illegal activity, and drug treatment experiences.

In-person interviews were conducted anonymously with 1,203 randomly selected residents of 42 institutions, drawn from four groups: 868 in 20 correctional institutions; 207 in 6 psychiatric institutions; 55 in 7 noncorrectional institutions for juveniles (e.g., homes for abused youths, training schools); and 73 individuals from 9 group homes in the D.C. MSA. The study excluded nursing homes, military installations, religious quarters such as monasteries and convents, homes for the developmentally disabled, and homes for the deaf. The overall response rate was 78 percent, with an institution-level response rate of 88 percent and an individual response rate of 89 percent among those eligible.

Some of the key findings are the following:

- Rates of any illicit drug use among the institutionalized population were 84 percent in the lifetime, 50 percent in the past year, and 8 percent in the past month. The relatively low rates of past month illicit drug and alcohol (15

percent) use largely reflect the fact that the respondents were in institutions part of this time and lacked easy access to these substances.

- Marijuana had the highest lifetime prevalence (81 percent). Crack cocaine and other cocaine had the highest past year (30 and 20 percent, respectively) and past month prevalences (crack cocaine, 4 percent; other cocaine, 1 percent).
- Rates of alcohol use were 93 percent during the lifetime, 67 percent during the past year, and 15 percent during the past month.
- Rates of cigarette smoking were 86 percent in the lifetime, 75 percent in the past year, and 66 percent in the past month.
- Illicit drugs were used by 9 percent of residents during their current institutionalization. Marijuana (6 percent), crack cocaine (2 percent), and other forms of cocaine (2 percent) were the drugs most likely to be used during confinement. Alcohol was used by 12 percent of residents while institutionalized.
- Many residents used multiple substances, including alcohol, before their current institutionalization. A drug use typology was created to help summarize these relatively complex patterns prior to institutionalization. The typology identified five groups: Non-Users (17 percent), Alcohol Only Users (28 percent), Sporadic Users (28 percent), Crack/Alcohol Users (18 percent), and Heroin/Polydrug Users (9 percent). These groups were used to characterize the severity of drug-related health problems, psychological problems, social problems, and treatment needs.
- Overall, 23 percent of residents used a needle to inject drugs at some time during their lives. Lifetime use of needles was reported by 73 percent of Heroin/Polydrug Users, 27 percent of Crack/Alcohol Users, and 26 percent of Sporadic Users.
- During the past year, 50 percent of residents had at least one major medical problem and 12 percent had three or more. For drug-related illnesses, 8 percent reported that they had a sexually transmitted disease during the past year, and 1 percent reported having been diagnosed as having AIDS, AIDS-related complex (ARC), or human immunodeficiency virus (HIV) infection.

Household and Nonhousehold Populations Study

This study (Technical Report #8) estimates the prevalence of illicit drug, alcohol, and tobacco use among members of household and nonhousehold populations. It aggregates data from the household and nonhousehold populations and compares the aggregated data on the prevalence of drug use and number of users with prevalence estimates from the household survey alone. The study examines whether adding the nonhousehold population permits detailed demographic analyses to be conducted on specific drug-using behaviors (e.g., crack cocaine, heroin, and needle use). Finally, it identifies methodological issues that arise when data from household and nonhousehold populations are combined and analyzed.

Household population data, collected as part of the D.C. MSA oversample for the 1991 NHSDA, consisted of interviews with 2,547 residents from a sample of 5,399 households and selected group quarters (e.g., college dormitories). Nonhousehold population data were drawn from the 1991 DC*MADS Homeless and Transient Population study (908 interviews) and the 1991 DC*MADS Institutionalized study (1,203 interviews).

Data were combined from the household, institutionalized, and homeless populations to produce an aggregate population for the D.C. MSA based on interviews with 4,658 individuals. Aggregate data were adjusted for potential sampling overlap across the surveys. For the household studies, the household/institutional response rate was 94 percent; the individual interview response rate was 82 percent.

Primary findings include the following:

- The demographic characteristics of the household population differed markedly from those of the homeless and institutionalized populations. An estimated 48 percent of the D.C. MSA household population were male; 62 percent were white; 27 percent, black; and 5 percent, Hispanic. Only 13 percent had not completed high school. The homeless and institutionalized populations tended to be male (76 and 91 percent, respectively) and black (76 and 69 percent). Forty percent of homeless and transient adults, and 65 percent of the institutionalized, had not completed high school.
- Illicit drug use was more prevalent in the homeless and transient and institutionalized populations than in the household population. Variability in racial and other demographic attributes among the subpopulations is common, which suggests a need to control statistically for those factors when comparing results from the different DC*MADS samples.
- Combining data from the household and nonhousehold surveys had only a small effect on the overall estimates of prevalence of drug use based on the household survey alone. Past year use of any illicit drug increased by only

0.3 percent, from 11.7 percent in the household survey to 12.0 in the aggregate.

- However, when the different data sources are combined, estimates of the number of users of specific drugs noticeably increase. The estimate of the number of crack users went up 32 percent (representing 9,000 more users); heroin users, up 26 percent (3,200 more users); and needle users, up 46 percent (3,000 more users).
- Estimates from the aggregate population suggest that over 50,000 people in the D.C. MSA used crack cocaine, heroin, or needles in the year prior to the survey. In these aggregated data, an estimated 15,549 people reported using heroin, but roughly half of those users--8,740 people--reported using needles. Other users may have smoked or snorted heroin.
- In the household population, rates of illicit drug use were 40 percent in the lifetime, 12 percent in the past year, and 6 percent in the past month. Marijuana was the most commonly used drug: It was used by 36 percent in the lifetime, 8 in the past year, and 4 in the past month.
- Among those in the D.C. MSA household population, 2 percent reported using crack cocaine--0.9 percent during the past year and 0.3 percent during the past month. Crack cocaine use in the past month was higher among D.C. residents (1.2 percent) than among Maryland (0.2 percent) or Virginia residents (0.1 percent).
- Reported rates of alcohol use in the household population were 85 percent in the lifetime, 74 percent in the past year, and 56 percent in the past month. An estimated 4 percent drank heavily in the past month.

Drug Use and Pregnancy Study

This study (forthcoming) examines the prevalence and correlates of drug use among women delivering in D.C. area hospitals. Three sources of data were used: self-report data from the study questionnaire; abstracted medical records of the women who gave informed consent; and a separate and independent screening of urine tests for women admitted to the same hospitals during the same period of time. Although the respondents in the drug study may have been included among those who gave urine samples, there was no direct link.

Eight out of nine D.C. area hospitals participated in the study. The sample consisted of 772 D.C. residents. The mothers of low-birth weight (LBW) babies were oversampled. Thirty percent of the women had LBW babies compared with 15 percent of D.C. residents generally. The study undersampled women with very LBW babies. Two

percent of the women had very LBW babies, while 4 percent of D.C. women did. Thirty percent of the infants born to women in the study were born preterm.

Of those included in the sample, 90 percent were black and 45 percent were between ages 18 and 25. Twenty-one percent were married; 36 percent had less than a high school education. Seventy-five percent used some form of public payment for their hospitalization, compared with 20-30 percent for D.C. residents generally. It was difficult to access privately insured patients: Two hospitals declined to permit interviews.

Findings on drug use include the following:

- Licit drugs were more widely used than illicit drugs. Tobacco was the most prevalent licit drug; 26 percent reported that they used it less than weekly, and 4 percent reported more than weekly use. Fifteen percent reported using alcohol less than weekly, and 7 percent reported using it more often.
- Crack cocaine was the most prevalent illicit drug. Six percent reported using it less than weekly, and 7 percent reported using it more often. Fourteen percent reported using crack during the past month. Thirteen percent of the independent urine screens--reflecting drug use over the past two or three days--were positive for cocaine.
- Marijuana was used by 4 percent less than weekly, and 2 percent used it more often.
- Heroin was used by 0.3 percent less than weekly, and by 1 percent more often.

Current Treatment Clients Study

This study (Technical Report #5) examines the prevalence of illicit drug use and related problems among a population aged 18 and older who entered drug treatment in the D.C. MSA in the spring and summer of 1991. Drug abusers entering treatment are a minority of all substance abusers; they generally have more severe drug use and associated problems. Studying those entering drug treatment provides information on the patterns and context of drug use, the consequences and correlates of heavy drug use, and the social, psychological, and medical needs of a known drug-abusing population. This study provides information on alcohol and cigarette use, criminal activity, physical health, mental health, employment, problems attributed to drug and alcohol use, previous experience with treatment, and accessibility to treatment for the current episode.

In-person interviews were conducted anonymously with 640 clients entering 28 long-term residential, short-term residential, methadone, and outpatient drug-free treatment

programs in the D.C. MSA. Findings are based on 507 interviews with clients in residential and methadone programs. Outpatient drug-free clients, who constitute the largest segment of the treatment population, had such a low response rate (21 percent) that they were omitted from the results.

Some of the key findings include the following:

- Those entering treatment differed from the D.C. MSA household population on many demographic characteristics: They were more likely to be male, members of racial or ethnic minorities, have a high school education or less, and not be employed full-time.
- The three treatment modalities served different types of clients. Clients differed on demographic characteristics, treatment history, drug use problems, criminal activity, employment, and physical and mental health problems. Those employed full-time were more likely than others to use marijuana or to be heavy alcohol users. Blacks were more likely to be current users of crack cocaine, and whites were more likely to be heavy drinkers.
- Most clients from each modality had been in treatment before. Methadone clients had the largest number of previous episodes: 43 percent had been in treatment at least three previous times compared with 29 percent of long-term and 16 percent of short-term residential clients.
- Drug treatment clients had used a wide range of illicit drugs during their lifetime, and different patterns of use were observed across the three modalities. During the past year, long-term residential clients were most likely to have used cocaine (87 percent), with crack use (80 percent) much more common than use of other forms of cocaine (49 percent). Cocaine use was less frequent among short-term residential clients (60 percent), but was still the most commonly used drug within this modality. Heroin was the most frequently used drug among methadone clients (97 percent), but a significant proportion (84 percent) also used cocaine.
- Heavy alcohol use within the past month was reported as a major problem by drug treatment clients, ranging from 17 percent of methadone clients to 44 percent of short-term residential clients. Among those from long- and short-term residential programs who had previously been in treatment, the majority were treated for either alcohol problems alone or in combination with other drugs.
- Needle use was widespread among methadone treatment clients--86 percent of those entering this modality reported injecting behavior in the previous

year. Among long- and short-term residential clients, the percentages using needles were 16 and 17 percent, respectively.

- Among methadone clients, 6 percent had illnesses related to HIV and 2 percent to tuberculosis.
- Relatively small sample sizes limited reportable findings. However, drug use during pregnancy was a problem for women entering treatment.

Adult Offenders Study

This study was in progress at the time of meeting. It is investigating the prevalence of drug use among adult felony offenders. Eventually, this study will be combined with the juvenile offenders study (see below).

The population to be sampled consisted of 1,285 felony offenders who appeared before 11 district courts within a two-month period in 1991. Incarcerated adult offenders, as well as those on probation or parole, were sampled. The final sample for the study consisted of 351 adult offenders, for an overall response rate of 59 percent. Among the incarcerated population, the response rate was 83 percent. However, only 47 percent of those on probation or parole who were selected for interview actually responded; this rate is indicative of the elusive nature of this population.

No findings are yet available from this study.

Juvenile Offenders Study

This study is investigating the prevalence of drug use among juvenile offenders. As noted, eventually this study will be combined with the adult offenders study.

Originally, this study was to have been based on the identification and contacting of juveniles from court records. However, after first agreeing to the study, one jurisdiction later decided not to participate due to concerns about the confidentiality of juvenile court records. The study was then redesigned to include interviews with juveniles in maximum security juvenile correctional facilities. From a census of 355 eligible youths, 261 were interviewed. The overall response rate was 74 percent, with 86 percent response rates in D.C. and Maryland and a 49 percent response rate in Virginia. In Virginia, parental consent was necessary before youths could be interviewed; many parents were not available or could not be found.

Findings from this study are not yet available.

School Dropout Study

This study (forthcoming) was intended to estimate the prevalence and correlates of drug use among school dropouts. However, the study was methodologically complex. The final report will emphasize these issues and attempt to summarize the lessons learned. In brief, it is very difficult to conduct a study of this complexity across jurisdictions without a unifying mandate.

The study design required examining high school enrollment records for consecutive years to identify potential dropouts. Once a list of potential dropouts had been identified, each individual was to be contacted to determine whether he or she actually had dropped out. Six out of 11 school districts agreed to participate. Two of the five were major school systems in the MSA, so the study data would have been less than representative even from the beginning.

Each school wanted to negotiate different study methods. For example, one school wanted only school personnel to contact potential dropouts. Another wanted letters sent to parents to obtain their signed informed consent.

Response rates varied across jurisdictions. In terms of simply locating the dropouts, response rates ranged from 28 to 68 percent. Once the dropouts were found, the response rates for interviews were 70 to 86 percent. However, the overall response rate was 59 percent and the sample of 326 dropouts is not fully representative.

Findings are limited--and will emphasize the methodological lessons learned.

Opinion Leaders Study

The opinion leaders study (Technical Report #3) assesses and compares the views of opinion leaders in the D.C. MSA about the drug abuse problem in their jurisdiction. Opinion leaders were defined as those who influence policy decisions and who, directly or indirectly, address the drug abuse problem. The study objectives were to:

- Describe opinions and perceptions about drug abuse among individuals representing a range of professions and areas of expertise in the D.C. MSA in 1991; and
- Develop a methodology for similar types of research among opinion leaders in other metropolitan areas of the country.

Respondents were asked about the nature and extent of drug abuse and drug-related problems (including drug trafficking) in the D.C. metropolitan area, effective prevention and intervention strategies, barriers and solutions for implementing prevention and intervention

practices, and needs for additional anti-drug abuse efforts. Respondents were also asked about the sources they used in forming their opinions, as well as their assessments of the quality of information currently available about drug abuse.

The sample was selected using nonprobability, purposive techniques rather than probability-based procedures because of difficulties in defining and identifying the population of opinion leaders and because of budget limitations. Respondents were selected based on their type of responsibility (e.g., political decision makers and drug abuse experts), substantive area (education, criminal justice, public health, and government--elected local officials), and jurisdiction (D.C., Maryland, and Virginia). Respondents were surveyed by telephone after being contacted by mail and telephone and asked to participate. Of the targeted sample size, 81 percent participated, resulting in a final sample of 162 opinion leaders.

Key findings include the following:

- The respondents agreed on the severity of the drug abuse problem in the metropolitan area: Nearly all (91 percent) thought the problem in their jurisdiction was at least somewhat severe. Most agreed that the drug problem had not improved in the past year (i.e., since 1990). Only 15 percent thought that there had been a decrease in drug use during that time.
- The two drugs (including both licit and illicit drugs) mentioned most often as causing a severe problem were alcohol (78 percent) and crack cocaine (54 percent).
- The family was mentioned repeatedly. Nearly all (91 percent) mentioned the influence of families and friends as a deterrent to initiation of drug use, and 76 percent reported that family and friends were influential in urging users to stop using drugs. Similarly, strengthening the family and improving the living environment were the most frequently mentioned effective drug abuse prevention strategies (42 percent). Many respondents (43 percent) thought families should be doing more to reduce drug abuse, even though 83 percent of the respondents reported that families were involved in efforts to reduce drug abuse.
- A high proportion of leaders (90 percent) agreed that the resources to address the drug abuse problem were insufficient: Lack of resources was most often mentioned as a barrier to drug abuse prevention and intervention efforts (both 71 percent).
- Differences were found between respondents representing D.C. and those from jurisdictions in Maryland and Virginia: D.C. respondents (93 percent) were more likely than their counterparts in Maryland (27 percent) or Virginia

(12 percent) to view the drug problem as very severe. They were likelier to identify crack cocaine (74 percent) and heroin (56 percent) as the drugs causing a severe problem than were Maryland respondents (50 percent crack cocaine and 10 percent heroin) or Virginia respondents (48 percent crack cocaine and 7 percent heroin). Maryland (81 percent) and Virginia (84 percent) respondents were more likely than D.C. respondents (63 percent) to mention alcohol as the major cause of the problem.

- D.C. respondents (89 percent) were more likely to view drug trafficking as being a very severe problem, compared with those in Maryland (24 percent) or Virginia (10 percent).
- Criminal justice and public health officials (both 43 percent) were more likely to view the drug problem as very severe than were government officials (17 percent) or education officials (22 percent).
- Respondents said they used multiple sources of information on drug abuse, which included contact with drug users and programs (86 percent), drug abuse research (78 percent), the media (82 percent), and "other" sources (62 percent), such as police reports, governmental agencies, professionals involved in the substance abuse field, and conferences on drug abuse. They viewed contact with drug users (63 percent) and "other" sources (56 percent) as very accurate; few (6 percent) viewed the media this way. They were somewhat critical of the quality and utility of drug abuse research (36 percent perceived research to be very accurate and 36 found it to be very helpful).
- The uses of research varied for different types of opinion leaders. For example, those in D.C. (28 percent) were likelier than their counterparts in Maryland (15 percent) and Virginia (14 percent) to be looking for recommendations to reduce and prevent drug abuse and its consequences. Involving the information "consumer" (i.e., policymaker, practitioner) throughout the research process--from early in the conceptual phase, to design, implementation, and results--can help to ensure the applicability and usefulness of research information to those who may need it most.

For additional information, see the following reports of the DC*MADS project:

U.S. Dept. of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse--

Prevalence of Drug Use in the DC Metropolitan Area Household Population: 1990.
Technical Report #1.

Prevalence of Drug Use in the Washington, DC, Metropolitan Area Homeless and Transient Population: 1991. Technical Report #2.

Views of Area Opinion Leaders About Drug Abuse in the Washington, DC, Metropolitan Area: 1991. Technical Report #3.

Prevalence of Drug Use in the DC Metropolitan Area Institutionalized Population: 1991. Technical Report #4.

Current Treatment Client Characteristics in the Washington, DC, Metropolitan Area: 1991. Technical Report #5.

Prevalence of Drug Use in the DC Metropolitan Area Household and Nonhousehold Populations: 1991. Technical Report #8.

Figure 1

District of Columbia Metropolitan Statistical Area (D.C. MSA)



Note: The District of Columbia Metropolitan Statistical Area (DC MSA) includes the District of Columbia; the Maryland counties of Calvert, Charles, Frederick, Montgomery, and Prince Georges; the Virginia counties of Arlington, Fairfax, Loudoun, Prince William, and Stafford; and the Virginia cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park.

Source: 1991 NIDA DC*MADS Homeless and Transient Population Study.

**Issues and Strategies for a Comprehensive Community Program
To Combat Drugs and Crime in Baltimore:
A Panel Discussion**

Tony Whitehead, Moderator
Lt. Col. Marcellus Boles
Thelma Millard
Kevin Jordan
Curtis Price
Shirley Stokes

Each panelist was asked to respond to these questions:

- What conditions in Baltimore lead to drug use and/or violence?
- How have people tried to address these conditions in the past? To what extent were they successful?
- What needs to be done now?

Lt. Col. Marcellus Boles of the Baltimore City Police Department described the isolation of officers from the communities they serve. As officers stopped walking beats and started driving patrol cars and responding to 911 calls, they lost their knowledge of local neighborhoods. They also ceased to be an influence on community youth.

In response to this isolation and the attendant problems, most police agencies now are engaging in community policing or problem-oriented policing. Community policing is customized to different jurisdictions, based on different problems and resources. In Baltimore, the community policing initiative reflects a philosophy and organizational strategy designed to address crime and related problems. This initiative has five main elements: 1) a partnership of community and police; 2) two-way accountability between the community and the police; 3) an emphasis on problem-oriented policing as an element of community policing; 4) providing service to residents; and 5) empowering residents and individual officers to make decisions at the local level. As part of the community policing strategy, one officer will be put into each of the 266 neighborhoods in Baltimore.

Commissioner Edward Woods began establishing a police presence in Baltimore's neighborhoods with a community policing program that began in 1991. Internal and external sources of information were used to identify areas for improvement. Eleven major areas were identified, some of the most important of which are described below. Fiscal support for the program had to be found. In addition, the organizational structure and management needed improvement: Because the Department had "too many chiefs, and not

enough Indians," the department's hierarchical structure was flattened and three ranks were eliminated.

The program then had to be marketed to the rank and file. There was a perception that community policing was "soft on crime" and that police officers would become social workers. Because police officers were being asked to do something different--to get out of their cars and establish relationships--the department asked for volunteers and increased training.

A district deployment model was used. Residents did not like having their communities split into different police districts, however, so the department changed the district boundaries to conform to the neighborhoods.

The system for handling emergency or 911 calls was also revamped so that officers were not run ragged responding to calls. The department tried to streamline the emergency system, and defer some calls, so that more urgent calls would get a quicker response. A telephone reporting unit currently handles 2 to 4 percent of calls, and the department hopes to increase it to 20 to 30 percent.

Interagency support is being coordinated with other agencies, such as the sanitation department and the public housing authority, to increase the impact in the community.

The Eastern District, which has 20 neighborhoods, served as the pilot district. The area was selected because it was saturated with drugs. Profile surveys were done with area residents to identify the problems in each neighborhood. Residents were asked, "What could police officers do?" "What could residents do?"

In conclusion, Col. Boles stressed that community policing is not a panacea, but it can have an impact on drugs and crime.

Thelma Millard of the Baltimore City Housing Authority Family Support Services pointed out that the housing authority has only a small staff and few resources. In the past, when funding was scarce, recreation programs were cut and youths ended up hanging out on streetcorners with drug dealers. Programs directed to preventing drugs and violence have been fragmented, but the authority is attempting to provide comprehensive programs. She noted that there is a need to go back to basics and provide alternative programs.

Ms. Millard described a number of programs. The substance abuse prevention program, Kids to Kids, engages youths by providing activities that are attractive to kids. Team Leadership Development teaches youths to be role models to their peers. Because it is also necessary to involve parents, the Parents Against Drugs program engages adults. A Mini-Olympics is an athletics showcase for the best talent. Youth Development Centers include computers to help youths do their homework, provide mentors, and engage youths

in sports, art, and cultural programs. Midnight basketball is offered and martial arts classes are taught. An advisory board of state and local officials coordinates efforts to pool resources.

Initially, none of these programs worked. Drug dealers were dealing in the housing buildings, and people were afraid to come out of their apartments and take part in program activities.

A new commissioner, Daniel Henson, began the Extraordinary House Cleaning Operation (ECHO) program to take back the housing authority buildings, hold them, and empower the community. The ECHO program is a team effort involving the city police, the housing authority, social workers, and legal advisers. It has three steps. First, letters are sent to all residents informing them about the program. Then, during ECHO, teams of city and housing authority police go in to secure the building. Next, teams made up of counselors, maintenance workers, and security personnel visit the residents in their homes to identify problems. Maintenance problems are addressed. The buildings are cleaned up, painted, and given new landscaping. Security is enhanced, and new IDs are issued to all residents.

Of 16 buildings, 14 have been cleaned up. Thus far, the housing authority has saved enough money on elevator repairs alone to pay for the additional security measures.

New programs are being offered to residents, including youth employment and entrepreneurship programs. In the Safe Neighborhood Program, youths reach out to other youths. They clean up hazards, such as sweeping glass from pre-school playgrounds. Anyone who stays in the program through the 12th grade receives \$1,000 to be applied to additional schooling or job training. Resident patrols, block watches, and empowerment and employment programs are also being offered to residents.

Kevin Jordan of the Citizen's Planning and Housing Administration described working to close open-air drug markets and make the neighborhood streets safe. Reconnecting members of a neighborhood to each other is an essential first step.

He described open-air drug markets as corners where drugs are openly sold to people driving by. Much of the violence is occurring in these areas. The existing drug policy has been to arrest people, put them in jail, and then build more jails. However, this policy alone does not reclaim neighborhoods.

Jordan recommended the book, *The Winnable War*, which describes three basic strategies to close drug markets:

- Broadcasting a sense of community intolerance of drug dealers.
- Denying drug dealers the public space they occupy.

- Removing the sense of impunity that drug dealers feel as they evade arrest or plea bargaining reduces sentences.

To carry out the first strategy, marches and vigils are organized. In some cases, when people living in the neighborhood are too afraid to come out, those who work in the neighborhood can be persuaded to meet. Some communities hold vigils every Friday night; they may pray or sing hymns. A collective effort to display signs in windows stating that drug dealing will not be tolerated is another tactic.

To occupy the open areas, public activities (such as checkers tournaments) may be held. Drug nuisance abatement laws permit civil actions to evict drug dealers from the spaces they use. Abandoned houses can be securely boarded up to prevent them from being used as crack houses; eventually, they should be renovated. Closing off vacant lots with wrought iron fencing discourages dealers. Eliminating drug enablers may mean removing pay phones from corners with open-air drug markets. If dealers are paying store owners to let them enter their stores to elude police (who then need warrants), the owners have to be convinced that the community wants them to stop this behavior. As the dealing goes down, levels of violence decline--and people find that they can come out of their homes safely.

To remove the sense of impunity that drug dealers feel, communities can organize and talk with state's attorneys about the sentencing of specific dealers: "Tell them that the neighborhood thinks that this guy is a real problem--and they want him locked up." Training citizens to make reports and voice complaints to the police results in more exact descriptions that are more useful to the police. Setting up phone trees, so that a whole group of people call in when an incident is occurring is more effective than a single 911 phone call. Above all, Jordan suggested conveying to police and other agencies that this is an organized community. Communicating community plans for action in advance reinforces that message.

Driving drugs from open-air markets and back into homes does not solve the drug problem. Users continue to use drugs--but violence in the neighborhoods declines, and people can come out of their homes. Organizing the community provides a sense of identification and allows people to really take a stand.

Curtis Price, Street Voice, offered a nontraditional view of drugs and violence, pointing out that Street Voice is a group of current and former drug users, many of them homeless, who circulate through the various soup kitchens, shelters, and treatment and rehabilitation programs in Baltimore.

To describe the conditions that lead to drug use and violence, Price noted that "drug use" must be situated in a social context. Drug use does not occur in a vacuum. In the past 15 to 20 years, people most at risk have had much taken from them. Economically, the good jobs have gone--replaced by minimum wage service jobs with no benefits. "Budget

cutbacks have forced more and more people to scramble for less and less." The twin effects of economic changes and cutbacks can be seen in increased cocaine use, Price said.

Culturally, competitiveness and individualism are on the increase. What Cornel West refers to as "market values" means that you only need other people to get what you need for yourself. Other people are objects to your ends. The community institutions that used to be a buffer to the slum have become tattered and frayed. Churches, community organizations, and the unions are shrinking. People refuse to participate in anything outside of their own private interests and have withdrawn into private life.

Yet at the same time that change is everywhere, Price noted that the goals that people strive for have remained the same:

You get as many material things as you can, or you are not living the good life. But the means to achieve all this have changed. People cannot get material things the straight way, but only by breaking the law. At \$4.65 per hour, options are different than they were at \$12.50 per hour. If before people may have had poverty, they had hope. Now we have poverty without hope.

For people living in a shelter, he continued, drugs fill the gaps between goals and reality. Each element of people's lives has multiplying effects that trap them: Drugs lead to unemployment, which leads to homelessness, which leads to more drugs.

What succeeded in the past? What stands a chance of working? In the past, communities were a mechanism for change. Now, communities are not like that--so the earlier communities must be rebuilt.

On the drug issue, Price said:

We have to stress harm reduction. Harm reduction usually is interpreted in a narrow sense, as in whether there should be a needle exchange or not. I propose we expand the term and deal with all the things that people are experiencing and holding them back. You can't just hand out a glossy pamphlet on TB, without talking about lack of housing, or employment.

At Street Voice, he continued, they try to put these things into practice in modest ways:

Many of our people actively get high. Instead of marginalizing people, we keep them involved. For example, we ask them to distribute our newsletter, Street Voice. This may be the one activity that still keeps them tied to a wider society.

"Frankly", he concluded, "this is politically unsupportable. To use the energy of active drug users is just not accepted. But it's part of a conscious strategy. Sometimes, the

best way to deal with social problems is not to talk about them directly, but to involve people holistically."

The second concept Price suggested is the "base community." Harold McDougall describes base communities in his book *Black Baltimore: A New Theory of Community*, which Price recommended everyone read. A base community is a flexible group of 5 to 20 unrelated people who network and are involved in many aspects of each other's lives at a grass-roots, micro level. Creating these base communities, especially around drug issues, helps people to address the problems in their own lives. Base communities cannot be created from above by hierarchical public and private sector organizations.

How are base communities incubated and strengthened when they are so informal and fragile? Here, there are unanswered questions. Funding is a problem. The logic of awarding grants does not support the flexibility and experimental measures needed. Base communities can only be supported outside the traditional means.

In discussion, Price rejected decriminalization as a strategy. Reverting to the economic argument that drug use resulted from the loss of jobs, he noted that the drug industry in Baltimore was precisely that--an industry. Decriminalization on a widespread scale he argued would not necessarily decrease violence. Rather, it would create new displaced workers.

Shirley Stokes, Baltimore City Health Department, noted that there is much talk about community empowerment, but that when she considers the communities in which she grew up and compares them to the drug-infested communities found today, the most striking difference is the absence of role models. As people become successful now, they leave their communities and move elsewhere.

Rather than having state and local agencies decide what to do with available funds, community empowerment means letting local communities decide for themselves. The Sandtown-Winchester Project in Baltimore City began as a community empowerment project. The community wanted employment and housing. However, after a foundation became involved, the people no longer recognized the plan as their own. The only way they could get the project going was to follow the plan of the people who controlled the money.

Successful prevention programming is not only directed to youths, but is more inclusive. Three separate programs that are needed are parenting programs, senior citizen programs, and mentoring programs.

Parenting programs try to teach parents how to become better parents to their children. Rather than giving youths single-shot activities and calling them prevention, youths need to be taught the means to love and develop themselves. Parents cannot teach their children what they have never learned to do for themselves, so we have to begin with

the parents--or even the grandparents. Grandparents, however, cannot be assumed to be the resource they once were: The grandparents may themselves be using drugs. Family systems need to be developed to help families take care of their own--as they once did.

The Health Department funds a senior citizen program. Many people assume that seniors are abusing only prescription drugs, but that is not the case.

Mentoring programs pair senior citizens and adolescents. Who would expect that they would hit it off? Initially, Stokes pointed out, often they do not. But after they get to know one another, both seniors and adolescents benefit.

Total community involvement is needed. For example, Stokes said, the churches need to be involved. When they ask for help, they should be asked, What are you giving back to the community? Do you let people use your church building? Wider agency involvement and coordination are needed, as well. When all the elements are in place and working together, communities can rid themselves of drug dealers. The issue then is, How long can they be kept out?

Conclusion

For those interested in drug indicators, this panel may seem rather far afield of the traditional epidemiological concerns. However, even a quick review of the issues raised suggests that indicators at best measure changes occurring within systems--and that some of the changes may be unintended. For example, if telephone complaints are one indicator of the level of severity of a neighborhood drug problem, the community telephone tree and the police telephone answering system are efforts to influence those indicators in different ways, for different purposes. Those who use indicators must consider the larger systems in which they occur.

For additional information, see:

Conner, Roger and Patrick Burns. *The Winnable War: A Community Guide to Eradicating Street Drug Markets*. Washington, D.C.: American Alliance for Rights and Responsibilities, 1991.

McDougall, Harold. *Black Baltimore: A New Theory of Community*. Philadelphia: Temple University Press, 1993.

West, Cornel. *Race Matters*. Boston: Beacon Press, 1993.

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Maryland Statewide Epidemiology Work Group (MD/SEWG)
Meeting
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Maryland Statewide Epidemiology Work Group (MD/SEWG)
Meeting
May 6, 1994

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Maryland Statewide Epidemiology Work Group (MD/SEWG)
Meeting
May 6, 1994

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APPENDIX

RESULTS OF THE MAY 1994 MD/SEWG FEEDBACK SURVEY

The May 1994 feedback survey contained 10 sections. Using a scale ranging from 1 (excellent) to 5 (unsatisfactory), participants were asked to rate: (1) the pre-meeting activities; (2) the Spring 1993 Proceedings reports; (3) the Fall 1993 Proceedings report; (4) the quality and usefulness of meeting presentations; (5) meeting materials; and (6) on-site meeting services. Participants were also asked to comment on: (7) the quality and usefulness of presentations; (8) the panelists; (9) overall usefulness of the meeting; and (10) the overall quality of the meeting. In addition, participants were asked what changes, if any, they would recommend in the meeting format. The survey form is included at the end of this section.

Forms were distributed to the participants so they could evaluate the usefulness, quality, and format of the MD/SEWG meeting. In addition, evaluation forms were mailed to participants who were invited to the meeting, but were not known to have turned in an evaluation form. Fifty-five participants, in addition to CESAR staff, attended the meeting. Twenty-seven participants responded, for a response rate of 45 percent.

The mean ratings for pre-meeting activities ranged between excellent and very good. This section included questions on helpfulness and usefulness of site visits, telephone assistance, the DEN data update packet and report, and the quality of the invitational packet and directions to the meeting site.

The Spring 1993 Proceedings report, Meeting Highlights, Volume I, received a mean rating of 1.6 for quality (between excellent and very good) and 1.9 for usefulness; DEN Reports, Vol. II, received mean ratings of 2 (very good) for quality and usefulness. The Fall 1993 Proceedings report, published in a single volume, received ratings of 1.6 for quality and 2 for usefulness.

The meeting materials were rated 1.7 (between excellent and very good). The mean rating for on-site services (registration, food and beverages, location/facility, room setups, and overall support of the meeting) ranged from 1.4 to 2.4 (between excellent and satisfactory). The room setup was problematical for many of the participants. Specific comments included the following: "The acoustics were very unsatisfactory"; "We could not see the overheads clearly"; "Chairs were too far from the speakers"; and "It was too cool in the room."

Comments on speaker presentations generally were favorable. The DC*MADS presentation received the most favorable comments: Participants stressed the usefulness of the data and excellent quality of the speaker. Other presentations received more varied ratings--ranging from good to satisfactory to marginal. Participants' interest and tolerance for epidemiological data and/or program descriptions varied, with some clearly preferring one over the other. At least one participant requested that the meeting be divided, with data presented in the morning and program information in the afternoon (or vice versa).

In addition to the usual presentations on drug trends, the May 1994 meeting included a group of panelists from community agencies and organizations who discussed "Strategies and Issues for a Comprehensive Community Program to Combat Drugs and Violence." Many participants commented that the panel was not relevant to the epidemiological focus of the MD/SEWG. Others thought the panelists did not adequately address the issues of drugs and violence. Some participants commented that the panel members were interesting and informative, and regretted that more time was not available to direct additional questions to the panelists.

The May 1994 meeting received generally favorable comments. However, the relatively low response rate suggests that some participants who may have viewed the meeting less favorably did not fill out evaluations. Concern was expressed that many of the local DEN members did not attend or send representatives.

Participants were asked to make suggestions for changes to the format for upcoming meetings. With the exceptions noted, participants generally were pleased with the meetings and did not specify any structural changes as being necessary. MD/SEWG members clearly value diversity in the format or style of reports to the meeting, but prefer the meeting to focus substantively on epidemiological data and their use and interpretation.

MD/SEWG Feedback Survey

Name (or if preferred member/observer): _____
Date of Meeting: _____

Rating Scale

1 = Excellent 2 = Very Good 3 = Satisfactory 4 = Marginal 5 = Unsatisfactory NA = Not Applicable

1. Pre-meeting activities:

a. Helpfulness of site visits	1	2	3	4	5	NA
b. Helpfulness of telephone assistance	1	2	3	4	5	NA
c. Quality/completeness of invitational packet and directions	1	2	3	4	5	NA

Comments, if any _____

2. Spring 1993 Proceedings reports.

a. Usefulness of Vol. I (Highlights)	1	2	3	4	5	NA
b. Quality of Vol. I	1	2	3	4	5	NA
c. Usefulness of Vol. II (LEN reports)	1	2	3	4	5	NA
d. Quality of Vol. II	1	2	3	4	5	NA

Comments, if any _____

3. Fall 1993 Proceedings report:

a. Usefulness	1	2	3	4	5	NA
b. Quality	1	2	3	4	5	NA

Comments, if any _____

4. Meeting Materials

a. Usefulness/met requirements	1	2	3	4	5	NA
b. Overall quality	1	2	3	4	5	NA
c. Timeliness	1	2	3	4	5	NA

Comments, if any _____

5. On-site Services

a. Registration	1	2	3	4	5	NA
b. Food and beverages	1	2	3	4	5	NA
c. Location/facility	1	2	3	4	5	NA
d. Room setups	1	2	3	4	5	NA
e. Overall support of meeting	1	2	3	4	5	NA

Comments, if any _____

6. Usefulness and quality of meeting presentations:

Please comment

a. Maryland Statewide Drug Trends

b. The Forthcoming Maryland Adolescent Survey: Overview and Discussion

c. A Comprehensive Program to Treat Drug Use During Pregnancy

d. The Washington, D.C. Metropolitan Area Drug Study (DC/MADS): Methodology and Preliminary Findings

e. Panel Discussion

f. Developing Community Action Plans: The Experiences of the Robert Wood Johnson "Fighting Back" Grantees

7. Overall comments on panelists:

8. Overall comments on meeting usefulness:

9. Overall comments on meeting quality:

10. Based upon your experience of the May 1994 meeting, what changes, if any, would you suggest for the November 1994 meeting?

PLEASE RETURN TO MD/SEWG COORDINATOR.