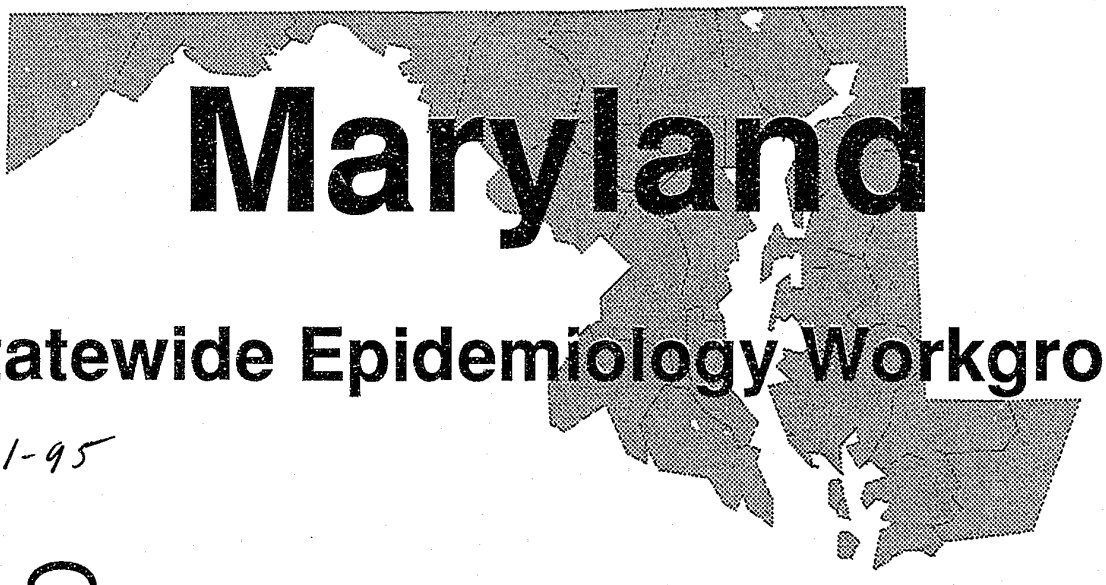
Proceedings
November 1993 Meeting



Maryland

Statewide Epidemiology Workgroup

Center for Substance Abuse Research
University of Maryland, College Park

Funded by the Governor's Drug and Alcohol Abuse Commission

154190

PROCEEDINGS

MARYLAND STATEWIDE EPIDEMIOLOGY WORK GROUP

NOVEMBER 1993 MEETING

Prepared by

The CESAR Staff
and Sharon Stout,
MD/SEWG Coordinator

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) has now entered its third year. Four full SEWG meetings have been held, and participation by both local and state agencies has remained high. The MD/SEWG is now reaching out to additional jurisdictions.

I want to acknowledge the support of the local participants and state agencies who have helped to create 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; Carol Anglin, the first 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

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NOVEMBER 1993 MEETING

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 is modeled after the national Community Epidemiology Work Group developed and supported by the National Institute on Drug Abuse.

MD/SEWG Mission and Objectives

The mission of the Maryland SEWG is to track, monitor, and analyze trends and patterns of use and abuse of legal and illegal substances throughout Maryland, with detailed focus on SEWG member counties and Baltimore City. Specific objectives of the work group are to (1) provide accurate and timely assessments 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 Maryland SEWG meets twice annually, which provides a unique forum for mutual exchange among representatives from local jurisdictions (counties and municipalities), key state agencies, and interested observers. Representatives of participating jurisdictions are responsible for forming Drug Epidemiology Networks (DENs). Each DEN, composed of representatives from local law enforcement, treatment, prevention, education, and public health agencies, analyzes local indicators for patterns and trends in the local drug problem. DEN representatives then report on those data at the semiannual SEWG meeting. Other speakers may be invited to make presentations. Generally, these presentations describe new sources of data on drug trends and patterns, indicators of possible interest, or methods of using or disseminating indicator data.

Structure of This Report

This report contains the Proceedings of the fourth meeting of the Maryland SEWG, held on November 8, 1993, 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 to their local agencies and to state drug policy and program officials?

Components of this meeting included (1) presentation of reports by DEN members, followed by discussion among DEN members and state agency representatives and (2) presentation of reports from state agency representatives and other guest speakers regarding relevant indicators and survey data.

This Proceedings report contains highlights of drug data included in DEN reports submitted at the November 1993 MD/SEWG meeting. It also includes the agenda for the meeting, summaries of the speakers' presentations, an SEWG membership list, and a list of attendees. Included as appendixes are the results of the November 1993 MD/SEWG meeting evaluation and the reports submitted by the DENs.

The MD/SEWG is indebted to the Governor's Drug and Alcohol Abuse Commission for its continuing support of SEWG activiites. In addition, the Commission provided financial support for a number of the projects summarized in this volume.

Maryland Statewide Epidemiology Work Group (MD/SEWG)

Fall Meeting
November 8, 1993

AGENDA

8:15	Registration and continental breakfast
9:00	Welcome, Participant Introductions, and MD/SEWG Update **Eric Wish and Sharon Stout**
9:15	Indicator Mini-Shop: Hotline Data **Mike Wagner, CESAR**
9:30	DEN Discussion: Using Data in Program Planning and Evaluation--Intervention with Adolescents and Young Adults **Henry Brown and Andrea Harris, Washington County**
10:30	**BREAK**
10:45	DC/CEWG Update: Drug Trends and Patterns in Washington, D.C. **Clare Mundell, CESAR**
11:15	Leading versus Trend Indicators **Daniel Sherman, Ph.D., Abt Associates, Bethesda**
12:00	**LUNCH**
1:00	Indicator Workshop 1: Using and Interpreting Discharge Data from MD General and Private Psychiatric Hospitals **Paul Gentile, Maryland Health Resources Planning Commission**
1:45	Indicator Workshop 2: Using Risk Indicators and Mobilizing Communities for Prevention Programs **Sue Henry, Harford County; Denise Gottfredson, Ph.D., Institute of Criminal Justice and Criminology, UMCP**
2:45	**Break**
3:15	Indicator Workshop 3: Drug Trends in Baltimore City and Price/Purity Data **Shiv Soni, Ph.D., Baltimore City Police Department**
4:00	**Open Discussion and Planning for May, 1994 Meeting**
4:30	**Adjourn**

DEN REPORTS

HIGHLIGHTS

The highlights on the following pages represent the major points made in reports submitted by the following DENs.

- Harford County
- Howard County
- Prince George's County

HARFORD COUNTY

J. Sue Henry and Megan Williams-Yeager
Drug/Alcohol Impact Program

- Drug arrests of juveniles increased from 1989 to 1992. Arrests for possession increased. Arrests for distribution decreased (after peaking in 1991).

- Drug arrests of adults decreased from 1988 to 1991, and then increased greatly from 1991 to 1992.

- Treatment admissions of juveniles increased from 1988 to 1992, and then declined from 1992 to 1993. The pattern of juvenile treatment admissions may follow that of juvenile drug arrests because drug-involved juveniles referred to the Department of Juvenile Services are referred to treatment.

- Treatment admissions for adults followed the same pattern as for juveniles: Admissions increased from 1988 to 1992, and then declined from 1992 to 1993.

- DWI arrests of juveniles decreased from 1989 to 1992.

- DWI arrests of adults decreased from 1988 to 1990--and then increased from 1990 to 1992.

HOWARD COUNTY

Joyce Brown and Bonnie Cook
Howard County Office of Substance Abuse Impact

- According to the Alcohol and Drug Abuse Administration's FY 1993 Substance Abuse Management Information System (SAMIS) report, 79 percent of Maryland juveniles being treated for substance abuse mentioned alcohol as a problem. The Howard County Department of Health and private substance abuse treatment providers indicate that alcohol is the main drug of abuse among adolescents in the county.

- According to the 1992 Maryland Adolescent Survey (MAS), in each grade level surveyed Howard County students led the state in the percentage of adolescents who drink. Howard County students seem to be drinking at an earlier grade level than students reporting from other jurisdictions.

- The 1992 MAS survey indicates a higher tolerance by parents for alcohol consumption than for other drug use. Public school administrators and PTA members confirmed that perception.

- A 1993 undercover investigation conducted by the Howard County Department of Police to determine whether minors can purchase alcohol from local liquor establishments found that minors can easily purchase alcohol: Three out of five liquor establishments checked sold alcohol to a minor.

PRINCE GEORGE'S COUNTY

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

- Adolescent drug use indicators continue to show a decline in the use of cigarettes, alcohol, and illicit drugs by county juveniles. The Public Schools Student Survey reports use levels by county high school students that are significantly lower than the statewide average. Treatment referrals from schools and juvenile services have declined to approximately one third the level of five years ago.

- DWI arrests and alcohol-related vehicle crashes continue to decline from previous levels. DWI arrests are down by almost 30 percent from five years ago. Alcohol-related vehicle crashes have dropped by more than 40 percent in seven years.

- Adult drug arrests continue unchanged from previous years and pretrial test results continue at previous rates. Adult treatment admissions have declined steadily, by 20 percent from 1989 through 1993. The resources of treatment programs have been reduced by 30 percent during the same period.

- Data from the Infant at Risk (IAR) program regarding maternal drug use during pregnancy remain substantially unchanged from previous years. Over 30 percent of the IAR referrals are prenatal drug abusers and an additional 30 percent received no prenatal care. The IAR program reported 25 HIV cases in 1992 and expects 26 cases for 1993.

PRESENTATIONS

HIGHLIGHTS

The highlights on the following pages summarize the major points of the speakers who made formal presentations at the meeting.

- Indicator Mini-Shop: Hotline Data - Michael Wagner
- Using Data in Program Planning and Evaluation: Intervention with Adolescents and Young Adults - Henry Brown and Andrea Harris
- DC/CEWG Update: Drug Trends and Patterns in Washington, D.C. - Clare Mundell
- Leading versus Trend Indicators - Daniel Sherman
- Using and Interpreting Admissions Data from Maryland General and Private Psychiatric Hospitals - Paul Gentile
- Using Indicators and Mobilizing Communities for Prevention Programs - Denise Gottfredson and J. Sue Henry
- Drug Trends in Baltimore and Price/Purity Data - Shiv Soni

Indicator Mini-Shop: Hotline Data

Michael Wagner
CESAR

The primary goal of the Maryland Automated Hotline Reporting System (MAHRS) study is to build a database of substance abuse indicators common to all Maryland hotlines. Although crisis hotlines potentially are a valuable source of information about the types of drugs causing acute medical episodes, before this study there was no comprehensive database of hotline information in Maryland.

The study objectives are as follows:

- Design a scannable data collection form to be used by participating hotlines to collect standardized data elements.
- Estimate the prevalence of drug-related calls among total hotline calls.
- Estimate the prevalence and pattern of drug-related calls by age, gender, and regional subpopulations.
- Determine the self-perceived need for treatment among hotline callers.

CESAR identified the participating hotlines through a state-sponsored project, the Youth Crisis Hotline. Six hotlines agreed to participate: Grassroots Crisis Intervention, Howard County; Hotline & Suicide Prevention Center Inc., Prince George's County; Life Crisis Center, Wicomico County; the Frederick County Mental Health Association; the Mental Health Association of Montgomery County; and Walden/Sierra, Inc., St. Mary's County. Together, these hotlines handle some 80,000 calls per year.

Before the study began each hotline kept a record of its calls, and each had a procedure followed by telephone counselors in recording data from calls on paper forms. Some of the hotlines later transferred this information to computers. All the hotlines generated reports, but typically several months would elapse between the reporting of calls and the production of reports. All the hotlines wanted to produce reports containing more information, and in a more timely manner. Individual hotlines generally collected little information concerning drugs that were mentioned by callers. Detailed information on drug-related calls was collected only on reports of suicide attempts; otherwise, the counselors tended simply to note a substance abuse problem.

In working with CESAR on designing a common form, the hotlines agreed to use the most comprehensive existing form as the starting point. Staff at all six hotlines then reevaluated the information being recorded by counselors from calls to their hotline. A decision was made that up to four issues mentioned by the caller as problems would be recorded. A separate section devoted to substance abuse issues was developed to record

additional information on callers who mentioned alcohol or drugs as a problem. Over a series of meetings, the common form was refined as the hotline staff and administrators reviewed and evaluated the form. During this process, CESAR worked with National Computer Systems to design a scannable version of the form.

Because it was important to keep information on the caller's identity confidential, a two-part form was developed. The scannable sheet, which is sent to CESAR, is the first page, and the second sheet is a non-scannable copy of the first. Confidential information on the caller, including the caller's name, if known, is recorded on the back of the second sheet, along with the counselor's notes on the call.

Hotline counselors fill out one form for each telephone call. If alcohol or drugs are identified as an issue, the counselors follow through to get additional information, such as whether the call concerns use by the caller, a third party, or both; which drugs are involved; whether drugs are ever injected; and whether treatment is needed for drugs, alcohol, or both. The scannable forms are sent to CESAR once a month for scanning and preliminary analysis. Each hotline is sent its data files on a monthly basis. CESAR also created a customized software program with which the hotlines can easily generate their own reports and graphs.

Hotline staff initially estimated that 60 to 70 percent of their calls were drug- or alcohol-related. However, of the 4,200 to 5,000 calls per month, roughly 500 calls, or 10 to 11 percent, are drug- or alcohol-related. The overall volume of drug- and alcohol-related calls remains very stable at roughly 500 calls per month, although the number per hotline varies considerably. Of the 500 calls per month, 300 mention alcohol, 100 mention cocaine, 50-75 mention crack, 50 mention marijuana, 25 mention cigarettes, and about 25 mention heroin.

This new and potentially valuable indicator of substance abuse in the state is interesting because hotline data may lead other indicators, and because several service providers collaborated to meet their own operational needs, as well as create a useful research tool.

For additional information see:

E. Levine, M. Wagner, and E. Wish. 1994. The Maryland Automated Hotline Reporting System (MAHRS): Background and Early Findings. Center for Substance Abuse Research, University of Maryland, College Park.

Using Data in Program Planning and Evaluation--Intervention with Adolescents and Young Adults

Henry Brown and Andrea Harris
Washington County Health Department

This summary provides an overview of the genesis and evaluation of a program for youth, the State Police Early Assessment and Recovery (SPEAR) program. The SPEAR program is designed to reduce the risk for adolescent substance abuse, addiction, and/or continued criminal behavior by providing early intervention and referral services for alcohol- and other drug-impaired juveniles and their families.

In the last quarter of 1989, the Alcohol and Drug Abuse Administration (ADAA) organized a planning committee to address a critical problem identified by Lt. Col. Thomas Carr of the Maryland State Police. Law enforcement agencies were finding juveniles between the ages of 13 and 17 years old who were committing minor offenses (such as impaired driving, speeding, breaking and entering, or vandalism). The offenses did not warrant detaining the youths, so the youths were being taken to police barracks, given civil citations, and then released.

Traditionally, the juveniles were released to the custody of a parent or guardian. Although indications of substance abuse often were apparent, police personnel were unable to provide information on appropriate referral services. Moreover, the offenses often occurred during hours when clinics were not open, for example, Friday evening through Sunday.

Concerns arose because there were no treatment resources available, and the parents might or might not learn that the youth had committed an offense. The decision was made to develop a rapid response approach--to try to keep youth from coming back into the system for a more serious offense.

In 1989, Washington County law enforcement agencies estimated they encountered approximately 600 juveniles each year who fit the profile identified above. The juveniles' level of substance abuse ranged from experimental use of alcohol or drugs, to abuse, to addiction. Many of the juveniles were also involved in the drug distribution process. Those juveniles having had no prior contact with the system often appeared relatively stable and seemingly resided in functional family settings. Therefore, little or no intervention was provided or accessed.

The local Department of Juvenile Services estimated that the majority of the first-time offenders showed up later in the system for higher levels of criminal behavior, at a cost to the system of approximately $6,000 per adolescent receiving placement services. (This estimate is based on an average of $100 per day per juvenile, and an average length of stay of 60 days.) This estimate does not include the impact of adolescent substance abuse on the family system; abuse often results in emotional and financial stress leading to increased healthcare costs and lost productivity in the workplace.

SPEAR is a cooperative effort involving the Maryland State Police, the Washington County Sheriff's Department, the Hagerstown City Police Department, the Department of Juvenile Services, the Juvenile Court System, and the Washington County Health Department. In a coordinated effort, these agencies target juvenile offenders, ensure early assessment of juvenile offenders and their families, and provide referral and follow-up to ensure treatment and facilitate evaluation of the SPEAR program. The goal is to keep juveniles from entering the system at a higher level of criminal behavior, thus reducing the cost of care and the negative impact that adolescent substance abuse has on the individual, family, and larger society.

SPEAR is in operation 24 hours a day, seven days a week. It provides immediate clinical assessment and substance abuse and family counseling referral services for impaired juveniles (and their families) who have contact with law enforcement agencies, but whose offenses do not warrant immediate criminal charges, detention, emergency medical referral, or psychiatric commitment. Ten clinicians are on call and will respond within 15 minutes to calls to come to the police barracks. The consultants contain the crisis, explain the services available, and schedule follow-up appointments.

We now have data for the first 42 months of the program. No juvenile offered the opportunity to speak to a SPEAR counselor has ever refused. We think that is because we are offering them a service at a time of crisis, when they are most receptive. Of the 331 juveniles who have gone through the SPEAR program, 45 percent are involved in follow-up services. Although not a perfect record, that is a fairly high rate compared to youths coming through other referral sources. The local Department of Juvenile Services, for example, processes about 900 juveniles a year. No follow-up is offered. Moreover, there is a waiting list to get through the intake system to the court system. SPEAR hooks youths in much sooner. Within 1 to 3 weeks, a youth can get a treatment admission.

The program handles an average of 8 referrals per month, rather than the 50 per month we expected. Although we thought that referrals might cluster in conjunction with outside events such as concerts or carnival season, we are finding that the clusters reflect instead events such as parties. Referrals decreased from 1990 to 1992, as did the number of arrests for driving while intoxicated or while under the influence, alcohol citations, and juveniles being processed through juvenile services. Fewer police are out making arrests or issuing citations because of a decrease in manpower. We have also been told that speeding, not drugs and alcohol, is a law enforcement priority. At the same time, we are seeing an increase in binge drinking. We know that there are juveniles still slipping through the cracks.

One difficulty we face is that we live in a small community: To some extent, some officers continue to feel that it is simpler to just take juveniles home to their parents. We work on providing motivation to participate in the program; for example, we give awards to officers. Now, we have started writing commendation letters to be placed in their files.

Statistics provided by the local Department of Juvenile Services indicate that, since the implementation of SPEAR, the number of their formal cases has declined, from an

average of 19 per month to an average of 14 per month. This suggests that SPEAR is reducing the number of cases requiring formal disposition. The average number of informal cases remained at about 32 per month. Informal cases require no follow-up work on the part of Juvenile Services' workers.

We are working with the Institute of Criminology and Criminal Justice at the University of Maryland, College Park, to evaluate the program. As part of this effort, we designed a survey to assess how law enforcement officers perceive and understand the program. Between 40 and 60 percent of the officers thought it was an effective intervention. We attempted to design the program to be responsive to officers' concerns. For example, to save officers' time, they simply drop juveniles off at the police barracks, rather than having to wait to meet the SPEAR counselors. At the same time, we attempt to give them feedback on what happened as a result of their intervention.

Total SPEAR program costs are $39,000, which covers the beeper system and the consultants. We would like to do a long-term follow-up of youths who went through the program so we can quantify what we are saving in placement costs by averting further involvement by youths in alcohol and drugs and more serious offenses. However, it is difficult to track them once they turn 18 years old and leave the juvenile justice system.

One unforeseen result of this program is that we have identified another group in need of similar services. We found we had 400 young adults, between the ages of 18 and 21, who were stopped and let go. Of this group, 350 never received any services. We are starting a new program for this group.

For additional information see:

Washington County's MD/SEWG Report, Appendix B-4 in this volume.

District of Columbia Community Epidemiology Work Group (DC/CEWG), Drug Trends and Patterns in Washington, D.C.

Clare Mundell
CESAR

This presentation has two underlying themes:

- To understand what is really happening, we have to combine quantitative data with qualitative information.
- To be effective, we have to use data for action--to support prevention, treatment, and law enforcement efforts.

It is not enough to simply present information on trends in drug use and abuse. We must also consider what factors are driving the trends and how to address them, or at least how to provide sufficiently timely and compelling information that may be of use to others. Finally, we must address the interplay between drug use and wider cultural phenomena.

A brief review of the recent history of drug trends in Washington, D.C. underscores the point that the drug of choice tends to change over time. In the mid-1980s, PCP was the drug of choice. PCP was supplanted in the late 1980s by cocaine and crack. About the end of 1989 or in early 1990, there were indications that cocaine use was starting to decline. In late 1990, the price of heroin declined and heroin purity rose. The same changes in price and purity have been observed in other cities, such as Baltimore and Boston, where indicators suggest heroin use is increasing. Thus far in D.C., however, a significant increase in heroin use is not evident.

The Drug Abuse Warning Network (DAWN) tracks a sample of drug-related emergency room episodes. From the first quarter of 1990 to the third quarter of 1992, total cocaine-related episodes in the D.C. metro area decreased 21 percent. It is tempting to consider this decrease an indication of success in combating drug abuse. However, the entire decline is accounted for by the decrease in the number of people seeking detoxification. (See Figure 1.) In that time period, the number of people seeking detox declined by 59 percent, while the number of people seeking help for the negative effects of cocaine (overdoses, withdrawals, and the chronic effects of use) rose.

Why did fewer people seek detox services? Is it because there is less incentive to seek treatment when it is easier to get cocaine? Are there fewer people needing treatment? Two factors may help explain these changes. First, in 1992, a treatment facility opened near the grounds of D.C. General Hospital; people who went there rather than to D.C. General were not included in the DAWN system. Second, in the third quarter of 1990, one of the

Figure 1

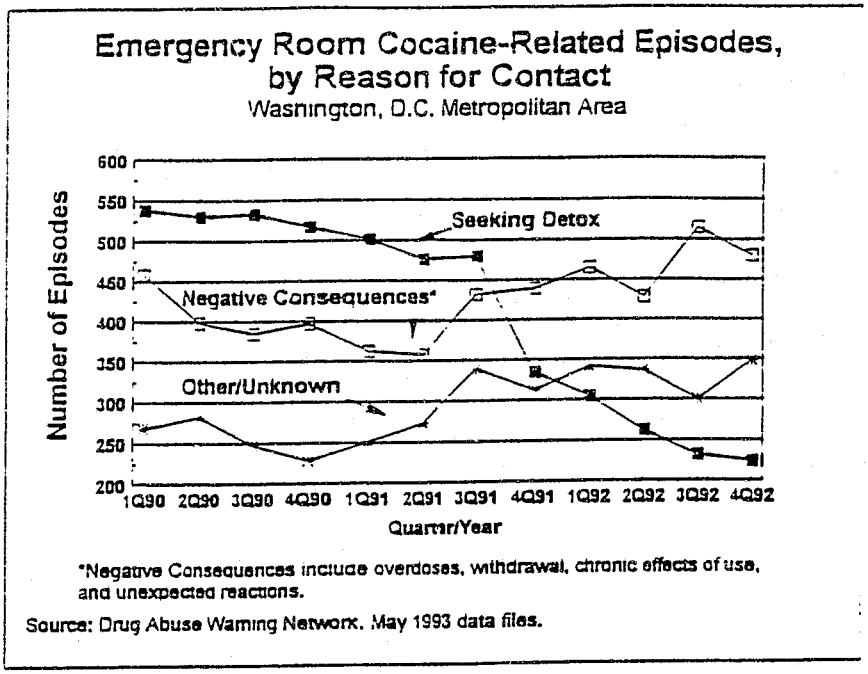
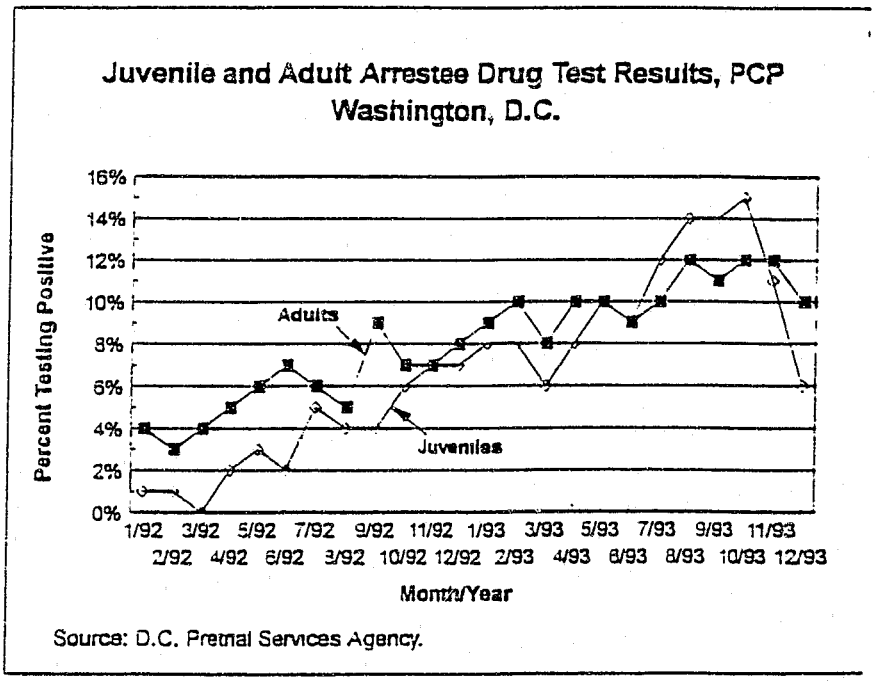


Figure 2



major reporting hospitals closed its detox facility. Fewer services are offered through the reporting hospitals.

Figure 2 shows the trends in PCP use among juvenile and adult arrestees. The Pretrial Services Agency (PSA) tests each arrestee at booking. Among adult arrestees, PCP use reached its highest point in June 1987, when 49 percent tested positive; the low, 1 percent, occurred in November 1991. In August 1993, 12 percent of the adult arrestees tested positive. Among juveniles, PCP use reached its highest point in June 1987, when 34 percent tested positive. Although PCP use had declined to 0 or near 0 percent from 1990 through the first part of 1992, by August 1993, 14 percent of juvenile arrestees tested positive.

In November 1992, as Figure 2 shows, juvenile arrestees tested positive for PCP at a higher rate than adult arrestees. These data offer one indication that we may be seeing a new generation of drug users--at least in this population. It also suggests that juveniles may be turning away from crack--given the devastation they have witnessed--and returning to a drug they perceive as a safer alternative. The same pattern is being seen in Prince George's County, Maryland. In the past, in some areas, changes in drug use among the arrestee population have preceded major drug epidemics.

The greatest change in D.C. drug trends is in marijuana use--and in particular, the smoking of blunts. A blunt is a cigar that is gutted of tobacco and refilled with marijuana. "Phillies blunts" are a brand of cigars popularly used for this purpose. In October 1990, 2 percent of juvenile arrestees tested positive for marijuana. (See Figure 3.) By November 1991, 7 percent tested positive, and by August 1993, 46 percent tested positive--the highest level ever recorded by PSA. An informal survey conducted by PSA found that of 22 juveniles admitting to using marijuana, 21 had used it by smoking blunts. Interestingly, informal interviews conducted by Street Voice with people on the street in Baltimore indicate that people either did not know about blunts--or associated them with D.C.

Figure 4 shows the patterns of marijuana use among adult arrestees. Although males and females showed similar patterns of use until mid-1991, use among males increased to higher levels thereafter. Although the number of females in the sample is small, the change in patterns is also consistent with the hypothesis that more males than females were smoking blunts.

Other indicators also suggest an increase in marijuana use. Figure 5 shows the number of removal samples of marijuana submitted by the Metropolitan Police Department (MPD) to the Drug Enforcement Agency (DEA) for analysis. More marijuana samples were analyzed in the third quarter of 1993 than in all of 1991.

Although there is evidence from the indicators that marijuana use is increasing and anecdotal evidence from PSA about the use of blunts, can the case be made that use of blunts

Figure 3

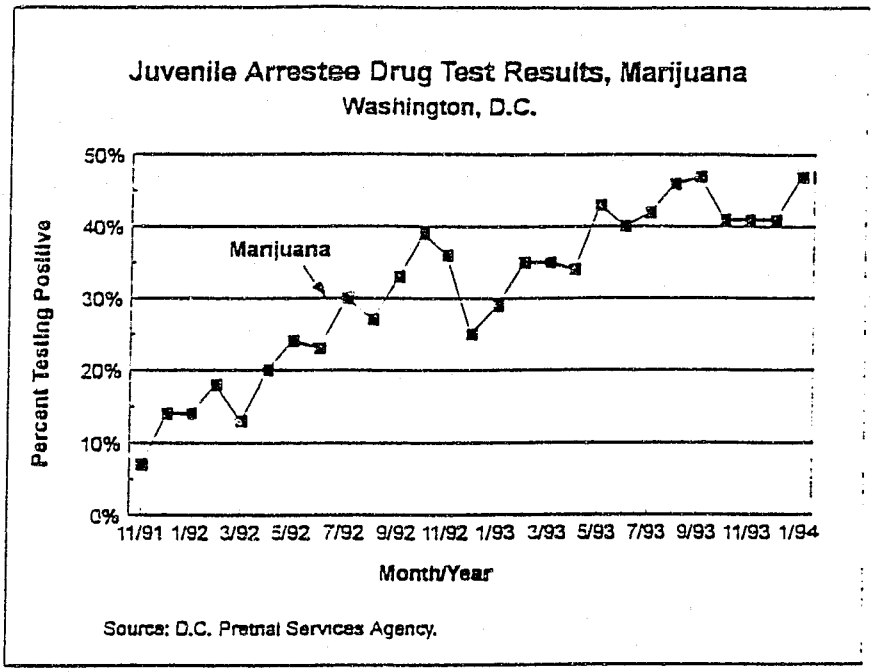
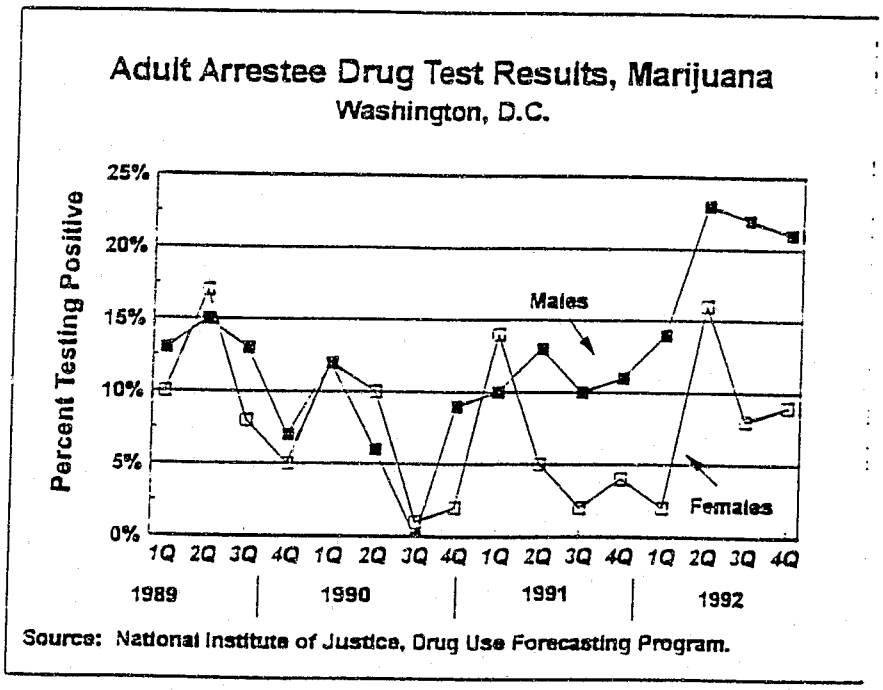


Figure 4



is driving the trend in D.C.? To check this link, I called the Phillies Blunt company for their sales figures. Although the company would not single out its own sales, it did provide tobacco industry figures on cigar sales. (These figures were later confirmed by the Cigar Association of America.) The number of large cigars (the category that includes blunt-style cigars) shipped into the D.C. metropolitan area increased from 1.3 million in 1988 to 6.2 million in 1992. Over the same period, the number of large cigars shipped into Maryland declined from 51.2 to 24.8 million.

Figure 6 shows the results of plotting the increase in cigar shipments against the increase in marijuana use. The trends track all too well.

The emergence of blunts in relation to other cultural phenomena is plotted on the time line shown as Figure 7. The time period covered corresponds to that covered in Figure 3, on juvenile drug test results, and particular points in time are numbered. At point 2, when marijuana surpassed cocaine as the drug most commonly detected in tests of juvenile arrestees, a local radio station asked as the question of the day, "Is it good or bad that marijuana has become the drug of choice among youth?" It is disturbing that essentially the same question was asked in the fall of 1993 (point 6), when the rate of use had risen to 46 percent. In this two and a half years, what could the DC/CEWG have done? What information could we have given prevention planners? Does media coverage of drug use--and particularly coverage of popular culture associated with drug use--encourage or discourage use? How do we use our information to counter the influence of popular culture?

Discussion of these questions centered on the following issues. Inhaling of cigar tobacco in conjunction with marijuana poses a long-term threat to health. Although it is tempting to see marijuana use as less harmful than use of other drugs, marijuana is a gateway drug. Blunts also have this potential: Focus groups of drug users are reporting that blunts are being filled with other drugs, including PCP and cocaine, as well as marijuana. Levels of tetrahydrocannabinol (THC) found in marijuana have increased over time, and marijuana is more potent now than when it was widely used in the 1960s. Although it is important to identify who is at risk of using drugs--by population subgroup and area--and to keep up the basic prevention message, it is also useful to develop prevention materials directed to use of particular drugs. As one participant noted, the available videos on marijuana use are so outdated that students watching them laugh at how people are dressed and do not pay attention to the basic messages.

For additional information see:

C. E. Mundell, and C. Johnson, Patterns and Trends in Drug Abuse in Washington, D.C. Paper presented at the December 1993 meeting of the Community Epidemiology Work Group of the National Institute on Drug Abuse. Available from CESAR.

Figure 5

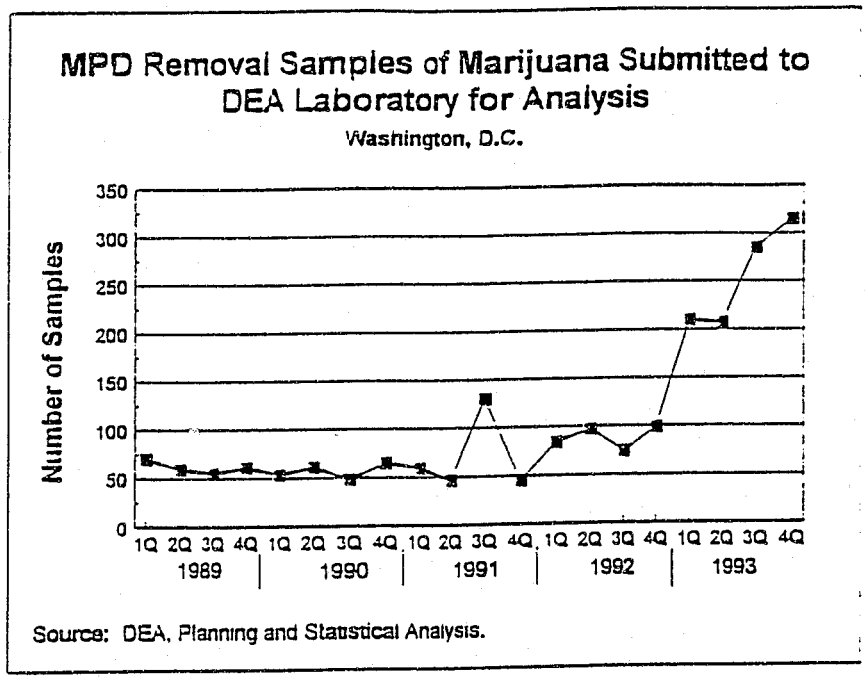


Figure 6

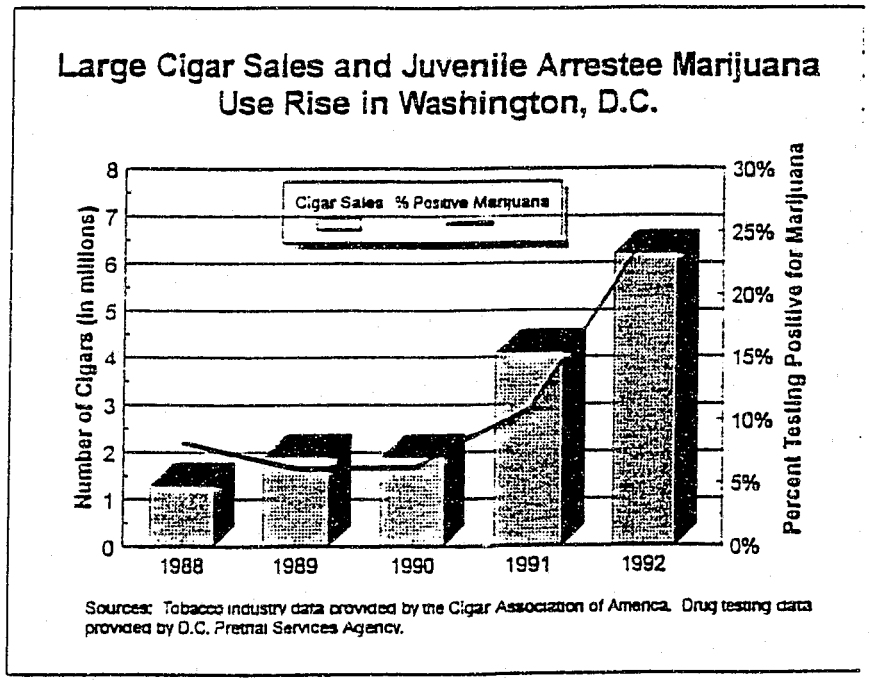


Figure 7

The Emergence of Blunts

1. Winter 1990-91

The percentage of Washington, D.C. juvenile arrestees testing positive for marijuana, at only 2% in October, begins to rise. Adult positives also begin to rise.

2. Spring 1991

Marijuana surpasses cocaine as drug most commonly detected in urine tests of juvenile arrestees.

WKYS (local radio station) question of the day is: "Is it good or bad that marijuana has become the drug of choice among youth?"

The number of large cigars shipped into Washington in 1991 nearly doubles over 1990.

3. Winter 1991-92

Washington area emergency room marijuana-related episodes begin to rise

4. Spring 1992

Article on blunts, in which rapper B-Real demonstrates how to roll a blunt, appears in *High Times* magazine. Rap group Cypress Hill appears on the cover.

Rap group Beastie Boys appears on MTV with tee-shirts boasting Phillies Blunt logo.

Tee-shirts promoting blunts appear in Washington, D.C.

Washington, D.C. outreach workers report that youths are smoking blunts.

Percentage of Washington, D.C. juvenile arrestees testing positive for marijuana reaches highest level since testing began in 1986, with 24% testing positive in May.

The number of samples of marijuana removals submitted by the Metropolitan Police Department to the DEA laboratory begins to rise.

The number of large cigars shipped into Washington in 1992 is 50% more than in 1991 and more than triple the 1990 figure.

5. Spring 1993

High Times runs second major article on blunts. Rap singer Redman appears on the cover.

Florida newspaper reports that Havatampa, Inc., owner of Phillies Blunt cigars, donates to the Partnership for a Drug-Free America.

High rates of marijuana use among juvenile arrestees are responsible for highest overall positive rate detected in this population since testing began in 1986. Out of 22 marijuana-using arrestees interviewed by the Pretrial Services Agency, 21 reported they used blunts.

6. Summer 1993

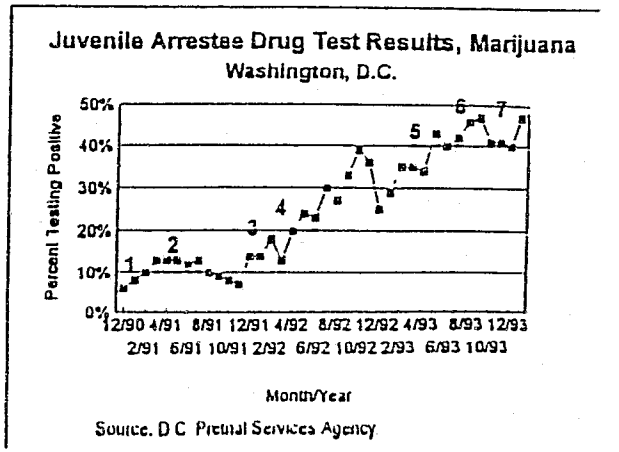
High Times letter to the editor appears encouraging boycott ofPhillies Blunts due to the company's donation to the Partnership for a Drug-Free America.

46% of juvenile arrestees test positive for marijuana in August.

7. Fall 1993

The annual number of removal samples of marijuana submitted to DEA reaches highest level since 1984.

Front Page *Washington Post* article appears on rise in marijuana use. WKYS question of the day is: "Is marijuana use harmful?"



Leading versus Trend Indicators: Observations from Economics

Daniel Sherman
Abt Associates, Bethesda, Maryland

Economists have a long tradition of using data collected over time as indicators of either current or future economic activity. This presentation provides some examples of such indicators, reviews how they are used, and discusses some of their limitations. Researchers and policymakers are beginning to use social indicators to monitor and prevent social ills, including drug abuse. The methodology and experience of using indicators in the field of economics may be useful to policymakers seeking to monitor and prevent drug abuse in that there are issues and problems common to creating and using indicators based on quantitative data.

Many economic indicators are based on data collected over time. Analysts typically seek to measure and anticipate the performance of the economy over time. At the national level, economic indicators may focus on one sector of the economy (e.g., manufacturing) or the economy as a whole (e.g., gross domestic product). The questions addressed by these indicators are what is the "health" of the economy at a point in time and whether there are likely to be changes in the future.

A *leading* economic indicator is a data series collected over time that anticipates changes in another data series. For example, the number of building permits issued in a month is an indicator that leads or anticipates housing construction: If the number of building permits issued increases, construction activity is likely to increase at some point in the future. Some hypothetical data are plotted in Figure 1, in which a change in the number of building permits (the bottom line in the graph) anticipates a change in construction three months later. Based on the data presented in this type of graph, one can estimate the length of time by which changes in one data series anticipate changes in another.

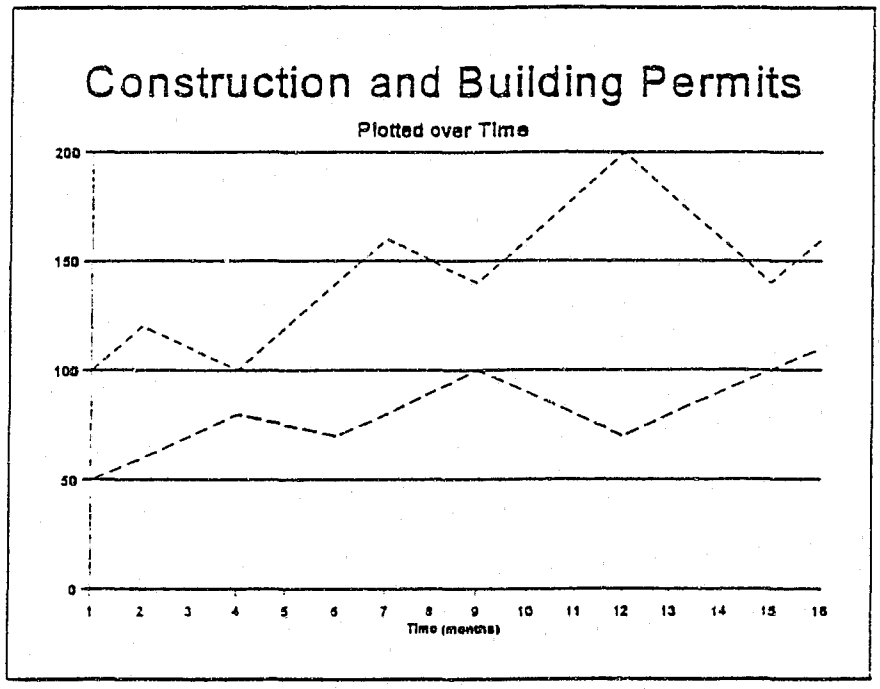
The federal government maintains an Index of Leading Economic Indicators, which combines information on a number of data series to predict the course of the economy. In addition to building permits, the index includes such information as unemployment insurance claims, orders for new business equipment, and the length of the average workweek. Each of these data series has been shown to predict the course of the economy with differing degrees of accuracy. By combining several different data series, it is possible to make predictions that do not depend on changes in any one data series alone. Thus, the index is less sensitive than any one of its component data series.

Developing leading indicators is an ongoing process. The lead time and accuracy of an indicator may change over time, so it is necessary to examine the performance of indicators continuously to decide if they need to be modified. A fundamental practical issue in developing indicators is how to measure lead times and how to measure whether a data series is a "strong" or "reliable" indicator of another data series.

An important consideration in developing and using leading indicators is whether there is a conceptual link between the data series used to create the indicator and the outcome of interest to be predicted. For example, there is an obvious theoretical link between building permits and subsequent construction. However, a data series may follow another series over time on a purely random basis. The danger here lies in projecting a relationship between data series into the future: If the relationship is indeed random, then it is unlikely to hold over time. In economics, a well-known example is trying to predict the future prices of stocks. Experience has shown that throwing darts at the stock pages of *The Wall Street Journal* on a given day will often produce a list of stocks that perform better than stocks chosen by financial experts. Although there are data series that appear to predict changes in the stock market (such as the length of dress hemlines or the winner of the Superbowl), such indicators are more likely to break down.

Leading economic indicators typically are used to gauge the direction of the economy and to predict when the direction will change (i.e., whether there will be a recession). In contrast, *trend* indicators are used to make predictions of the value of different data series over time (i.e., how much construction will occur in each of the next six months). As the term implies, trend indicators identify trends in data series and project those trends into the future. One data series may be used to predict the future behavior of the same series or to predict the future behavior of another related series (e.g., if a company's earnings go up for two quarters, its stock price will increase).

Figure 1



The risk in using trend data is that past patterns may change, and previous relationships may no longer hold. In using trend data, it is best to identify series that correlate with the outcome of interest (e.g., drug use) and incorporate as many sources of information that are in some way conceptually linked to the outcome. The fact that drug use has increased in an area over time (or within an age group) does not necessarily mean that it will continue to increase over time. However, if the data series are conceptually linked, it is more likely that when factors correlating with drug use (e.g., the availability of drugs, high levels of unemployment) continue to increase drug use will also continue to increase.

Thus far, I know of only limited efforts to develop and test indicators of social ills. For example, although William Bennett explicitly cites the Index of Leading Economic Indicators in his *Index of Leading Cultural Indicators*, he does not present an index, nor does he explicitly link the data sources he uses to outcomes of interest. The Economic Policy Institute published a cross-sectional study linking increases over time in unemployment to increases in crime and other outcomes, but it did not include drug use. Given the breadth of experience in the drug abuse field in conducting longitudinal studies of individuals, a clear next step would be to generate and test aggregate measures--indicators.

In conclusion, the experience of economists is that leading and trend indicators can help to identify the future course of an outcome of interest. Indicators offer a means of combining different sources of information to make predictions. The accuracy of the predictions cannot be determined, however, until after the fact. This means that to the maximum extent possible, indicators should be based on theories that rationally link data series. This will help to reduce errors in using indicators that have in the past predicted well only on the basis of chance. The process of developing indicators is an ongoing one in which the performance of indicators must be monitored as new information becomes available and can be incorporated into indicators.

For additional information see:

W. J. Bennett, 1994.* The Index of Leading Cultural Indicators: Facts and Figures on the State of American Society. New York: Touchstone Books.

H. M. Brenner, 1984. Estimating the Effects of Economic Change on National Health and Social Well-Being. Testimony Before the Joint Economic Activity Committee, 98th Congress, Second Session, Washington, D.C.

M. Harris, 1975. Leading Indicators: Early Warnings and False Alarms. New York: Federal Reserve Bank of New York.

R. V. Horn, 1993. Statistical Indicators for the Social and Economic Sciences. New York: Cambridge University Press.

*Bennett issued a report with the same title in March 1993.

B. Malkiel, 1985. A Random Walk Down Wall Street. New York: Norton.

M. Merva and R. Fowler, 1992. The Effects of Diminished Economic Opportunities on Social Stress: Heart Attacks, Strokes, and Crime. Washington, D.C: Economic Policy Institute.

M. Newcomb, E. Maddahian, and P. M. Bentler, 1986. Risk factors for drug use among adolescents: concurrent and longitudinal analyses. American Journal of Public Health 76(5):525-531.

Using and Interpreting Discharge Data from Maryland General and Private Psychiatric Hospitals

Paul Gentile
Maryland Health Resources Planning Commission

This presentation has three goals:

- Report on the impact of alcohol and drug abuse addiction on the Maryland hospital system.
- Introduce and encourage the use of a new source of data, the Hospital Discharge Abstract Data Base.
- Demonstrate the need to use multiple measures to investigate apparent trends.

Hospitals are open 24 hours a day. When no other alternatives are available, they admit patients for alcohol and drug abuse treatment. Collecting and analyzing hospital data related to drug- and alcohol-related conditions can offer a valuable additional source of information on the need for treatment and the services available.

Discharge data were obtained from the Maryland Health Resources Planning Commission's Hospital Discharge Abstract Data Base. Although this presentation focuses on the number of patients and their diagnoses at discharge, other socioeconomic, cost, and utilization information is included in the data base.

This presentation uses data for calendar years 1990-1992, drawn from all Maryland general and private psychiatric hospitals. As of December 1992, there were 51 licensed acute care hospitals and 6 private psychiatric hospitals. Discharge data from state psychiatric hospitals are not included in this report because of insufficient data.

Whether the number of drug- and alcohol-related treatment discharges decreased or increased from 1990 to 1992 depends on which diagnoses are counted. Patients often may have more than one condition, and more than one diagnosis. However, statistics based on hospital records often include only one diagnosis. Thus, relying on only the primary diagnosis, rather than including the primary and the secondary diagnosis, may give an incomplete picture of the treatment being offered by hospitals.

When diagnoses are linked to rates of payment for hospital care, differences between the reimbursement rates for different medical conditions may influence a clinician's selection of a diagnosis. Thus, systematic biases may appear.

This presentation contrasts two diagnostic coding systems and examines the primary and secondary diagnoses. Two sharply divergent trends emerge.

Diagnostic related groups (DRGs) 433-437 include drug- and alcohol-related conditions. However, these groups are not exhaustive. For example, they exclude drug or alcohol poisoning, as well as certain other conditions (e.g., those related to pregnancy). These additional conditions are included in a more comprehensive set of drug- and alcohol-related diagnoses reflected in the International Classification of Disease, Ninth Edition (ICD-9-CM) codes. However, this set is still conservative. For example, tobacco- and smoking-related diagnoses were omitted from the ICD-9-CM code listing. (See Tables 1 and 2 at the end of this presentation for information on where the DRG and ICD-9-CM codes do and do not match.)

Examining only the DRGs 433-437, discharges for a primary diagnosis of alcoholism or drug abuse dropped about 9 percent in general and private psychiatric hospitals between 1990 and 1992. (See Figure 1.) In 1992, there were 15,646 such discharges in Maryland. In some areas, dramatic decreases occurred. These changes may be attributed to closing of detoxification and rehabilitation programs, changes in state Medicaid policies, and increases in managed care programs and in utilization review.

Using the wider definition of drug- and alcohol-related admissions, ICD-9-CM addiction codes, one still finds that discharges decreased from 1990 to 1992. However, the wider definition results in roughly 3,000 more discharges than the DRG-based tally. Using the ICD-9-CM classification, there were 18,863 discharges in 1992.

However, if secondary diagnoses are included (using ICD-9-CM addiction-related discharges), then the trend data show a stunning reversal: From 1990 to 1992, there was an overall **increase** in the number of addiction-related discharges from Maryland hospitals. (See Figure 2.) Of the over 40,000 substance abuse-related 1992 discharges, 67 percent result from secondary diagnoses and 33 percent from primary diagnoses. (Data on secondary diagnoses were obtained by omitting any primary addiction discharge diagnosis to produce an unduplicated discharge count.) It has been argued that non-addiction diagnoses are reimbursed at higher rates and are easier to get approved by utilization review agents than are primary addiction diagnoses.

Among these cases, the relationship between primary and secondary diagnoses requires further attention. Of the non-addiction primary diagnoses, five of the top 10 were mental health diagnoses. (The top 10 primary diagnoses, in descending order, were affective psychosis, schizophrenia, diseases of pancreas, cellulitis and abscess, adjustment reaction, birth, coma and stupor, organic psychotic, respiratory, and neurotic disorders.) The secondary diagnosis was an ICD-9 drug- or alcohol-related diagnosis. This dual-diagnosis phenomenon is consistent with other recent studies and reports surveying the population receiving mental health services, which have found that between 50 and 80 percent also have a drug- or alcohol-related diagnosis.

Figure 1

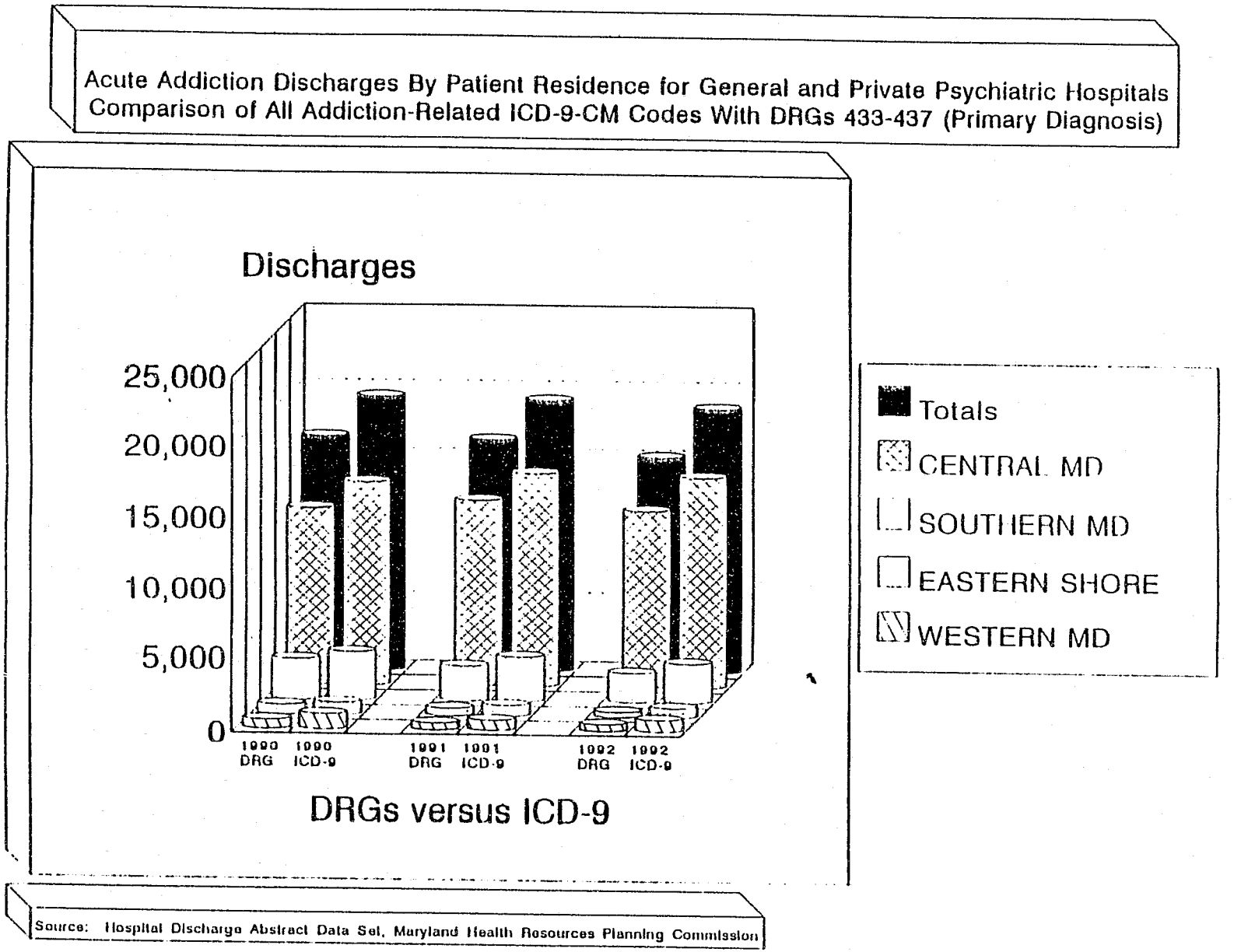
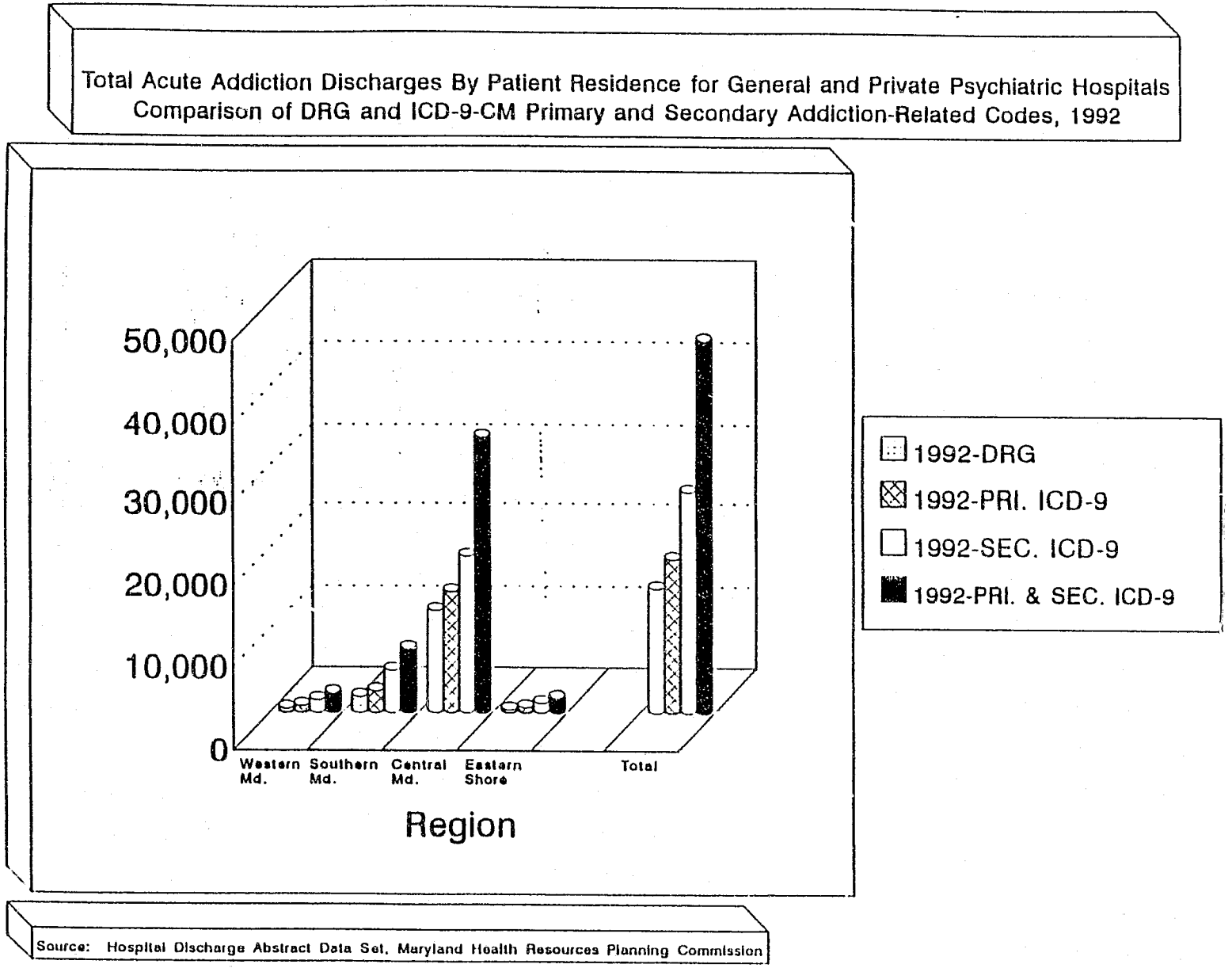

Acute Addiction Discharges By Patient Residence for General and Private Psychiatric Hospitals
Comparison of All Addiction-Related ICD-9-CM Codes With DRGs 433-437 (Primary Diagnosis)
Discharges
25,000
20,000
15,000
10,000
5,000
0
1990 DRG
1990 ICD-9
1991 DRG
1991 ICD-9
1992 DRG
1992 ICD-9
DRGs versus ICD-9
Totals
CENTRAL MD
SOUTHERN MD
EASTERN SHORE
WESTERN MD
Source: Hospital Discharge Abstract Data Set, Maryland Health Resources Planning Commission

Figure 2


Total Acute Addiction Discharges By Patient Residence for General and Private Psychiatric Hospitals
Comparison of DRG and ICD-9-CM Primary and Secondary Addiction-Related Codes, 1992
50,000
40,000
30,000
20,000
10,000
0
Western Md.
Southern Md.
Central Md.
Eastern Shore
Total
Region
1992-DRG
1992-PRI. ICD-9
1992-SEC. ICD-9
1992-PRI. & SEC. ICD-9
Source: Hospital Discharge Abstract Data Set, Maryland Health Resources Planning Commission

Professionals serving the mentally ill and addicted populations should work together in order to understand fully the needs of the populations they are attempting to serve. A deeper understanding of the entire continuum of care and the populations needing services is required to help even with such issues as how to staff our institutions. For example, hospitals serving the mentally ill need addictions counselors.

Figure 3 shows the rate of acute addiction discharges by county (using primary and secondary ICD-9-CM discharge codes, for each 10,000 residents). To construct these rates, population projections from the Division of State Planning for calendar years 1990-1992 were used. Most counties' rates of use ranged between 20 and 50 per 10,000 population. Allegany and Frederick counties had rates just over 60 per 10,000. The rate in Baltimore City climbed steadily, to 275 per 10,000, which was 500 percent higher than Allegany or Frederick County.

Since there is a greater burden upon Maryland's hospitals for caring for the addicted than previously reported, greater attention should be paid to the data and data sources. With over 40,000 primary and secondary ICD-9-CM addiction discharges reported in 1992, hospital-based addiction data can be used in conjunction with the Substance Abuse Management Information System (SAMIS), and other data bases that collect data on private and public non-hospital treatment facilities and programs, to obtain a more complete picture of the treatment continuum.

For additional information see:

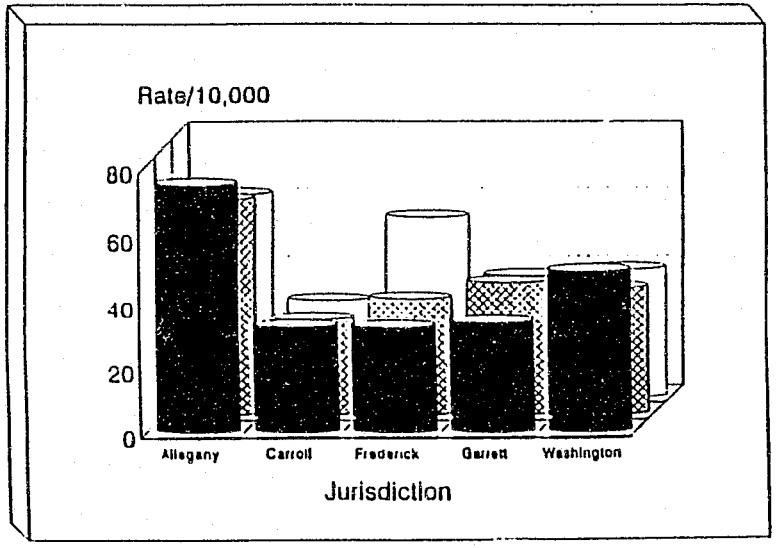
P. Gentile, Acute Addiction Discharges in Maryland General and Private Psychiatric Hospitals, 1991-1992. Maryland Health Resources Planning Commission, Baltimore.

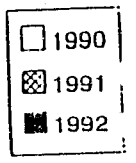
D. W. Simborg, 1981. DRG creep: A new hospital-acquired disease. New England Journal of Medicine 304:1602.

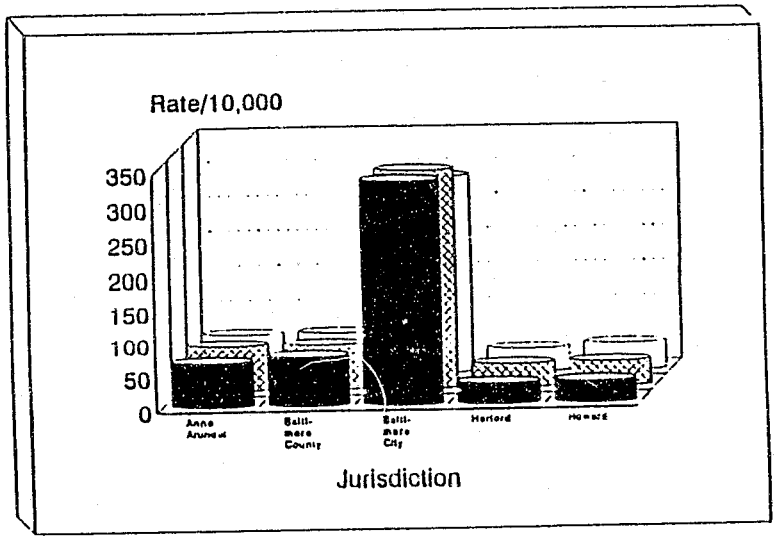
B. B. Cohen, S. Pokras, M. S. Meads, and W. M. Krushat, 1987. How will diagnosis-related groups affect epidemiological research? American Journal of Public Health 126:1.

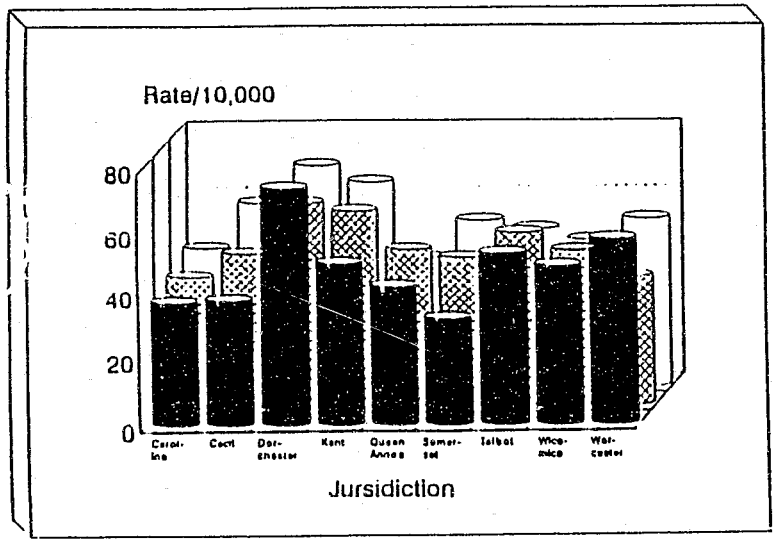
Figure 3

Resident Acute Addiction Discharges from General and Private Psychiatric Hospitals, Utilization Rates for Each 10,000 Residents 1990-1992 (*)









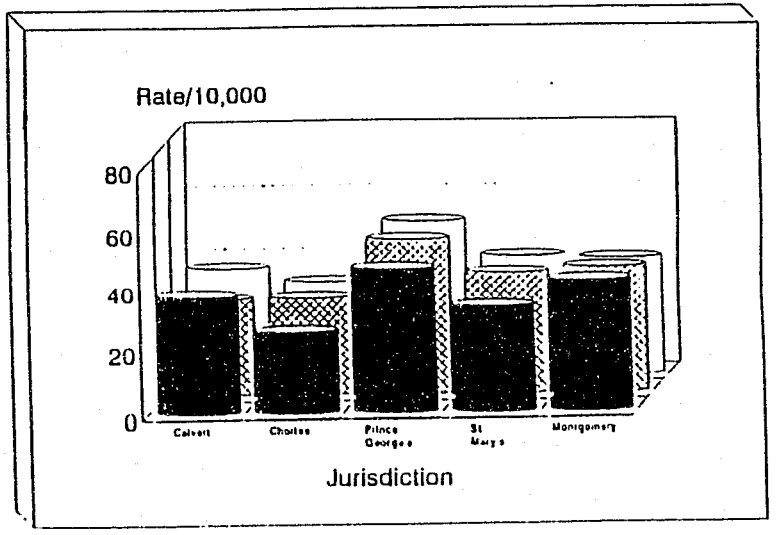


Table 1

DRGs 433-437 Matched to ICD-9-CM Codes
Substance-Induced Organic Mental Disorders

DRG 433-Alcohol/Drug Abuse or Dependence, Left Against Medical Advise

DRG 434 Alcohl/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment with Complicating Condition

Principal ICD-9 Code:
291 Psychosis, alcoholic
292 Psychosis, drug
303.0 Intoxication, acute alcoholic, or alcoholism
303.9 Drug dependence, alcohol; nondependent
304 Dependence, drug
305.0 Abuse, alcohol, nondependent
305.2 Abuse, cannabis, nondependent
305.3 Abuse, hallucinogen, nondependent
305.4 Abuse, barbituate, similarly- acting sedative or hypnotic; nondependent
305.5 Abuse, opiod-mixed; nondependent
305.6 Abuse, cocaine; nondependent
305.7 Abuse, amphetamine; nondependent
305.8 Abuse, antidepressant; nondependent
305.9 Abuse, unspecified drug; nondependent
790.3 Abnormal findings, alcohol in blood

DRG 435 - Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment without Complicating Condition (Same list as for DRG 434)

DRG 436 - Alcohol/Drug Dependence with Rehabilitation Therapy

Principal or Secondary ICD-9 Code:
291.0 Delerium, alcoholic, withdrawal
291.1 Syndrome, amnestic, alcoholic
291.2 Dementia, alcoholic, other
291.3 Hallucinosis, alcoholic withdrawal
291.8 Psychosis, alcoholic, specified
291.9 Psychosis, alcoholic, unspecified
292.0 Psychosis, unspecified drug, withdrawal syndrome
303.0 Intoxication, acute alcoholic, alcoholism
303.9 Dependence, alcohol, other unspecified
304 Dependence, drug
Non-operating room procedure
94.61 Rehabilitation, alcohol
94.64 Rehabilitation, drug
94.67 Rehabilitation, combination alcohol and drug

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

Non-Operating Room Procedures
94.63 Rehabilitation/detoxification, alcohol
94.66 Rehabilitation, Drug
94.69 Rehabilitation/detoxification, alcohol and drug combination

Source: St. Anthony's DRG Working Guidebook, 1993

Table 2

ICD-9-CM Addiction-Related Codes Not Matched to DRG Codes

265.2	Pellagra (alcoholic)
357.5	Alcoholic polyneuropathy
357.7	Polyneuropathy due to drugs
425.5	Alcoholic cardiomyopathy
535.3	Alcohol gastritis
571.1	Alcoholic fatty liver
571.1	Acute alcoholic hepatisis
571.2	Alcoholic cirrhosis of liver
571.3	Alcoholic liver damage, unspecified
572.3	Portal hypertension
573.3	Hepatitis (unspecified toxic)
648.3	Complicated pregnancy due to drug dependence
648.4	Complicated pregnancy due to drugs
655.40	Suspected damage to fetus from alcohol
655.50	Suspected damage to fetus from drugs
760.71	Fetus affected by alcohol (fetal alcohol syndrome)
760.72	Fetus affected by drugs
760.73	Fetus affected by hallucinogenic agents
760.75	Fetus affected by cocaine
965.00	Poisoning by opium
965.01	Poisoning by heroin
965.09	Poisoning by other drugs
968.5	Poisoning by topical and infiltration anesthetics (e.g., cocaine)
970.0	Poisoning by central nervous stimulants-analeptics
970.1	Poisoning by central nervous system stimulants-opiate antagonists
980.0	Toxic effect of alcohol

International Classification of Diseases - 9th Revision

Using Risk Indicators and Mobilizing Communities for Prevention Programs

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J. Sue Henry
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Harford County

The Maryland Project is an ongoing demonstration of a community mobilization effort aimed at reducing the risk for drug and alcohol involvement and crime in a community in Harford County. The project is a collaborative effort involving state agencies, local government, community residents, and researchers. In addition, the project included a community policing initiative, so it also is a collaboration of law enforcement and prevention. The Maryland Project is based on a "risk-based" approach to prevention, which we intended to teach to community residents. This approach is grounded in research that has identified several community-, school-, family-, and individual-related factors that are correlated with crime and drug use. In this presentation, we want to describe our efforts to engage the community in an action-research model, which was intended to include needs assessment, planning, implementation of program components, and evaluation. We also want to share the lessons we learned.

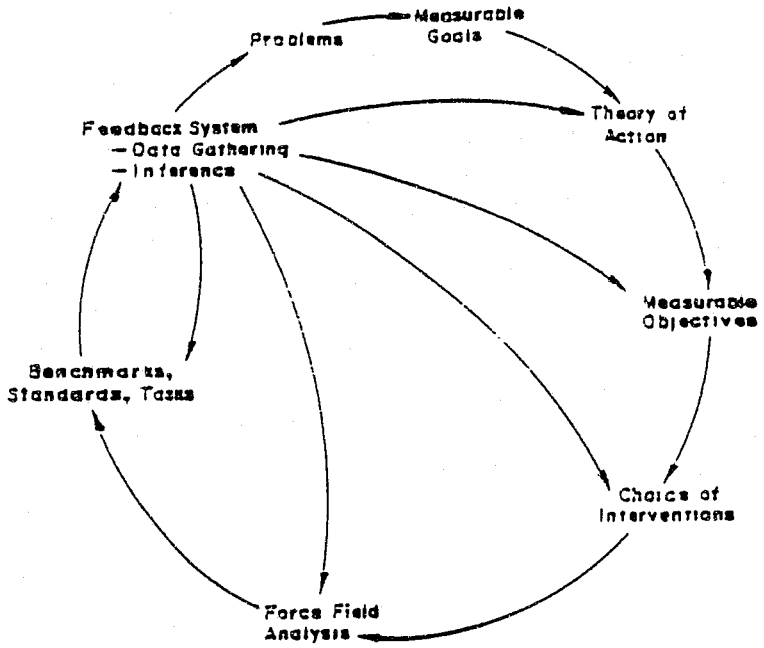
The community lies on the Route 40 corridor, which parallels Interstate 95 connecting New York, Philadelphia, and Washington, D.C. The Maryland Project developed out of a specific need in the community for increased enforcement and prevention services.

In planning the project, we selected as a model the Program Development and Evaluation (PDE) method (see Figure 1). The entire model uses a feedback system, in which data are gathered and inferences are drawn from the data. The model begins with the identification of community problems through a needs assessment. Once problems are identified, people then set measurable goals. Next, a theory of action is developed: People consider long-term outcomes in terms of risk and protective factors, and they think through how the long-term goals of reducing drug abuse can be related to more immediate outcomes. The more immediate outcomes are then expressed as measurable objectives. Interventions are then selected to address the particular risk factors in the community. The rest of the PDE method consists of managing the process. For example, the method requires analysis of the factors that are likely to get in the way.

Our initial idea was that in the first year the project would undertake the following tasks: We would do some publicity; form resident teams; conduct training sessions on the risk and protective factors; share the data from the needs assessment; break into neighborhood groups, and help them work through the PDE process and set their own goals and objectives; award mini-grants; and help the groups start their programs.

Figure 1

The Program Development Evaluation Method

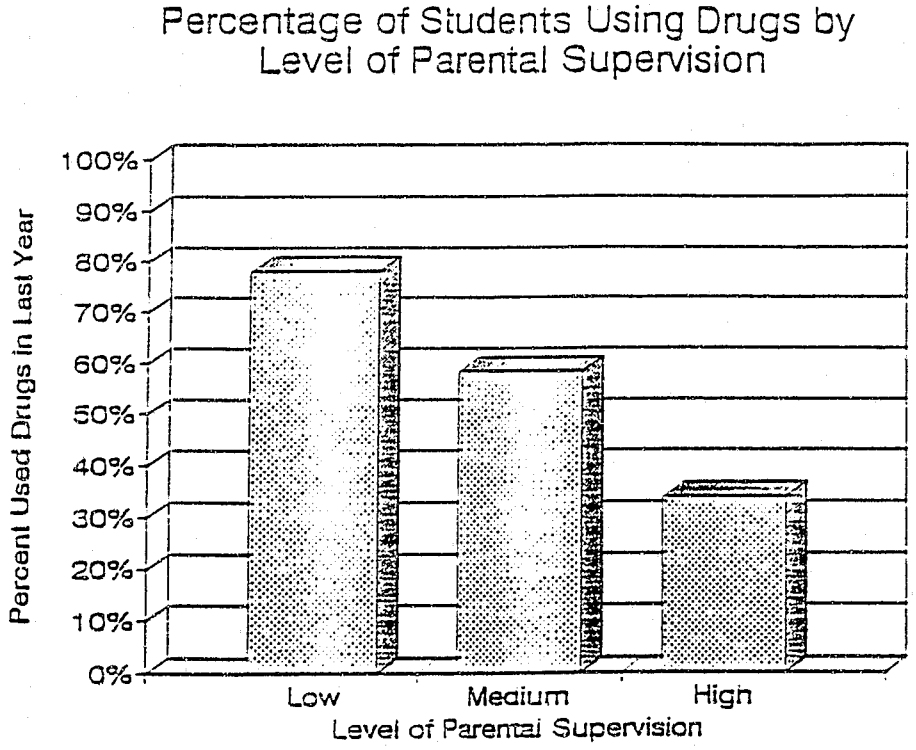


We used data from a survey done in the community to identify problems, organized the information from the surveys into teaching graphs, and related them to risk factors. Risk factors for drug abuse include social disorganization; ambiguous or inconsistent rules and sanctions regarding drugs and alcohol; availability of drugs in the school or the community; poor family management; early antisocial behavior; parental drug use and positive attitude toward use; academic failure; low commitment to conventional goals or lack of belief in conventional social rules; association with delinquent, drug-using peers; behavioral and cognitive skill deficits; attitudes and definitions favorable to drug use; and early first drug use. Figure 2, percentage of students using drugs by level of parental supervision, is one example. We wanted to convey to community members that regardless of the conditions in their communities. there were factors that made some of their children more susceptible than others to drug use and abuse.

The next step was to match each risk factor with a program component. (See Figure 3.) To help do this, we then put together a community program fair at a local community college. Speakers came in and talked about each of the different programs. For example, for each program component, they explained what resources were required to carry it out.

That was the basic plan. As noted, the process was very driven by data. We expected that people using this method would be informed by data at every step of the process. We had used this method with other groups--for example, with agency staff accustomed to planning. We

Figure 2



Source: Edgewood student survey, grades 6-11, Spring, 1991.

Figure 3

Matching Risk Factors with Programs and Services

If this risk factor is a problem...	This might be a program component*...
Poor family management practices	Parent training/education
Early antisocial behavior	Cognitive/behavioral skills training in pre-K or early elementary grades
Academic failure	Tutoring; improved instruction is schools
Behavioral and cognitive skill deficits	Skills training course
Ambiguous, lax, or inconsistent rules	School discipline program revision; media campaigns
Social disorganization	Community mobilization/empowerment activities

* Structure program prototypes with positive evaluations are available for all of these components.

had some concerns about using the method with community people who were not used to reviewing data or planning in this way.

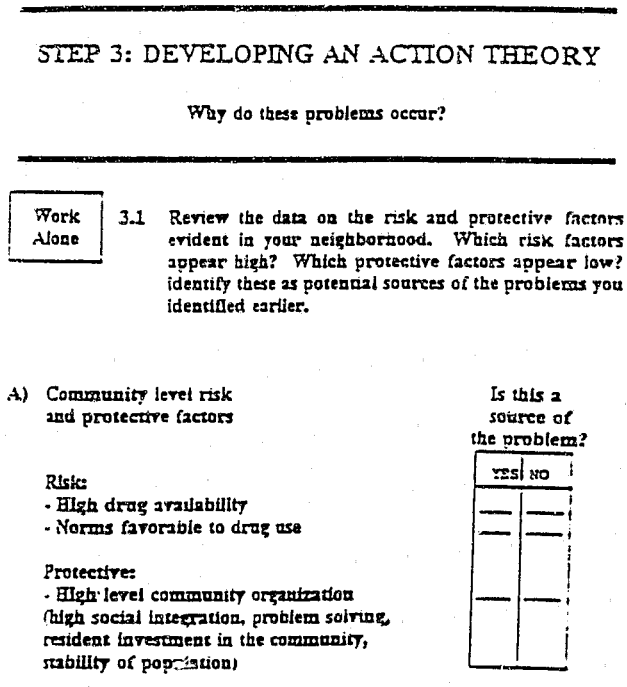
As part of the needs assessment, we gathered data from a variety of sources, including our own survey, on 21 identifiable neighborhoods in the community. Most of the risk factors were measured with student surveys. We also had geo-coded census data used to measure risk factors (e.g., such as divorce rates or the number of female-headed households within communities). Depending on the data source, we were able to make comparisons to national samples (e.g., on instruments normed to national samples), to the state of Maryland, to the larger community, or across the 21 neighborhoods.

We put the data into graphs and constructed workbooks to present the data and the PDE method. Figure 4, on developing an action theory, is a page from one of the workbooks. It was our expectation that residents would be able to review the graphs and identify risk and protective factors. We showed each community its own data. For example, we were able to break out the student survey by school and show that drugs were easy to get, especially in the high schools.

We found that the process did not work as planned. Although 85 community residents came to one of our early meetings, at each successive meeting attendance dropped by half. We had initially planned three Saturday workshops to go through the workbooks, but encountered great resistance to them. We ended up dropping the workbooks. We found that we were unable to teach community residents to use risk and protective factors to help identify long-term goals and more immediate objectives.

Our initial assessment is that the goals of the PDE method and community empowerment differ and clash in the Maryland Project. The PDE method calls for the residents to use

Figure 4



STEP 3: DEVELOPING AN ACTION THEORY

Why do these problems occur?

Work Alone

3.1 Review the data on the risk and protective factors evident in your neighborhood. Which risk factors appear high? Which protective factors appear low? Identify these as potential sources of the problems you identified earlier.

A) Community level risk and protective factors

Is this a source of the problem?

YES | NO

Risk:
- High drug availability
- Norms favorable to drug use

Protective:
- High level community organization (high social integration, problem solving, resident investment in the community, stability of population)

information from a community needs assessment and from prior research and evaluations about what strategies have worked. In the long run, such an approach is likely to produce the greatest reductions in drug use and crime. However, residents were impatient with the process of going through the data, learning the risk and protective factors, and addressing long-term goals. We found it hard to keep community volunteers interested in reviewing data when they wanted to go directly to action. As one resident said, "We just want to solve the problems in our communities. We don't want any more of these statistics. We just want to have a bake sale."

We did mobilize the community. In addition to attracting residents who wanted immediate results with specific neighborhood problems, the project also attracted some who were willing to struggle to get long-term needs met. The PDE method better suits those people who are willing to work toward long-term goals. Yet even these people became discouraged when the process delayed or even directed the action taken in what had been presented as a community-based project.

To some extent, the program has been a success insofar as the community took on a more positive identification. The community policing component has had some positive results. However, we still wrestle with how to mobilize community residents to use data and prior research in planning. Perhaps one solution is to make state and local agency people responsible for planning, with support from residents.

In discussion, a participant noted that many federal agencies and states are funneling money into neighborhood demonstration projects, so that many communities are trying to work at this issue from different perspectives. Given that the approach is being used so widely, what else can be done? Various suggestions were offered. One person noted that a VISTA volunteer working in his community had told him, "The most important thing is to do nothing, but to be there--make contact with people two or three times per week." Events such as bake sales give community residents the opportunity to begin where they are and to start forming a community identity. Then when problems occur, the residents can begin to address them. One participant suggested that perhaps the planning process should have begun with the bake sales, and then the residents would have been ready for more sustained action later.

Other participants suggested that the community should be more involved in identifying the problems, locating data sources, and conducting the needs assessment. Although residents in the community engaged by the Maryland Project knew there were problems in the community, when they actually saw the data, they argued that conditions really were not that bad. Community denial might have been avoided, had they been engaged. Another participant suggested that the community policing initiative, which did have some successes, addressed the residents' short-term goals of removing the immediate hazards from the community.

Finally, comments from people working on other community mobilization efforts indicated that the problem of motivating residents to use data and research is not unique to this project and that achieving the greatest impact on outcomes while working with empowered communities remains a challenge.

For additional information see:

D. C. Gottfredson and C. M. Fink, 1992. The Maryland Project: Lessons on Community Mobilization. Institute of Criminal Justice and Criminology, University of Maryland at College Park. CESAR Special Topics on Substance Abuse, Report 93-1.

C. S. Koper, 1993. The Maryland Project: Community-Oriented Policing and Drug Prevention in Edgewood, Maryland. Institute of Criminal Justice and Criminology, University of Maryland at
College Park. CESAR Special Topics on Substance Abuse, Report 93-3.

Drug Trends in Baltimore City and Price/Purity Data

Shiv Soni
Baltimore City Police Department

The Baltimore City Police Department has about 2,900 police officers serving the city. The Laboratory Division within the department consists of four functional units. Seventy criminologists provide assistance to the police in criminal investigation, using scientific techniques and procedures to detect and analyze evidence. They also provide expert testimony in courts of law. Fifteen criminologists in the Drug Analysis Unit contributed their efforts toward this presentation on drug trends and price/purity data.

Figure 1 shows trends in the number of cases submitted to the Baltimore Crime Lab from 1990 to late 1993. As can be seen, the pattern of the fluctuations is similar across years, but the magnitude changes.

In both 1992 and 1993, submissions dropped over the summer months; however, in 1992, the drop in summer submissions was much greater. The 1993 pattern reflects the changing priorities of the department and the deployment of police task forces to combat violent crime and control substance abuse. The end result is the increased drug submissions we are currently experiencing.

Figure 2 shows a 17 percent increase in total drug submissions in 1992 over 1990-1991. Comparing 1993 to 1990, we anticipate a 34 percent increase in drug submissions. The case load has more than doubled in the past 10 years.

A submission may involve 10, 20, or 100 bags containing different types of drugs. Each bag is defined as a unit. Figure 3, total drug exhibits, shows that there were 10.8 drug units per submission in 1990 (up from 8.8 drug units/submission in 1989) and in 1993, there were 13.5 drug units per submission. What does this increase mean? It suggests that aggressive drug interdiction efforts are being made by police officers against dealers and traffickers. The increase may also suggest that more drugs are available on the streets of Baltimore.

Figure 4, shows the distribution of different types of drugs among the total submissions. Four drugs--heroin, powder cocaine, crack cocaine and marijuana--accounted for 76 percent of submissions in 1990 and 84 percent in 1993. Throughout the period 1990 through 1993, PCP constituted less than 1 percent of the total submissions. During this

Figure 1

CASES SUBMITTED, BALTIMORE CITY CRIME LAB
JANUARY 1990 THROUGH SEPTEMBER 1993

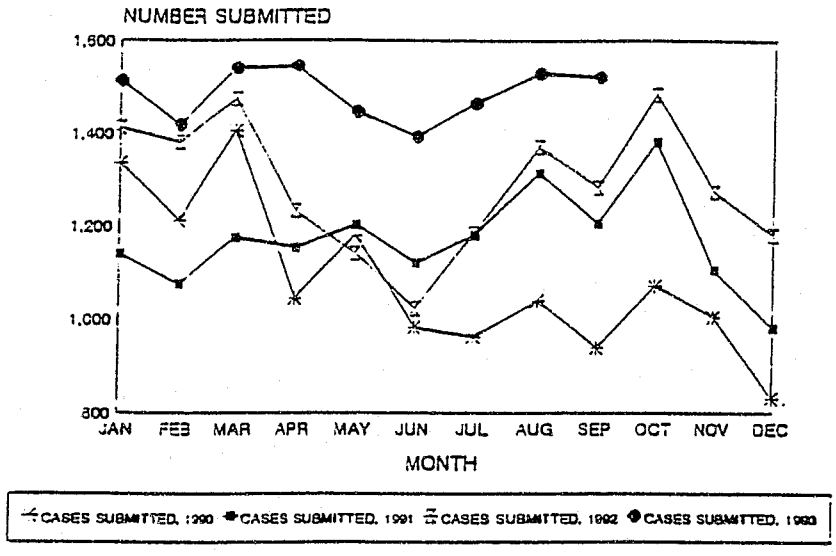


Figure 2

Total Drug Submissions

Year	# of Drug Submissions	% Increase	Cumulative % Increase Since 1990
1993	13368 † 18000 *	17 *	34 *
1992	15433	9	17
1991	14028	8	8
1990	13000		

† As of September 30, 1993
* Projected

Figure 3

Total Drug Exhibits

Year	# Drug Units in Total Submissions	Cumulative % Increase Since 1990	Average # Drug Exhibits per Submission
1993	180,785 † 240,000 *	71 *	13.5 †
1992	214,062	53	13.9
1991	171,325	22	12.2
1990	140,135		10.8

† As of September 30, 1993
* Projected

Figure 4

Percent of Drug Types Present in Submissions

	YEAR			
DRUG	1993 †	1992	1991	1990
Heroin	22.0	19.6	21.0	22.5
Cocaine	36.3	40.7	42.7	37.0
"Crack"	16.2	13.0	8.5	3.9
Marijuana	9.1	7.7	8.0	13.0
PCP	0.7	0.6	0.5	0.9
Non-CDS	14.5	16.5	17.0	20.0
Misc.	1.2	1.9	2.3	2.7

† As of September 30, 1993

period, between 14 and 20 percent of the drugs were uncontrolled drugs and cutting agents such as quinine, sugars (inositol, mannitol, lactose), baking powder (used to make crack cocaine), aspirin, and acetaminophen (a component of Tylenol). Miscellaneous drugs, such as benzodiazepines and synthetic and semisynthetic opium alkaloids, accounted for 1 to 3 percent.

Figure 5 illustrates a four-fold increase in drug submissions containing crack cocaine between 1990 and 1993. Almost all of the increase in drug submissions resulted from increased submissions of cocaine base (crack). Only a marginal contribution to this increase was made by other drugs.

Figure 6 shows an interesting "mirror image" effect, in which the monthly changes in heroin and cocaine submissions appear to move in equal and opposite directions. Discussion of this graph focused on whether these changes reflected changes in drug use on the street. For example, as one (cocaine stimulant) goes up in use, the other (heroin depressant) goes down and vice versa. Alternatively, the mirror image effect could be a statistical artifact created by plotting increases in percentages of parts of the same total. It appears that the availability and distribution of heroin and cocaine powder on the streets of Baltimore remain fairly stable. The demand for these drugs has not increased as has the demand for crack cocaine.

The crime lab submission data for 1990 through 1993 may be compared to data collected by the Baltimore City Pretrial Release Services on the number of arrestees testing positive for opiates. But the Drug Abuse Warning Network (DAWN) has recently reported a dramatic increase in heroin-related emergency room (ER) episodes in the Baltimore Metropolitan area during 1990-1992.

One answer to the heroin paradox lies in heroin's increasing purity (see Figure 7). One plausible explanation for the increase in heroin-related ER episodes is the increase in the purity of heroin as sold on the street, as well as the availability of very high quality heroin. Two grades of heroin are now being found on the streets of Baltimore: In the third quarter of 1993, one type was 9.7 percent pure heroin, and the other was 65.5 percent.

Our data agree with the 1992 Baltimore DAWN data, which also show an increased incidence of cocaine-related ER mentions. The urinanalysis data collected by DAWN and the Pretrial Release program cannot distinguish between crack and powder cocaine. It is likely that the increased incidence of cocaine mentions is due to the use of crack cocaine.

As is generally accepted, low prices of drugs on the streets indicate ample supply (and/or less demand); the reverse is true when the prices are high. If the demand for crack

Figure 5

BALTIMORE CITY CRIME LAB DATA
PERCENTAGE OF TOTAL SUBMISSIONS
COCAINE BASE, MARIJUANA AND PCP

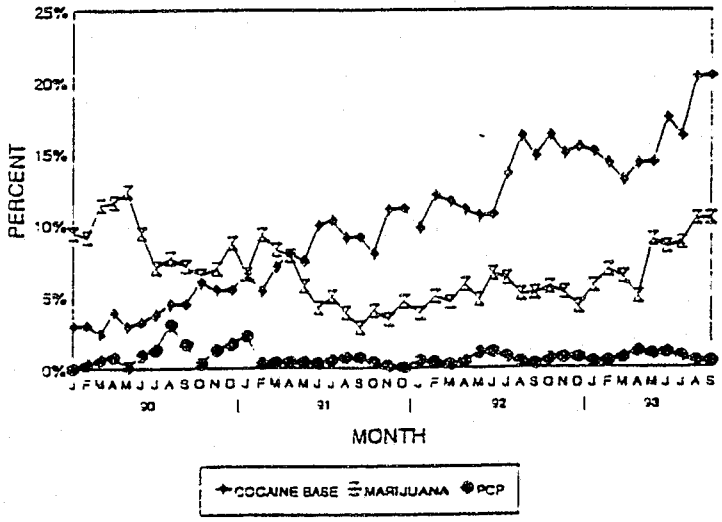


Figure 6

BALTIMORE CITY CRIME LAB DATA
PERCENTAGE OF TOTAL SUBMISSIONS
HEROIN AND COCAINE HCL

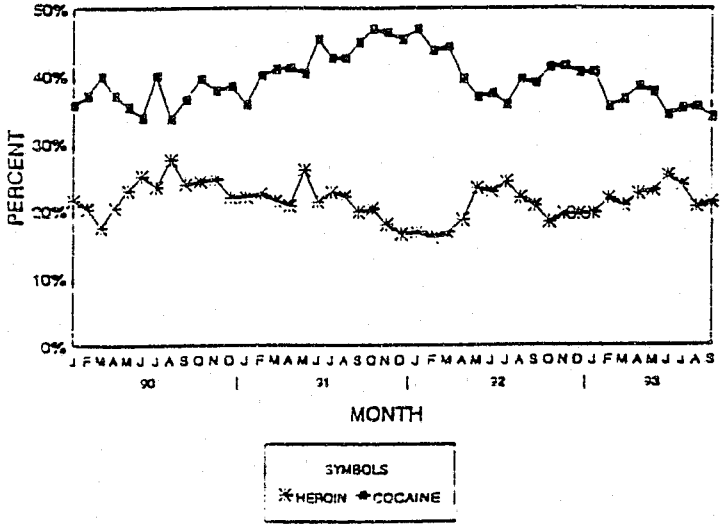


Figure 7

Average Percentage Purity of Drugs
(By Time Period)

Drug	July-Sept, 1993	March, 1992 * Sept, 1991 †	Aug, 1990-Jan. 1991
Cocaine (powder)	69.8	76.9 †	65.6
"Crack" Cocaine	73.7		81.6
Heroin I	9.7	6.3 *	5.3
Heroin II	65.5		

cocaine increased, one can speculate that there is an ample supply of the drug in the city. Our data on price/purity in the past year reveal that the price of crack cocaine has dipped slightly, from $135 to $115. These data on prices are based upon $10 and $20 buys by undercover police officers. Since crack cocaine is made from powder cocaine, there must be an adequate supply of powder cocaine. The price and purity of cocaine powder have not changed in the past year. Similarly, the price of heroin has not changed dramatically although its purity has increased. This suggests an ample supply of heroin.

In summary, despite all the interdiction efforts made by the police, there continues to be an abundant supply of drugs on the streets of Baltimore.

For additional information see:

Maryland State Police, 1992. Price/Purity: A Forensic Assessment of the Illegal Drug Market in Maryland. Criminal Intelligence Division.

Maryland Statewide Epidemiology Work Group (MD/SEWG)
MEMBERSHIP
November 8, 1993

Drug Epidemiology Network (DEN) Representatives

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Baltimore Substance Abuse Systems, Inc.

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Sharon Stout, MD/SEWG Coordinator

Clare Mundell, DC CEWG Representative

Maryland Statewide Epidemiology Work Group (MD/SEWG)
Meeting
November 8, 1993

ATTENDEES

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Bonnie Cook
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Montgomery County

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Valerie Hicks
Bureau of Drug Enforcement, MSP

Timothy Kerns
Shock Trauma Center
University of Maryland Hospital

Melody McEntee
Gov. Drug & Alcohol Abuse Comm.

Ruth Phillips
Maryland Dept. of Juvenile Services

ATTENDEES, continued

State Agency Representatives (continued)

Floyd Pond
Gov. Drug & Alcohol Abuse Comm.

William Rusinko
Maryland Alcohol & Drug Abuse Admin.

Tom Slahetka
Maryland State Police

Carl Soderstrom
Shock Trauma Center

Tom Spalding
State Highway Administration

Lisa Wiederlight
Maryland State Police

Observers

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Towson State University
Health Science Department

Sudha Alexander
Dept. of Health & Mental Hygiene

Carol Anglin
RII

Kim Ashburn
Maternal Child/Health Science Consortium

Mary-Catherine Augustine
Maternal Child/Health Science Consortium

Gladys Baxley
Healthcare Services Development Corp.

Robert Bozzo
D.C. Community Prevention Partnership

Jo DeWeese
Clarksville, MD

Phyllis Ensor
Towson-State University
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Robert Ferguson
Baltimore Coalition Against
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Denise Gottfredson
University of Maryland
Inst. of Criminal Justice & Criminology

Timothy Holmes
Criminal Justice Coordinating Commission

Robin Jacobs
Mental Hygiene Administration

Elizabeth Lambert
National Institute on Drug Abuse

Maryland Statewide Epidemiology Work Group (MD/SEWG)
Meeting
November 8, 1993

ATTENDEES, continued

Observers
(continued)

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STD/HIV Surveillance Unit
Baltimore City Health Dept.

Greta Noronha
D.C. ADASA

Timothy Santoni
Mental Hygiene Administration

Daniel Sherman
Abt Associates

Lt. Gary Simpson
Annapolis Police Department

Shiv Soni
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Ross Levitsky

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Ken Petronis
Marie Ragghianti
Jean Shirhall
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Mike Wagner

APPENDIXES

APPENDIX A

Results of the November 1993 MD/SEWG Feedback Survey

RESULTS OF THE NOVEMBER 1993 MD/SEWG FEEDBACK SURVEY

At the November 1993 MD/SEWG meeting, DEN members and observers were asked to evaluate the meeting and related activities. Participants were asked whether the MD/SEWG activities in general and the MD/SEWG meeting in particular were useful to them, met their needs, and were of high caliber.

The November 1993 evaluation form contained nine sections; the final section consisted of a mini-survey of what types of hardware and software members and observers used. Using a scale ranging from 1 (excellent) to 5 (unsatisfactory), participants were asked to rate (1) pre-meeting activities; (2) the Proceedings reports; (3) meeting materials; and (4) on-site meeting services. Participants were asked for their comments on (5) the usefulness and quality of meeting presentations; (6) the overall usefulness of the meeting; and (7) the overall quality of the meeting. In section 8, participants were asked what changes, if any, they would like in the format of the meeting. As noted, section 9 was the hardware/software mini-survey.

Thirty-four participants of the 45 who attended returned the evaluation forms (a 75 percent response rate). However, all participants did not answer every question: All questions were not necessarily relevant to all participants (e.g., questions on site visits), and not all of those who attended were present for every session.

The mean ratings for pre-meeting activities ranged from 1.6 to 1.9, between excellent and very good. This section included questions on helpfulness and usefulness of site visits, telephone assistance, the DEN data update packet, and the quality of the invitational packet and directions.

The mean ratings for all questions concerning the Proceedings reports ranged from 1.8 to 1.9 (with 2.0 indicating very good). These items included inquiries on the quality and usefulness of Volumes I and II of the May 1993 Proceedings report.

The mean ratings for meeting materials ranged from 1.5 to 1.6; mean ratings for on-site services (ranging from 1.3 to 1.5) were also rated between excellent and very good.

Participants varied in their assessment of the quality and usefulness of presentations. In general, every participant rated highly at least one presenter--and felt that at least one other presentation was of little interest or utility. However, participants responded differently to the presentations, so that those presentations that received favorable comments from some received less favorable comments from others. Two factors seem to account for some of the variability in responses. First, to the extent that participants identified themselves, it is

apparent that their interests and degree of experience enter into their assessments of the utility and quality of the presentations. Second, participants' comments indicated that they found some information useful--though not necessarily presented in the most inspiring way--or conversely, interesting, though of little immediate use. The presentation on DC/CEWG Update received very favorable comments, both for the information on smoking marijuana in blunts and as an example of investigating trends. The presentation on Hospital Discharge data received favorable comments, and participants noted that it offered a new data source. In general, the participants' ratings suggest that each meeting should include a variety of presenters from different disciplines using different approaches.

The meeting as a whole received favorable comments regarding utility and quality. A common theme in responses was that questions and responses from the participants were very valuable, and there were many requests for more time for discussion. Interestingly, some participants thought that some individual sessions went on too long, while others felt that valued discussion time was cut short.

Asked, "Based upon your experience of the November 1993 meeting, what changes, if any, would you recommend for the Spring 1994 meeting?", most participants suggested using the same format.

Among the participants who responded to the mini-survey on hardware and software, 93 percent used IBM or IBM-compatible computers. Seventy percent stated that the package most often used is word processing software. Many respondents did not have modems, which is of particular concern to CESAR staff because it means that those participants cannot access CESAR's electronic bulletin board.

We note that if those who attended the meeting and returned the forms were those most pleased with the MD/SEWG, these responses may be upwardly biased. We also note that there may be a problem with selection bias insofar as those who did not attend were not surveyed.

The CESAR staff want to continue to improve their work and meet the needs of MD/SEWG participants. Although we were quite pleased with the responses we received, we welcome any additional comments and suggestions.

APPENDIX B

County MD/SEWG Reports

APPENDIX B-1

Harford County

OVERVIEW
HARFORD COUNTY DRUG/ALCOHOL IMPACT PROGRAM

The Harford County Drug/Alcohol Impact Program (DAIP) is the lead agency for Harford County's DEN. The DAIP developed out of community cooperation initiated by the Harford County Drug Advisory Council. The program has been funded by local government since 1980 and is located in the Department of Community Services. The DAIP is responsible for the development, implementation, evaluation and coordination of prevention activities for alcohol, tobacco and other drugs.

Harford County is in a period of rapid transition. The population as calculated in the 1990 CENSUS is 182,132. It is projected to increase by 15% (209,128) in 1995. Currently, the medium household income is 41,700. There are 162,559 whites, 15,530 blacks and 4043 other/unknown. 91,196 are female, 90,936 are male. 54,296 of the population are under 20 years of age.

The Harford County DEN consists of a variety of members (see attached) who meet at a quarterly community networking meeting to discuss pertinent issues. These meetings were developed in FY 1985 by citizens and agency personnel to share ideas to explore current issues and to plan future programming. This has proved to be an excellent means for agency collaboration.

HARFORD COUNTY DEN MEMBERSHIP LIST

- HARFORD COUNTY GOVERNMENT

  DRUG/ALCOHOL IMPACT PROGRAM
  HEALTH DEPARTMENT

- DEPARTMENT OF JUVENILE SERVICES
- HARFORD COMMUNITY COLLEGE
- HARFORD COUNTY PUBLIC SCHOOLS
- HARFORD CHRISTIAN HIGH SCHOOL
- JOHN CARROL HIGH SCHOOL
- LAW ENFORCEMENT

  ABERDEEN POLICE DEPARTMENT
  BEL AIR POLICE DEPARTMENT
  HAVRE DE GRACE POLICE DEPARTMENT
  HARFORD COUNTY SHERIFF'S OFFICE
  JOINT NARCOTICS TASK FORCE

- MADD
- STATES ATTORNEY'S OFFICE
- TREATMENT CENTERS

  ADDICTION RECOVERY AND RELATED THERAPIES
  FATHER MARTIN'S ASHLEY
  NEW BEGINNINGS AT HIDDEN BROOK
  TOGETHER RECOVERY WORKS

- UPPER CHESAPEAKE HOSPITALS

KEY DRUG INDICATORS
HARFORD COUNTY DRUG/ALCOHOL IMPACT PROGRAM

- STUDENT SUBSTANCE ABUSE
- STUDENT ALCOHOL AND OTHER DRUG-RELATED SUSPENSIONS
- JUVENILE DRUG ARRESTS
- JUVENILE JUSTICE DRUG-RELATED INTAKES
- JUVENILE TREATMENT ADMISSIONS
- ADULT TREATMENT ADMISSIONS
- DRUG ABUSE DEATHS
- ALCOHOL AND OTHER DRUG RELATED CRASHES
- DWI ASSESSMENTS
- DRUG-RELATED AIDS CASES
- ADULT DRUG ARRESTS
- DWI ARRESTS

HIGHLIGHTS
HARFORD COUNTY DRUG/ALCOHOL IMPACT PROGRAM

In this report updated indicators include:

- Student Substance Abuse
- Juvenile Drug Arrests
- Adolescent Treatment Admissions
- Adult Treatment Admissions
- Alcohol and Other Drug Involved Crashes
- Adult Drug Arrests
- DWI Arrests

The following are interesting conclusions drawn from this data:

Juvenile Data

- Drug arrests have increased from 1989 to 1992; overall possessions have increased and distributions have decreased (distributions did peak in 1991).

- Treatment admissions increased overall from 1988 to 1993 and peaked in 1992.

- DWI arrests decreased from 1989 to 1992.

Adult Data

- Drug arrests decreased from 1988 to 1991 then increased significantly from 1991 to 1992.

- Treatment admissions have increased overall from 1988 to 1993 but decreased from 1992 to 1993.

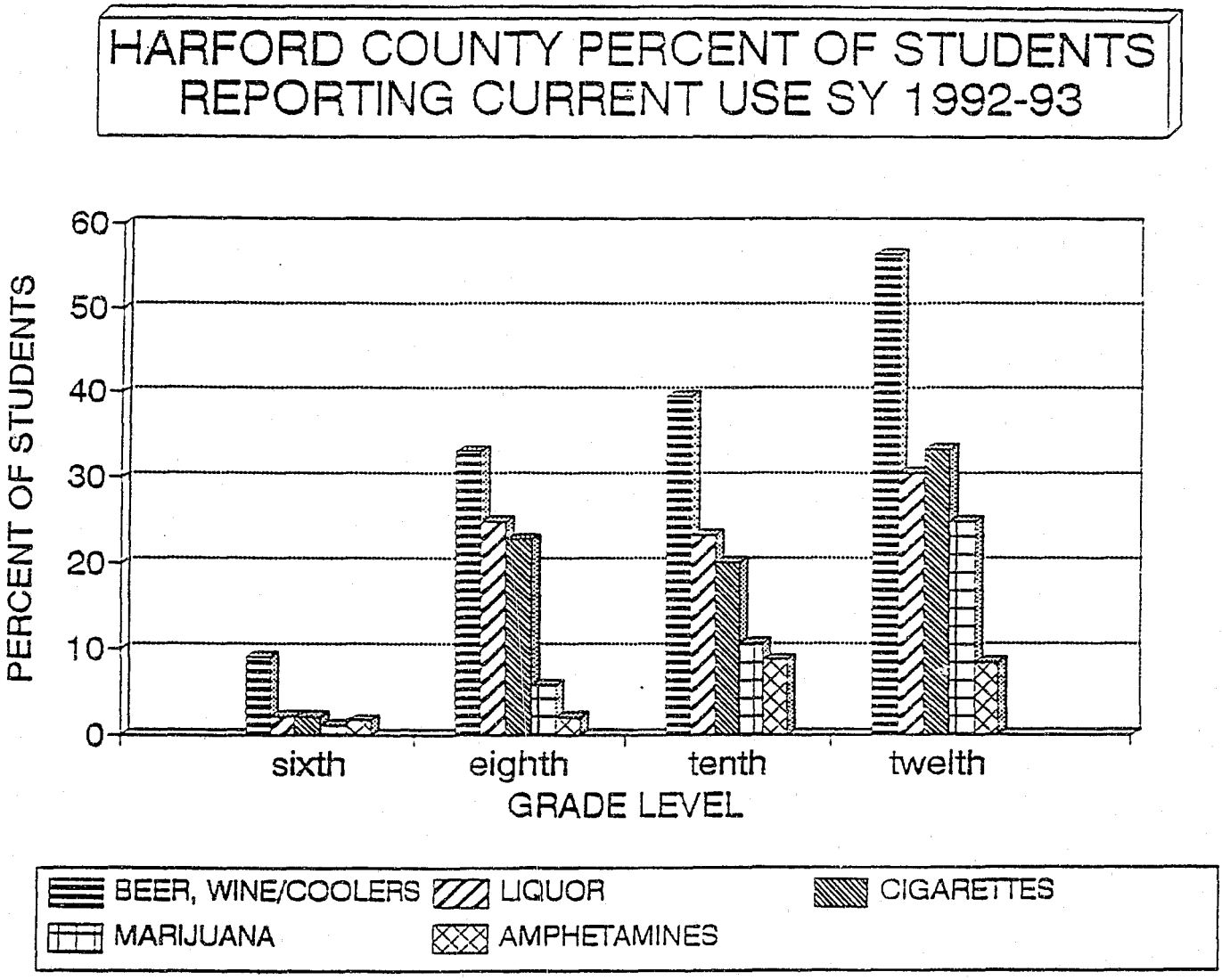
- DWI arrests decreased from 1988 to 1990 and then increased from 1990 to 1992.

INDICATOR #1: Student Substance Abuse

Brief Remarks: In all grades surveyed, 6th, 8th, 10th, 12th, beer, wine and wine coolers were the top drug used. Although smokeless tobacco is not part of the graph, it is important to note that smokeless tobacco was number two for 6th graders. Liquor was number two for eighth and tenth graders and cigarettes was second for twelfth graders.

Brief Comments: The continued revisions of the survey instrument and changes regarding responsibility for administration means that survey data cannot be compared over the past years and raises questions regarding reliability. Additionally, although controversial, it does not provide the more specific geographic descriptions for Harford County planning. That is where the students actually live.

INDICATOR: #: 1: Student Substance Abuse



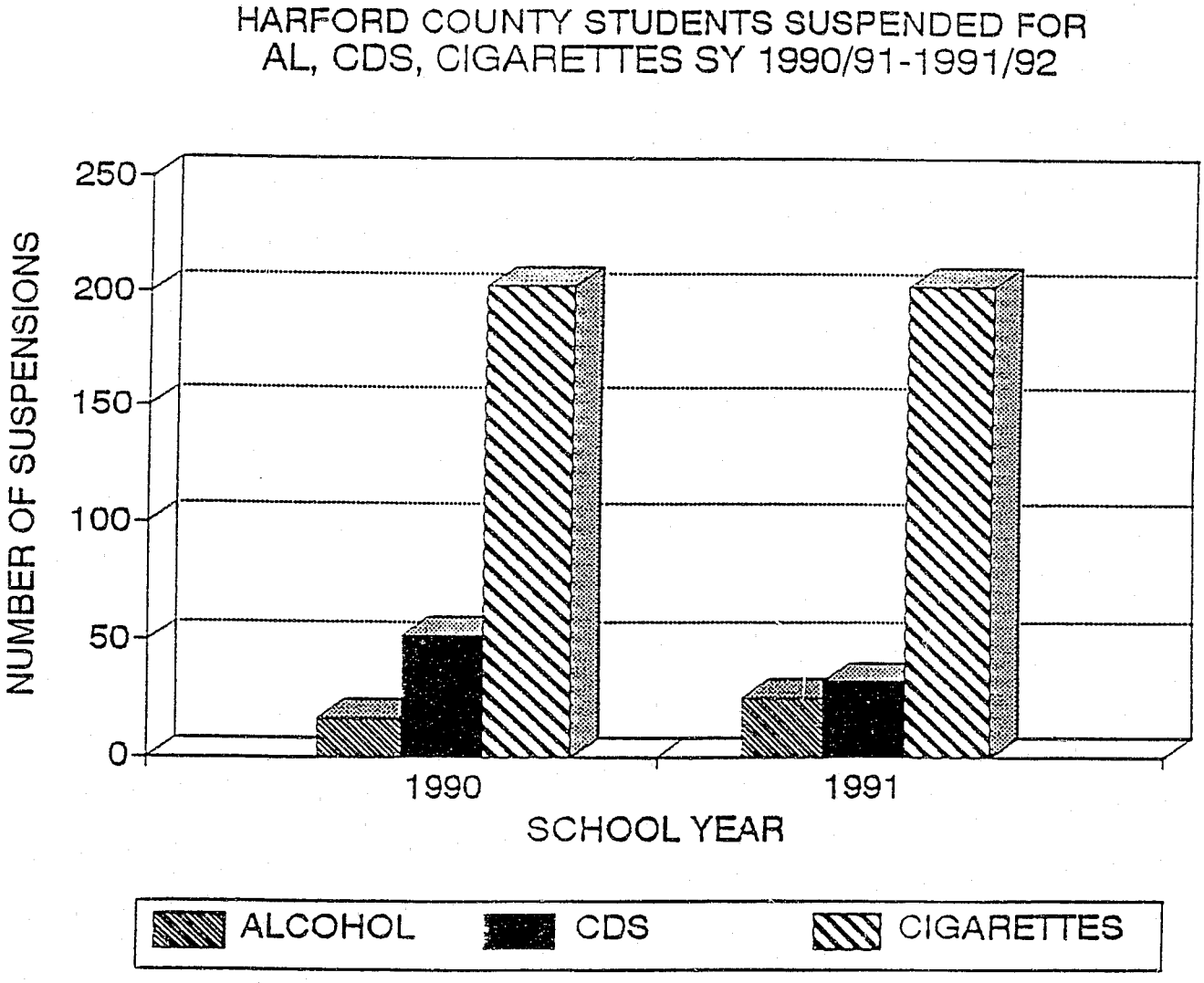
Source: 1992 Maryland Adolescent Drug Survey

INDICATOR #2: Student Alcohol and Other Drug-Related Suspensions

BRIEF REMARKS: There were significantly more smoking related suspensions than CDS or alcohol related suspensions in school years 1990/91 and 1991/92. Data is not complete for school year 1992/93. However, as of January 1993 there were significantly more smoking related suspensions.

Technical Comment: This may reflect the increase in emphasis on smoking related offenses as the school system continues it's efforts to be a totally smoke free environment. Faculty have also become more sensitized to the seriousness of tobacco as a "drug" and may be stronger in their enforcement.

INDICATOR #2: Student Alcohol and Other Drug Related Suspensions



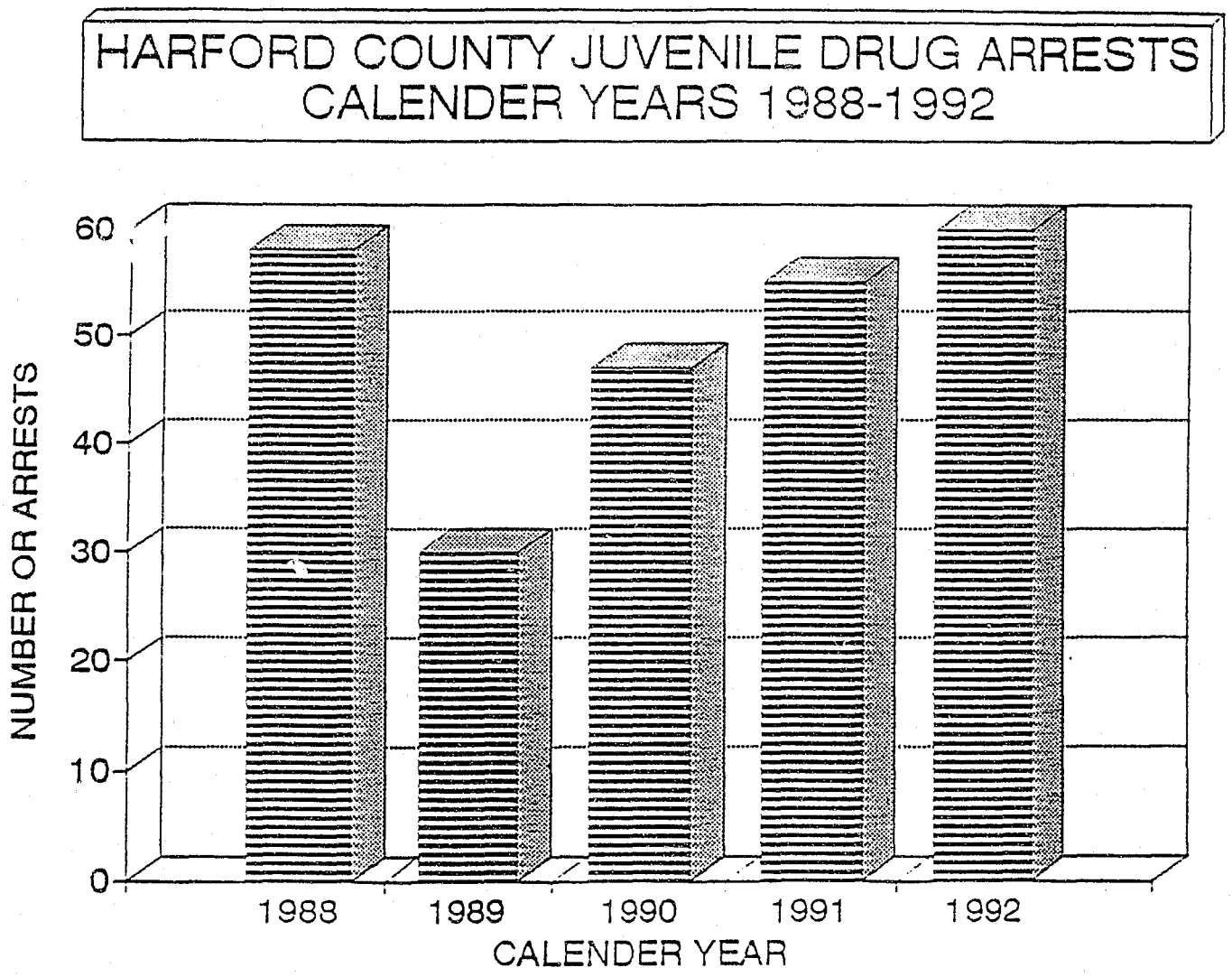
Source: Harford County Public Schools

INDICATOR #3: Juvenile Drug Arrests

Brief Remarks: Harford County juvenile drug arrests have decreased from 1988 to 1989 and increased steadily from 1989 to 1992. Of these arrests, possessions increased in 1992 and distributions decreased.

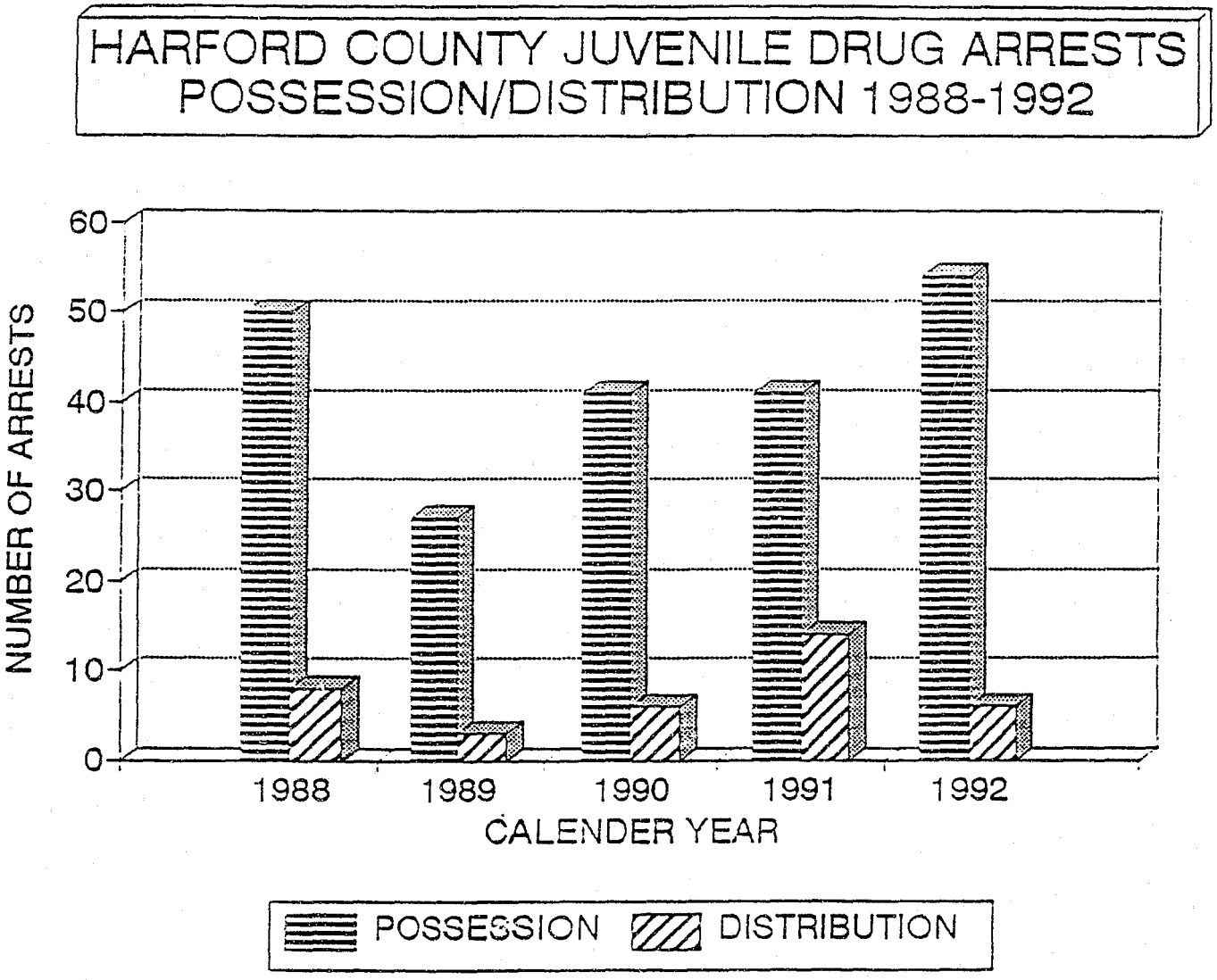
Technical Comments: The increase in arrests may in part be due to an increase in law enforcement and emergence of out of state drug dealers. The cause for large drop in arrests in 1989 has not yet been determined.

INDICATOR #3: Juvenile Drug Arrests



Source: Uniform Crime Reports

INDICATOR #3: Juvenile Drug Arrests



Source: Uniform Crime Reports

INDICATOR #4: Juvenile Justice Drug-Related Intakes

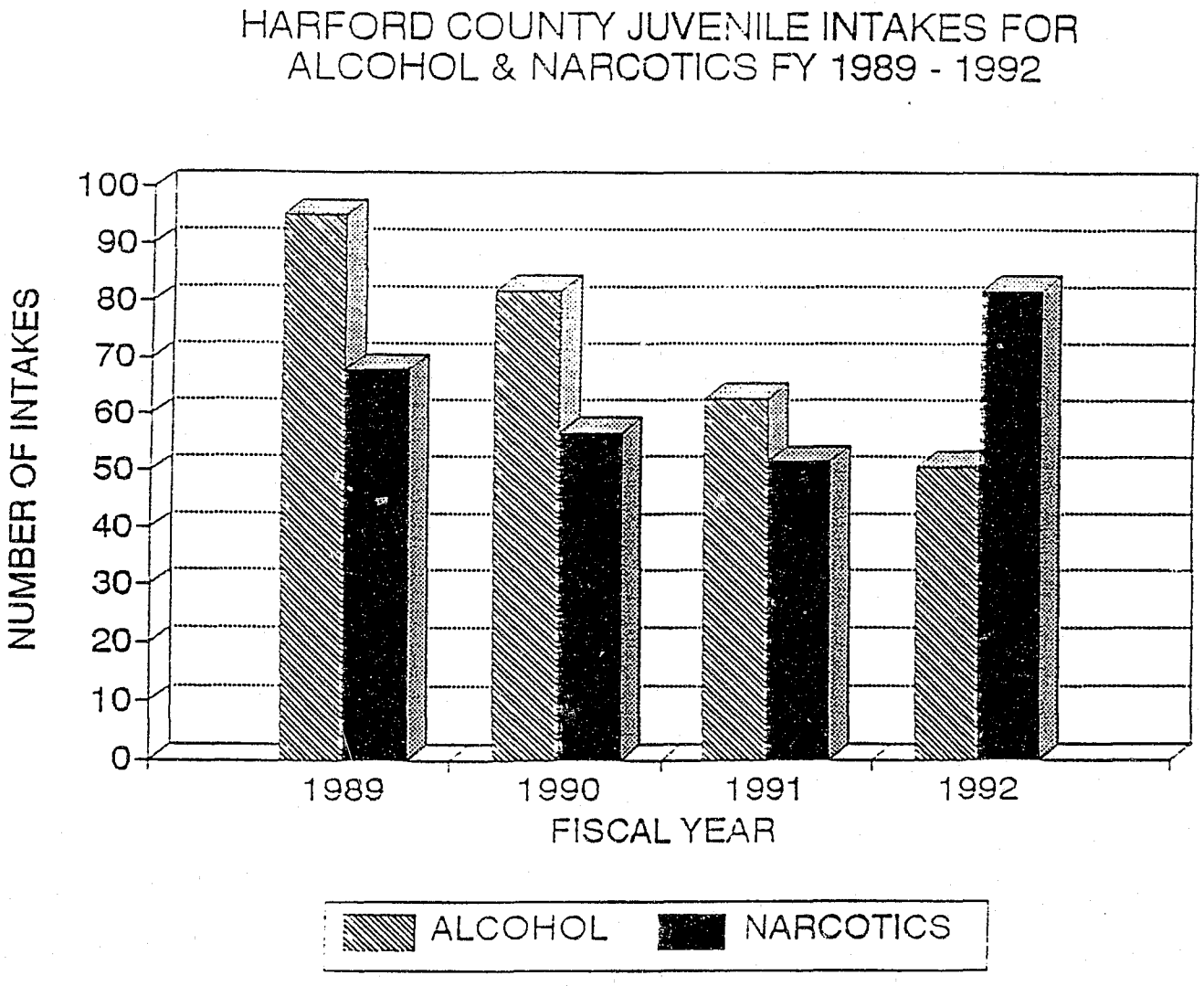
Brief Remarks: Harford County juvenile drug related intakes have decreased over a four year period from Fiscal Year 1989 to 1992. However, of these arrests, narcotic violations have increased by 21% from FY 1989 to FY 1992. Alcohol violations have decreased by 46% from FY 1989 to FY 1992.

Technical Comments: Part of Harford County's report includes more analysis of juvenile data. In particular, the increase in juvenile narcotic related intakes were examined. Several key agency people from Juvenile Services, Board of Education, Adolescent Addictions and the Joint Narcotics Task Force were interviewed for their interpretation of the data. The following are reasons they think intakes have increased:

- the emergence of out of state drug dealers
- increased law enforcement
- age of initial exposure to certain drug has decreased
- an increase in Harford County population

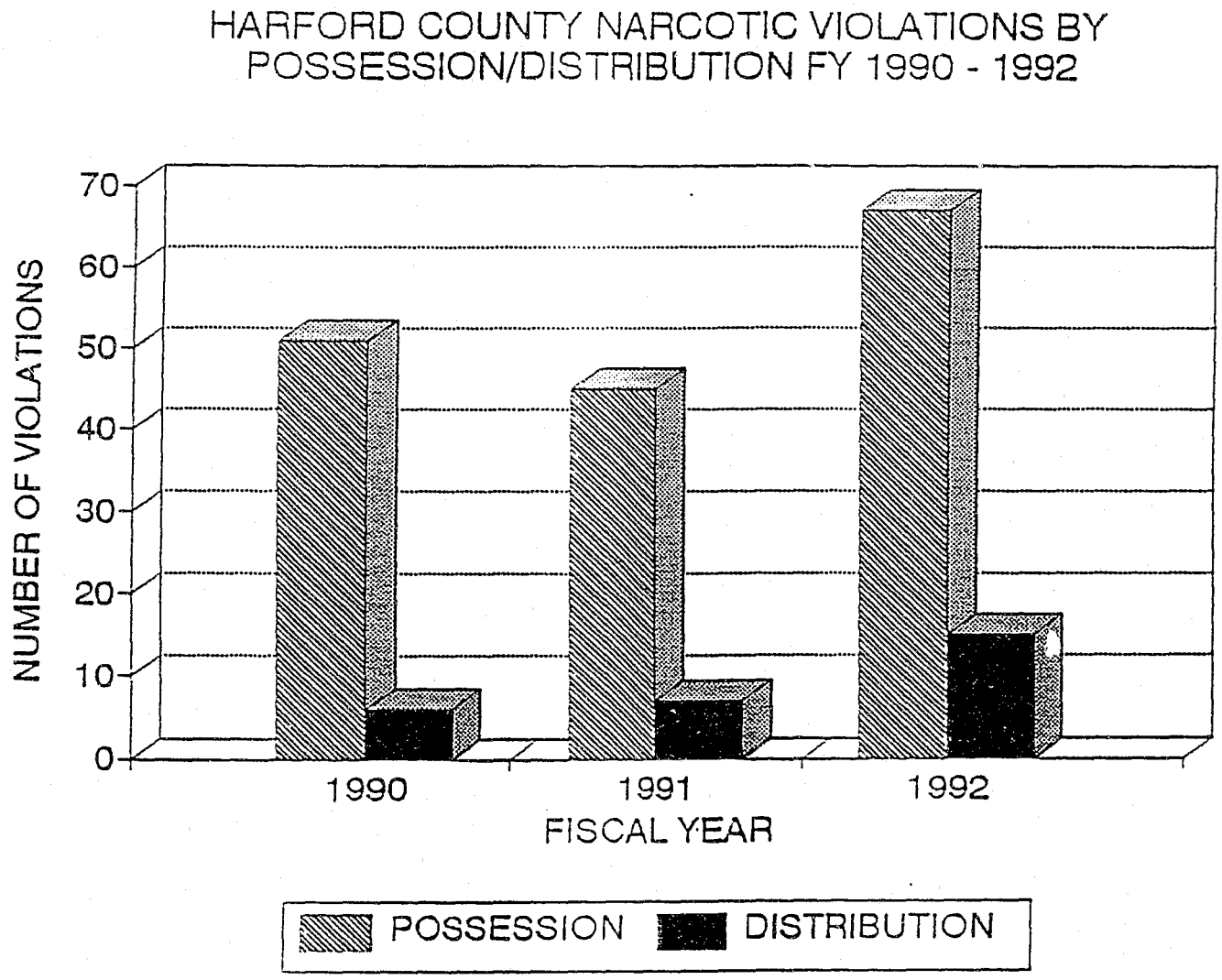
The above rationale does not fully explain this phenomena.

INDICATOR #4: Juvenile Justice Drug-Related Intakes



Source: Department of Juvenile Services

INDICATOR #4: Juvenile Justice Drug-Related Intakes



Source: Department of Juvenile Services (Center for Substance Abuse Research)

INDICATOR #5: Juvenile Treatment Admissions

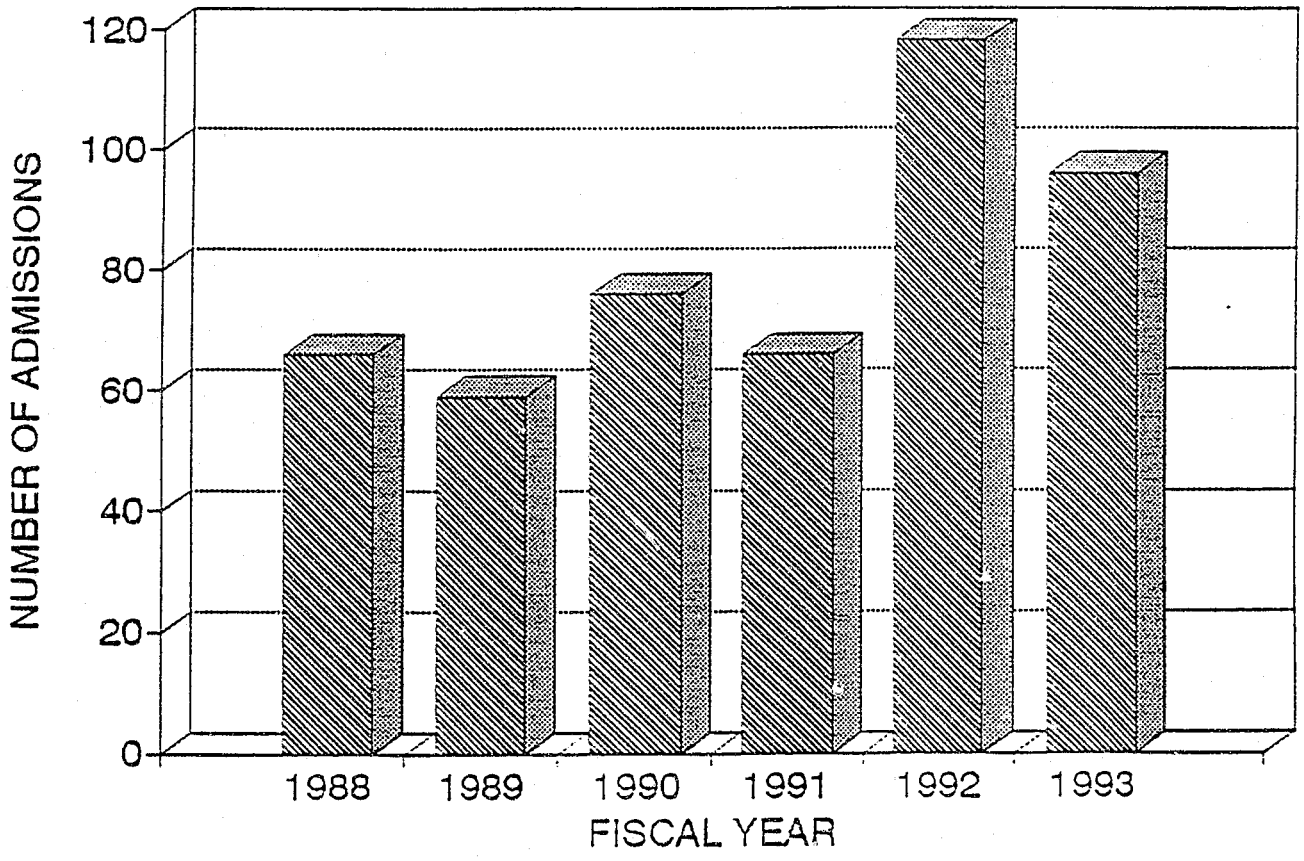
Brief Remarks: Harford County juvenile treatment admissions have increased by 45% from fiscal year 1988 to 1993 and peaked in fiscal year 1992. This increase does parallel the state trend.

Technical Comments: The increase in treatment admissions in 1992 may be in part due to the increase in juvenile drug arrests and those juveniles who were referred to the Department of Juvenile Services and needed substance abuse treatment. The increase may also reflect the decrease in availability of private treatment providers and insurance coverage.

Harford County Public Schools has been implementing the Student Assistance Program during this period of increase.

INDICATOR #5: Juvenile Treatment Admissions

HARFORD COUNTY ADOLESCENT TREATMENT ADMISSIONS FY 1988 - 1993



Source: Substance Abuse Management Information System
Alcohol and Drug Abuse Administration

INDICATOR #6: Household Drug Use

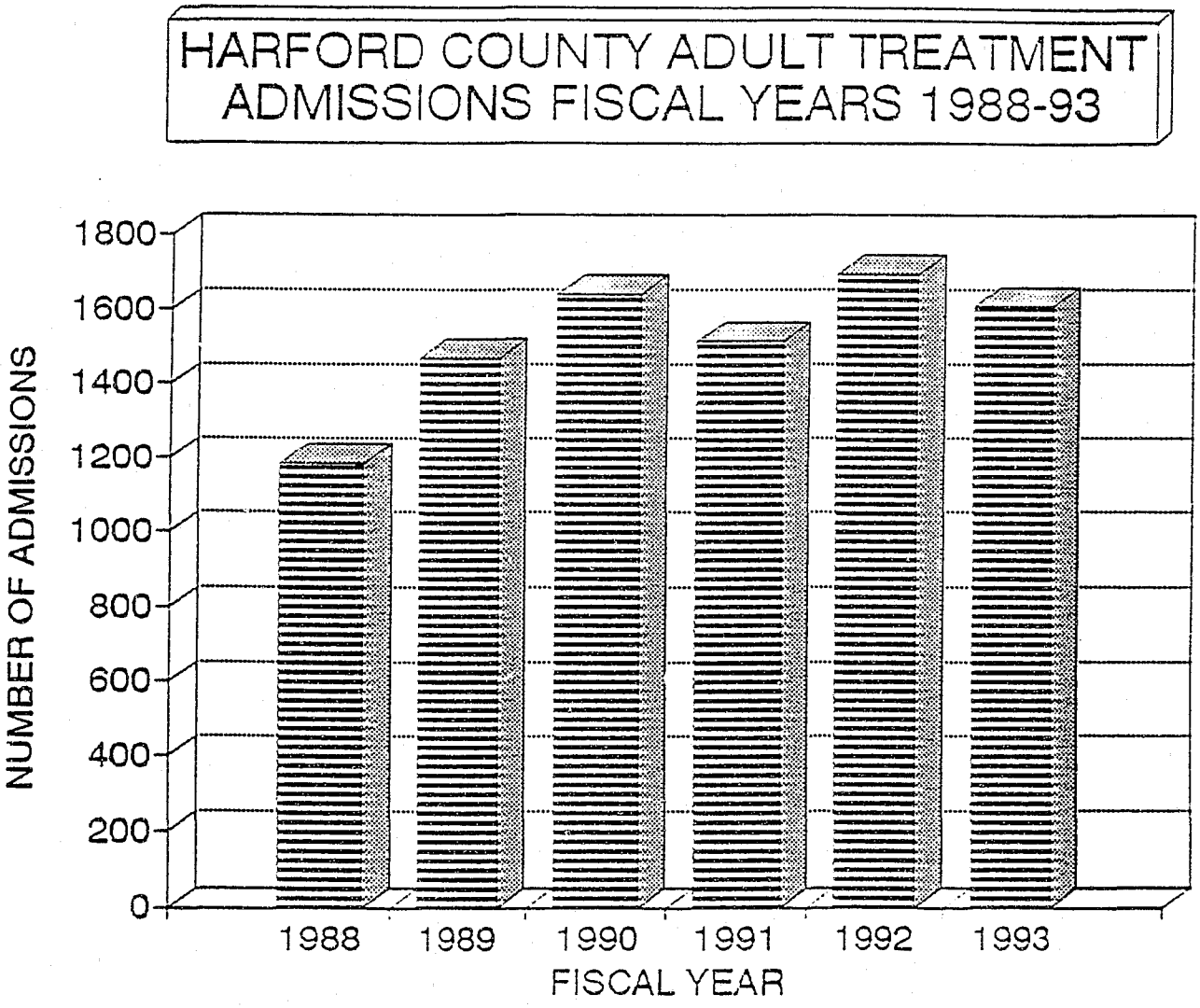
Survey to be completed Summer/Fall 1993

INDICATOR #7: Adult Treatment Admissions

Brief Remarks: Although Harford County adult treatment admissions have varied over fiscal years 1988 to 1993, there was a 35% increase from fiscal year 1988 to 1993 and a slight decrease (5%) from fiscal year 1992 to 1993.

Technical Comments: Adult drug arrests have also increased from 1991 to 1992 and adult DWI arrests have increased from 1990 to 1992. The increase in treatment admissions may reflect the decrease in availability of private treatment providers and insurance coverage.

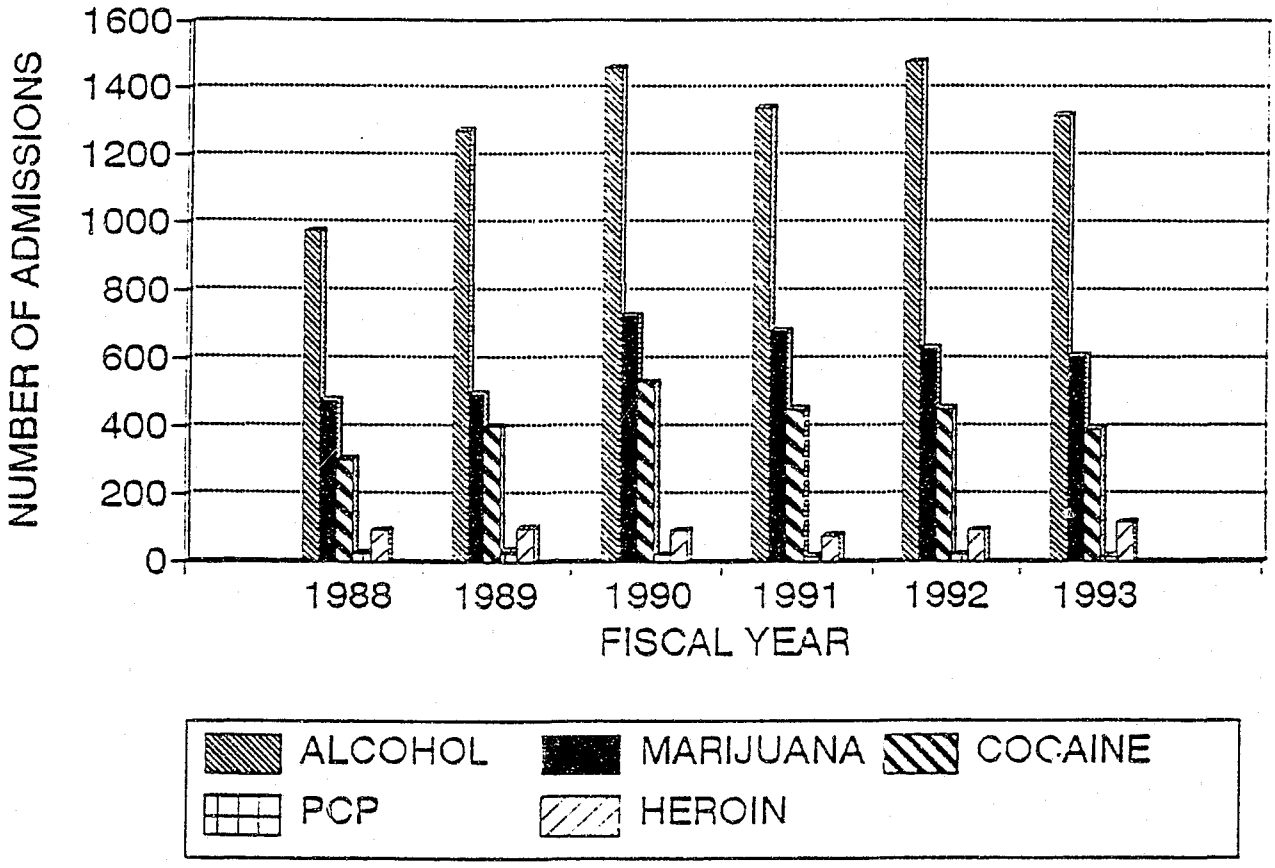
INDICATOR #7: Adult Treatment Admissions



Source: Substance Abuse Management Information System
Alcohol and Drug Abuse Administration

INDICATOR #7: Adult Treatment Admissions

HARFORD COUNTY ADULT TREATMENT ADMISSIONS BY DRUG MENTIONS FY 1988-93



Source: Substance Abuse Management Information System
Alcohol and Drug Abuse Administration

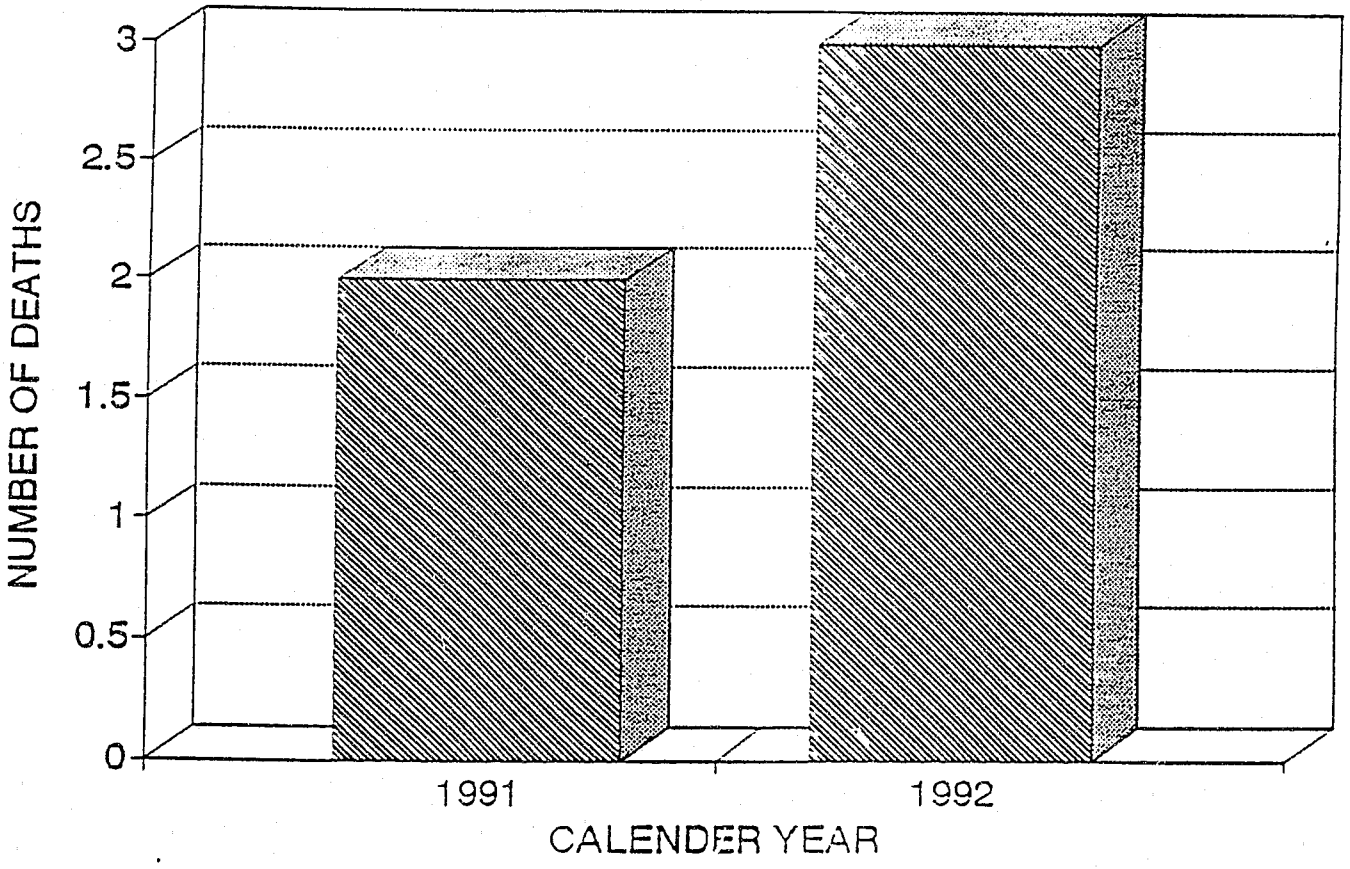
INDICATOR #8: Drug Abuse Deaths

Brief Remarks: There was only an increase of one death from 1991 to 1992. This is not a clear indication of any trend or pattern.

Technical Comments: These deaths are reported by the Office of the Chief Medical Examiner by the location of death rather than by the home residence of the victim. Harford County residents who die at Shock Trauma or out of county are not accounted. This is an important lack of information for a key indicator.

INDICATOR #8: Drug Abuse Deaths

HARFORD COUNTY
DRUG ABUSE DEATHS 1991 - 1992



Source: Office of the Chief Medical Examiner (O.C.M.E)
State of Maryland

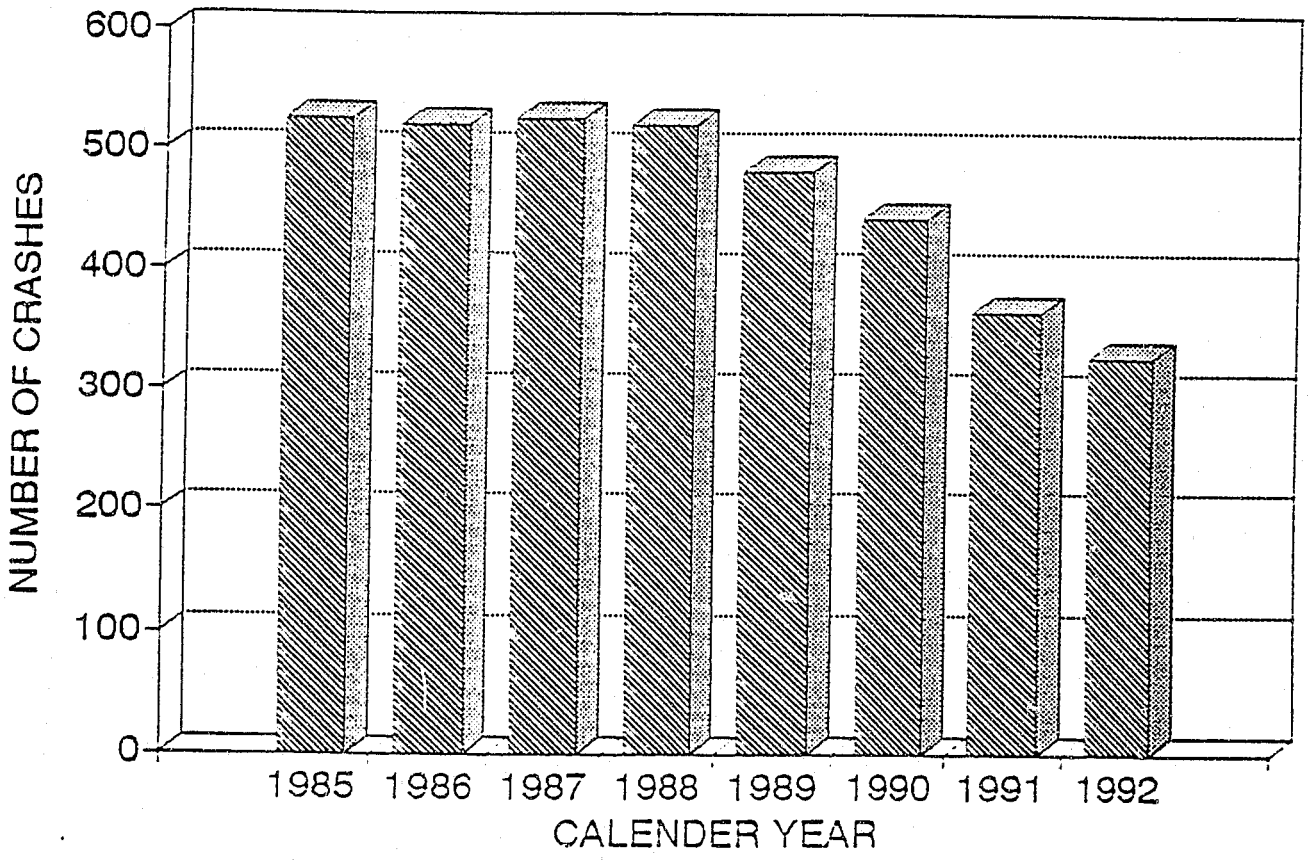
INDICATOR #9: Alcohol and Other Drug Involved Crashes

Brief Remarks: Harford County alcohol and other drug involved crashes have decreased by 38% from 1985 to 1992. This does parallel the state trend.

Technical Comments: This decrease may be in part a result of impaired driving counter measure activities funded by highway safety grants from the Maryland Department of Transportation. MADD has also become a visible and proactive organization during this time.

INDICATOR #9: Alcohol and Other Drug Involved Crashes

HARFORD COUNTY ALCOHOL AND OTHER DRUG RELATED CRASHES 1985 - 1992



Source: Maryland Automated Accident Reporting System (MAARS)/DART

INDICATOR #10: DWI Assessments

Brief Remarks: Harford County DWI assessments have increased by 23% from fiscal year 1990 to 1992.

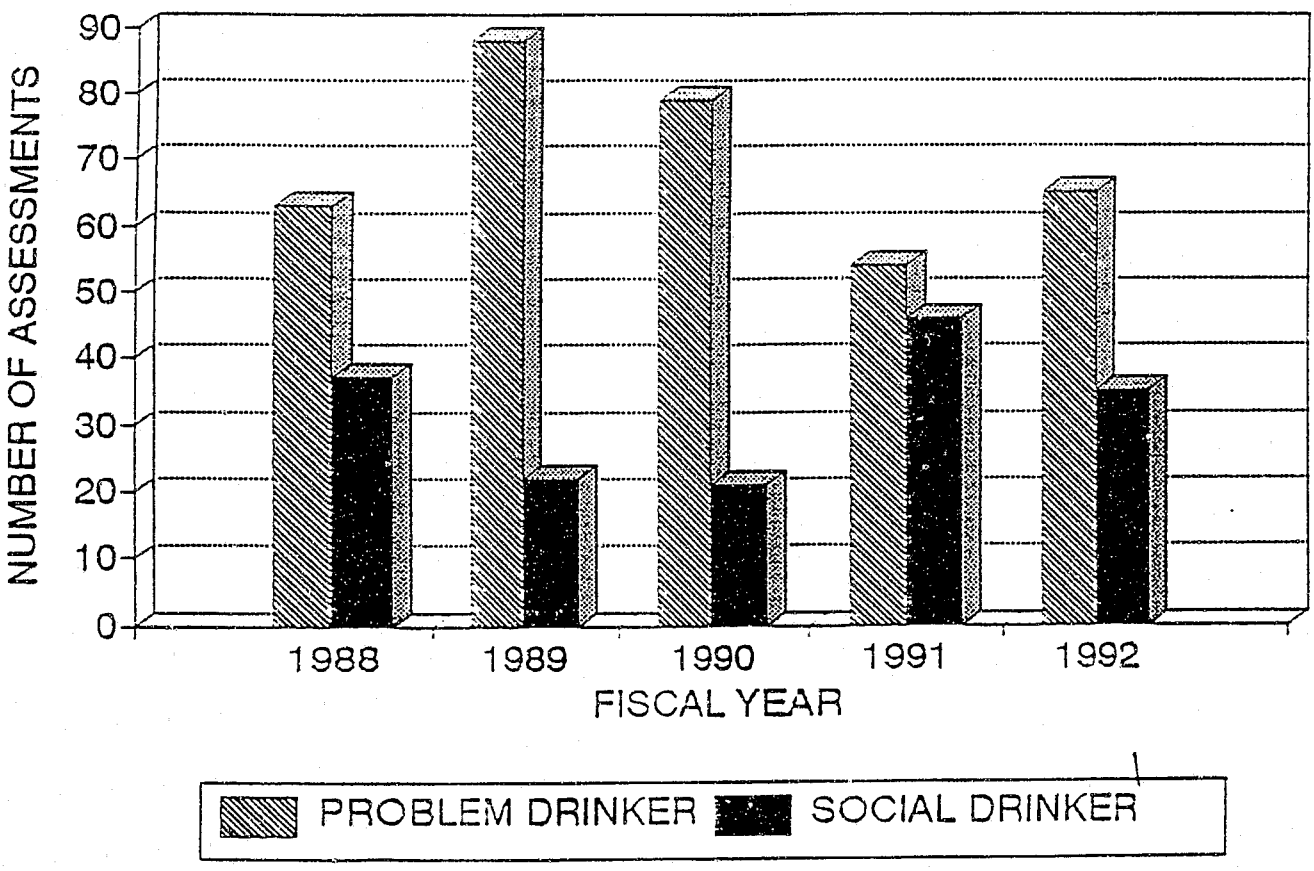
The majority of assessments were determined problem drinkers as opposed to social drinkers in all fiscal years except 1991.

Technical Comments: This data is not available by zipcode of residence from Harford County Health Department.

To make inferences regarding this data information needs to be obtained regarding the "who-what-when-where" of these assessments. These factors may account for the slight shift in diagnosis.

INDICATOR #10: DWI Assessments

HARFORD COUNTY DWI ASSESSMENTS BY DETERMINATION FY 1988 - 1992



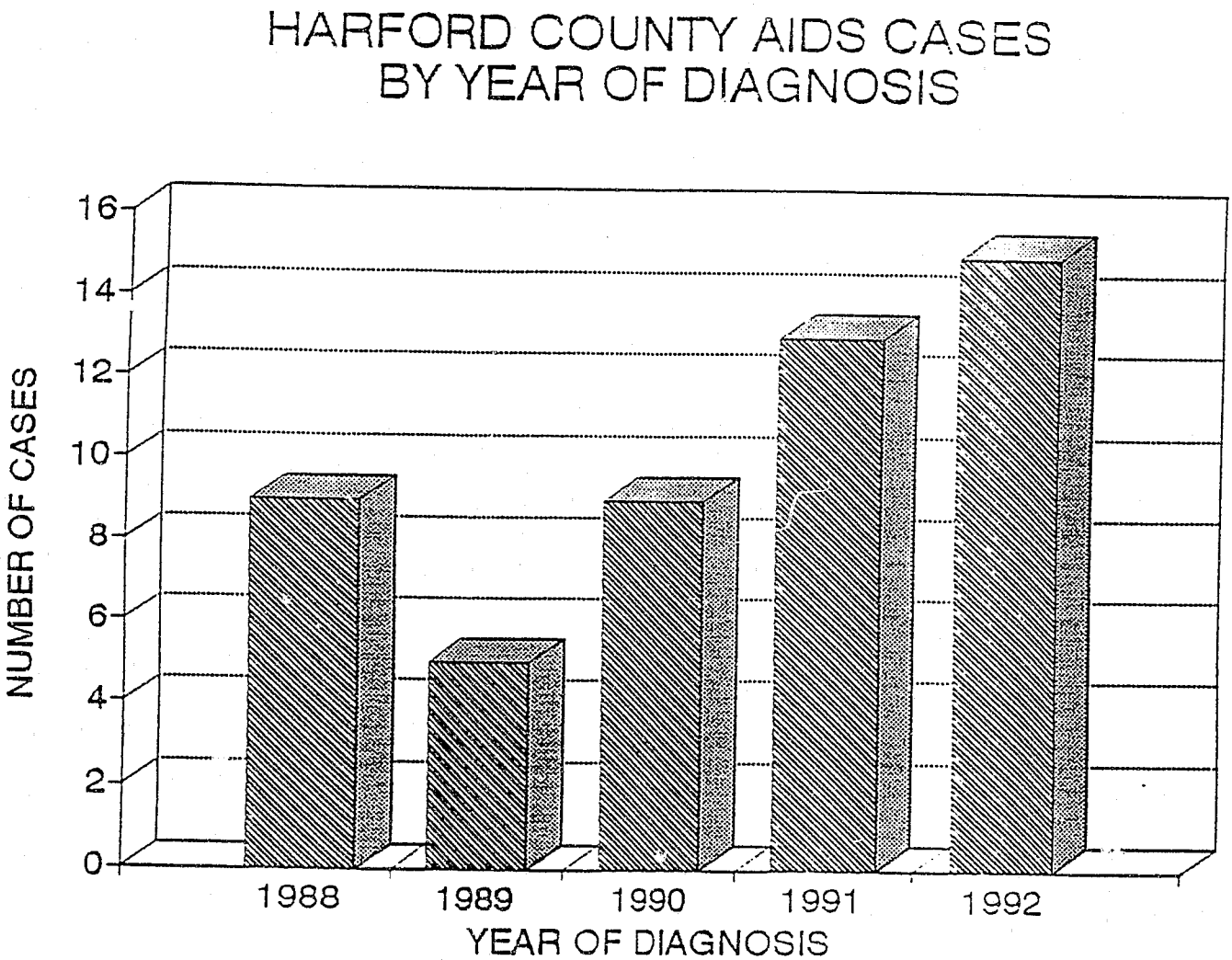
Source: Alcohol and Drug Abuse Administration

INDICATOR #11: Drug Related AIDS Cases

Brief Remarks: The number of AIDS cases by year of diagnosis have increased steadily from 1988 to 1992; However, there was a slight decrease from 1988 to 1989. This reflects what could be considered an anticipated trend. However, the rationale for the dip in 1989 is not known.

Technical Comments: These cases reflect individuals who have converted from HIV positive to "full blown" AIDS. Note that the chart reflects all Harford County AIDS cases. However, breakdowns of AIDS cases by demographic characteristics and transmission mode are not presented by county because they resulted in cells with five or less cases. In order to protect confidentiality, the counties were combined to geographic regions.

INDICATOR #11: Drug-Related AIDS Cases



Source: Department of Health and Mental Hygiene

INDICATOR #12: Drug Involved Pregnancies and Births

This data is not available for Harford County

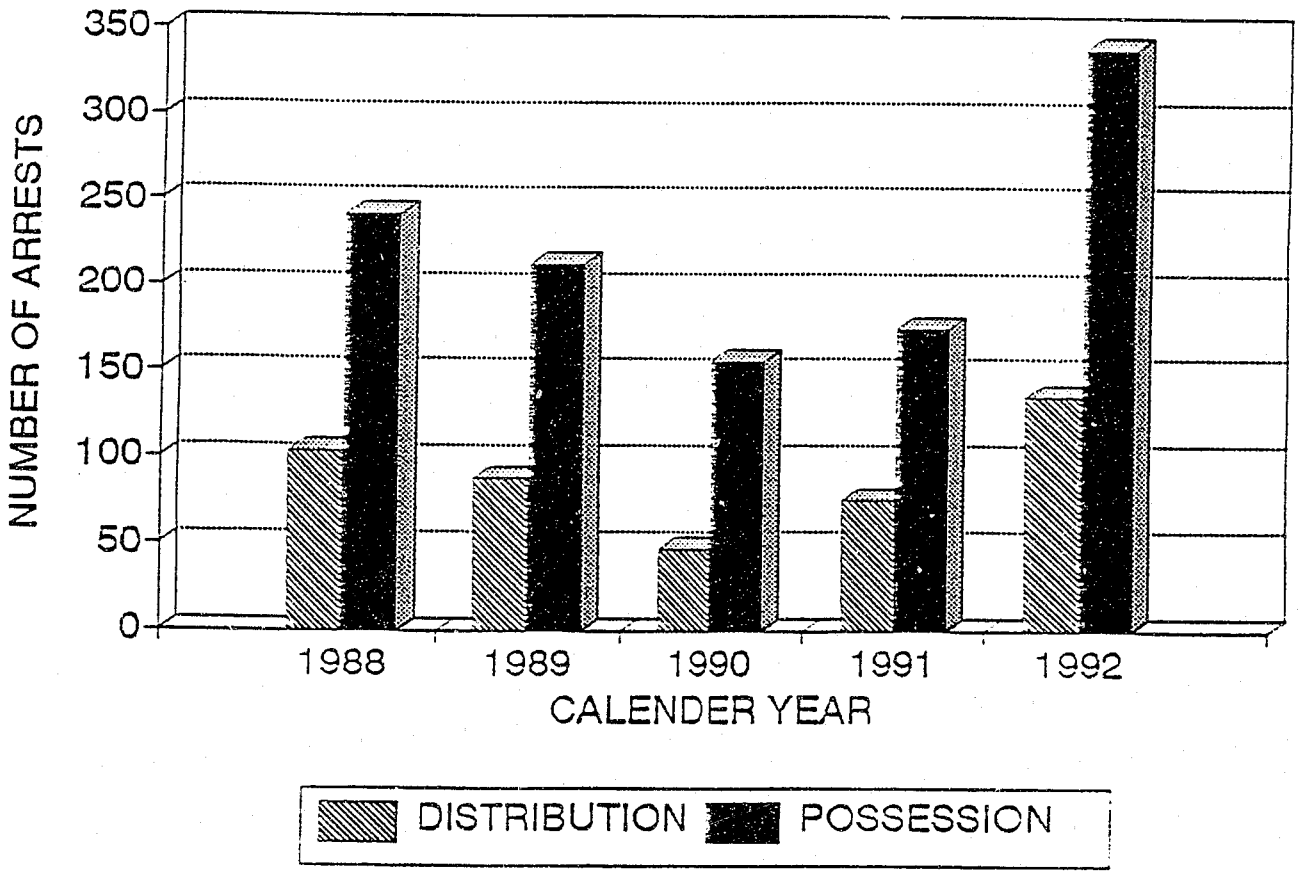
INDICATOR #13: Adult Drug Arrests

Brief Remarks: Harford County adult drug arrests decreased from 1988 to 1991 by 28% and then increased significantly (90%) from 1991 to 1992.

Technical Comments: Information needs to be examined regarding the development and changes in the Joint Narcotics Task Force who is a key in the generation of these statistics. This is more likely to be the rationale rather than a true reduction or increase in adult possession/distribution activities.

INDICATOR #13: Adult Drug Arrests

HARFORD COUNTY ADULT DRUG ARRESTS POSSESSION/DISTRIBUTION 1988 - 1992



Source: Uniform Crime Reports

INDICATOR # 14: DWI Arrests

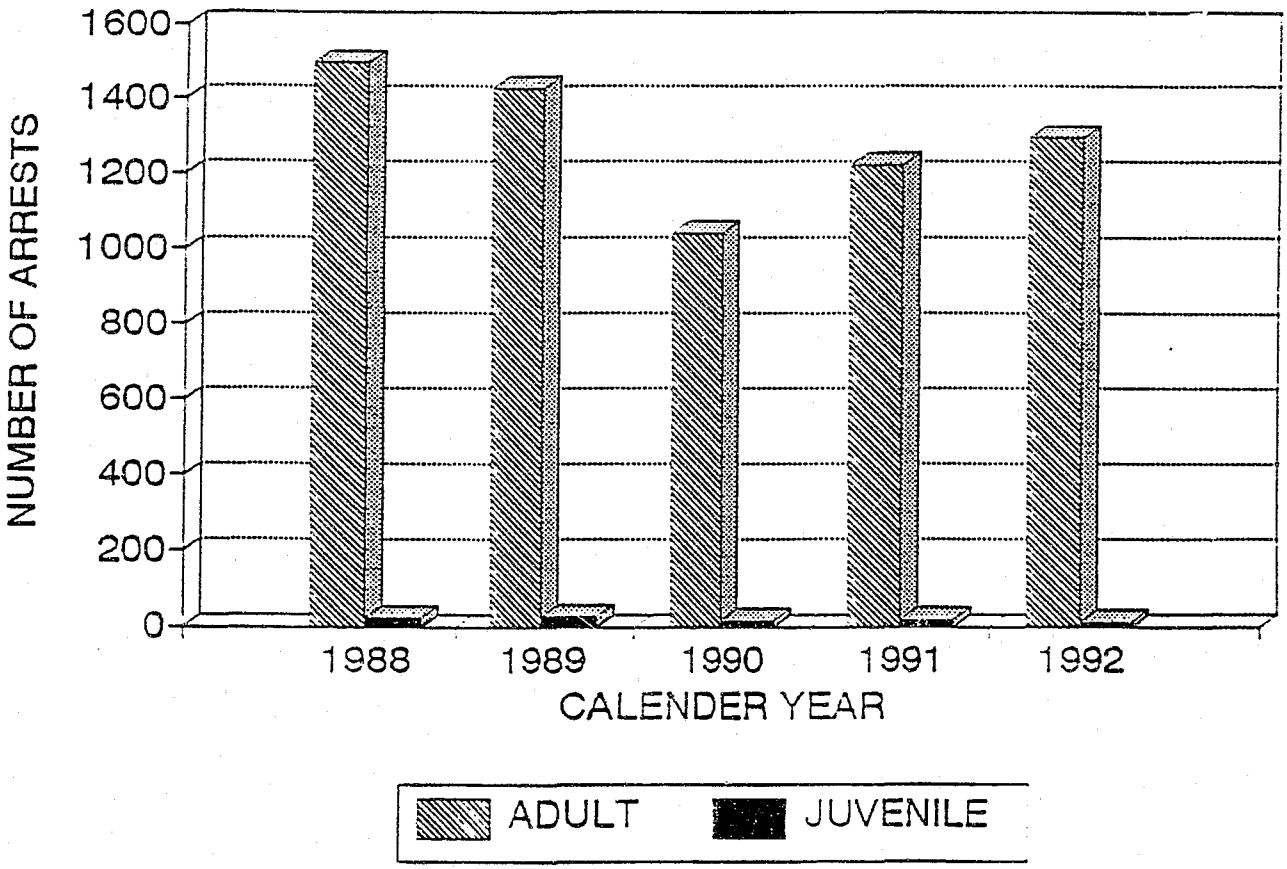
Brief Remarks: DWI arrests have increased by 24% from 1990 to 1992. However, juvenile arrests have decreased and adult arrests have increased.

Technical Comments: The increase in arrests from 1990 to 1992 could in part be a result of an increase in awareness regarding DWIs due to impaired driving countermeasure activities conducted with funds from the Maryland Department of Transportation. MADD has also become a visible and proactive organization during this time.

Perhaps juvenile DWI arrests have decreased due in part to the increase in juvenile treatment admissions and increase in juvenile drug arrests.

INDICATOR #14: DWI Arrests

HARFORD COUNTY ADULT/JUVENILE DWI ARRESTS 1988 - 1992



Source: Uniform Crime Reports

APPENDIX B-2

Howard County

Howard County

Section I. Overview

Howard County established a Data Collection Subcommittee under the leadership of the Howard County Alcohol & Drug Abuse Advisory Board to address priorities identified from the county's Substance Abuse Control Plan. The Date Collection Subcommittee also serves as the Den as defined by MD SEWG. The goal of the Date Collection Subcommittee/Den is to:

> Complete a thorough investigation of Howard County's substance abuse situation; nature and type of users; nature and type of treatment services and other critical areas that define the scope of the problem.

With the county's substance abuse theme of "Success Through Collaboration" the Den experiences a cooperative working relationship with every department, community agency and personnel it has contacted. The core membership of the Den includes:

County Community Groups & Organizations
- Mothers Against Drunk Driving

County & State Affiliated Agencies
- Department of Education
- Department of Health
- MD State Police/Criminal Intelligence Division
- Alcohol & Drug Abuse Administration

Howard County Government
- Information Systems Services
- Department of Police
- Alcohol & Drug Abuse Advisory Board
- Ho. Co. General Hospital
- Office of Substance Abuse Impact Services

Bonnie Cook,who started as the committee's volunteer project leader has been hired (August,1993) as the Data Collection Project Manager in the Office of Substance Abuse Impact Services. Our Data Collection Project efforts started late 1991 with its most recent group meeting being July, 1993. Accomplishments of the committee thus far include:

- Identification of data indicators local service providers are interested in.
- Identification of source (ie.county,state, local department or agency) of data indicators
- Type of reporting systems local departments and agencies are using to originate and access data.(ex. manual/automated - internal/external)
- Identification of data discrepancies
- Gaps in data local services providers want

- Time period data is available in and type of breakdown or fields (ie. by zipcode, police district, community)

- Establishing a chapter on CESAR's Electronic Bulletin Board and encouraging its use to access local data.

- Hiring of Data Collection Project Manager

We are currently examining data indicators by tracking it's origination to actual uses and qualifying it by identifying the strengths and weaknesses of each data element (ie. discrepancies, consistency, accuracy, interpretations, uses, thoroughness, etc.)

Demographics

Howard County is the State of Maryland's second smallest county but increasing becoming one of the fastest growing county in Maryland due in part to its ideal location between two large metropolitan areas: Baltimore and Washington. Historically a rural area, Howard County has become known for its innovative and progressively thought out "planned city of Columbia" started in 1960 by James Rouse. Columbia has earned the reputation as of the world's most successful planned communities and draws national recognition for its high quality of public education and quality of life. Today, the county is still one-third farmland making it an interesting blend of rural and suburban benefits.

From a population of about 65,000 in 1965,the county has grown to more than 185,000 today. Projections indicate that our population will be approximately 207,200 by 1995 increasing to 228,400 by the year 2000. Approximately two-thirds of that growth has occurred in the carefully planned community of Columbia, where more than 73,000 people live and more than 54,000 hold jobs. County residents earn a median household income of $60,634 in 1989 and more than 38% completed at least four years of college. Statically, the county's residents can be described as affluent and educated.

Females increased as a share of total population from 1970 to 198 (49.6% to 50%). During the 1980's the female share of the population increased reaching 50.2% by 1990. The school age population (persons 5 -17 years of age) which increased from 18,1956 children in 1970 to 28,268 in 1980, continued to increase by an additional 5,015 to 33,282 in 1990. Persons 18 to 44 years of age increased by 36,590 (65.8%) from 55,588 to 92,178 in 1990. This age group is the major component of the population representing 49.2% of the total population in 1990 compared to 46.9% in 1980. Persons 65 years and over increased by 5,318 persons, or 87.5% since 1980. The aging of Howard County's population continues as the elderly become a larger component of the total population, both in absolute and percent share. In 1980, the share of persons 65 years and over was 5.1 of the total population; by 1990 it increased to 6.1%.

Section 2. Key Drug Indicators

Indicator # 1
MD Adolescent Survey-1992

Brief Remarks:

* According to the 1992 Maryland Adolescent Drug Survey, Howard County students lead the state in the percent of adolescents drinking in each grade level surveyed: 6,8,10 and 12th. The same survey indicated that Howard County students seem to be drinking at an earlier grade level than students reporting from other jurisdictions.

Technical Comments:

* A 1993 undercover investigation conducted by the Ho. Co. Dept. of Police to determine if minors can purchase alcohol from local liquor establishments indicates that accessibility to alcohol is easy. Three out of five liquor establishments checked sold alcohol to a minor.

* The 1992 MAS survey indicates a high tolerance for alcohol consumption by parents than other drug use. Public school administrators and PTA members confirmed that perception.

* According to the FY 1993 Samis report, 79% of the juvenile participating in substance abuse treatment report alcohol as their drug of choice or most commonly abuse substance. The local Dept. of Health and private substance abuse treatment providers indicate that alcohol is the main drug of abuse for adolescents.

The Dept. of Education, the Alcohol & Drug Abuse Advisory Board, local substance abuse service providers, etc are still trying to understand the significant statistical increase in adolescent alcohol consumption. There is still a need to identify the variables that contribute to this finding.

Substance Use by Grade Level and Time Period

Howard County

Substance	Grade Level											
	6			8			10			12		
	Ever Used	Last 30 Days	Last 12 Months	Ever Used	Last 30 Days	Last 12 Months	Ever Used	Last 30 Days	Last 12 Months	Ever Used	Last 30 Days	Last 12 Months
Cigarettes	10.1	4.3	8.6	40.3	20.1	34.0	55.2	27.7	42.0	61.1	35.2	44.8
Smokeless Tobacco (chewing tobacco, Snuff, Skoal)	3.6	1.4	3.6	11.5	5.4	8.9	23.3	10.7	19.5	27.2	10.4	14.6
Beer, Wine (other than for religious use) or Wine Coolers	32.4	10.1	84.9	62.5	27.8	78.0	71.7	46.0	85.4	82.9	55.5	86.2
Liquor (such as rum, vodka, or whiskey)	10.8	5.0	8.7	34.7	13.3	25.0	59.7	30.2	49.6	73.9	37.0	54.5
Five or More Servings of Any Alcohol on the Same Occasion	2.2	1.4	1.4	15.6	4.1	13.0	39.5	25.0	36.7	61.5	37.0	55.2
Marijuana (pot, grass) or Hashish	1.4	0.7	0.0	6.0	3.2	5.1	18.4	12.9	18.7	34.6	16.0	20.4
Amphetamines (such as prescription diet pills, bennies, pep pills, uppers)	*	2.2	3.6	*	1.6	6.0	4.1	2.7	4.0	8.1	3.4	6.0
Methamphetamines (meth, speed, crank, ice)	1.4	0.7	0.7	1.6	1.3	1.6	*	1.3	1.8	4.3	1.3	2.6
LSD (acid)	1.4	0.0	0.7	1.9	0.8	1.6	6.3	2.2	5.8	13.7	2.2	7.8
PCP (angel dust, love boat, green)	2.2	1.4	0.7	1.0	0.9	0.9	*	1.8	2.7	7.7	3.0	5.7
Other Hallucinogens (mescaline, 'shrooms)	1.4	0.7	0.7	*	0.6	0.8	4.5	2.2	4.4	10.7	4.3	8.7

* Missing data

Source: 1992 Maryland Adolescent Survey

Substance Use Patterns

		Grade 6	8	10	12
Ever Used	Howard County	32.4	62.5	71.7	82.9
Use of beer or wine in last twelve months	Howard County	84.9	78.0	85.4	86.2
	State	21.7	41.5	59.3	72.2

1992 Drug Survey

APPENDIX B-3

Prince George's County

OVERVIEW

Prince George's County is a large Maryland political subdivision located northeast and southeast of Washington, D.C. The County includes the second largest land mass, five hundred square miles, and second largest population, 740,000 residents, of any Maryland jurisdiction. The County includes highly developed and densely populated areas close to the County - Washington D.C., boundary; suburban areas in the northern, central and southern regions; and large tracts of undeveloped rural areas in the southern end of the County. The citizens of Prince George's County enjoy many of the benefits of being part of a large metropolitan area that includes suburban Maryland, the District of Columbia and Northern Virginia and many of the public health and public safety problems associated with central cities plus rural poverty.

The 1990 Census revealed that the population of Prince George's County was over 50% African-American, 45% White, and 5% Hispanic and Asian. The African-American population enjoys one of the highest levels of education and income of any minority group in the United States. Between 1980 and 1990 this population experienced the largest per capita income increase of any African-American population in any U.S. city or county.

Prince George's County also includes a significant level of poverty. Sixty-five thousand County residents receive one form of public assistance or another. Each year the County records unacceptably high levels of homicide, infant mortality, HIV infection, sexually transmitted diseases, and abuse of alcohol and other drugs. In Maryland only Baltimore City exceeds Prince George's County in these public health and safety areas.

The Prince George's County Drug Epidemiology Network (DEN), was formed two years ago and continues to be coordinated by the Health Department's Division of Addictions. DEN membership includes several divisions within the health department, police department, public schools, department of corrections and hospitals. The DEN has been endorsed by the County Substance Abuse Advisory Council.

Report Highlights

Adolescent drug use indicators continue to show a decline in the use of cigarettes, alcohol and illicit drugs by County juveniles. The Public Schools Student Survey reports significantly lower use levels by County high school students than the statewide averages. Treatment referrals from schools and juvenile services have declined to approximately one-third the level of five years ago.

DWI Arrests and alcohol related vehicle crashes continue to decline from previous levels. DWI arrests are down by almost 30% from five years ago. Alcohol related vehicle crashes have dropped by more than 40% in seven years.

Adult drug arrests continue unchanged from previous years and pre-trial test results continue at previous rates. Adult treatment admissions have declined steadily by 20% from 1989 through 1993. Treatment programs resources have been reduced by 30% during the same period.

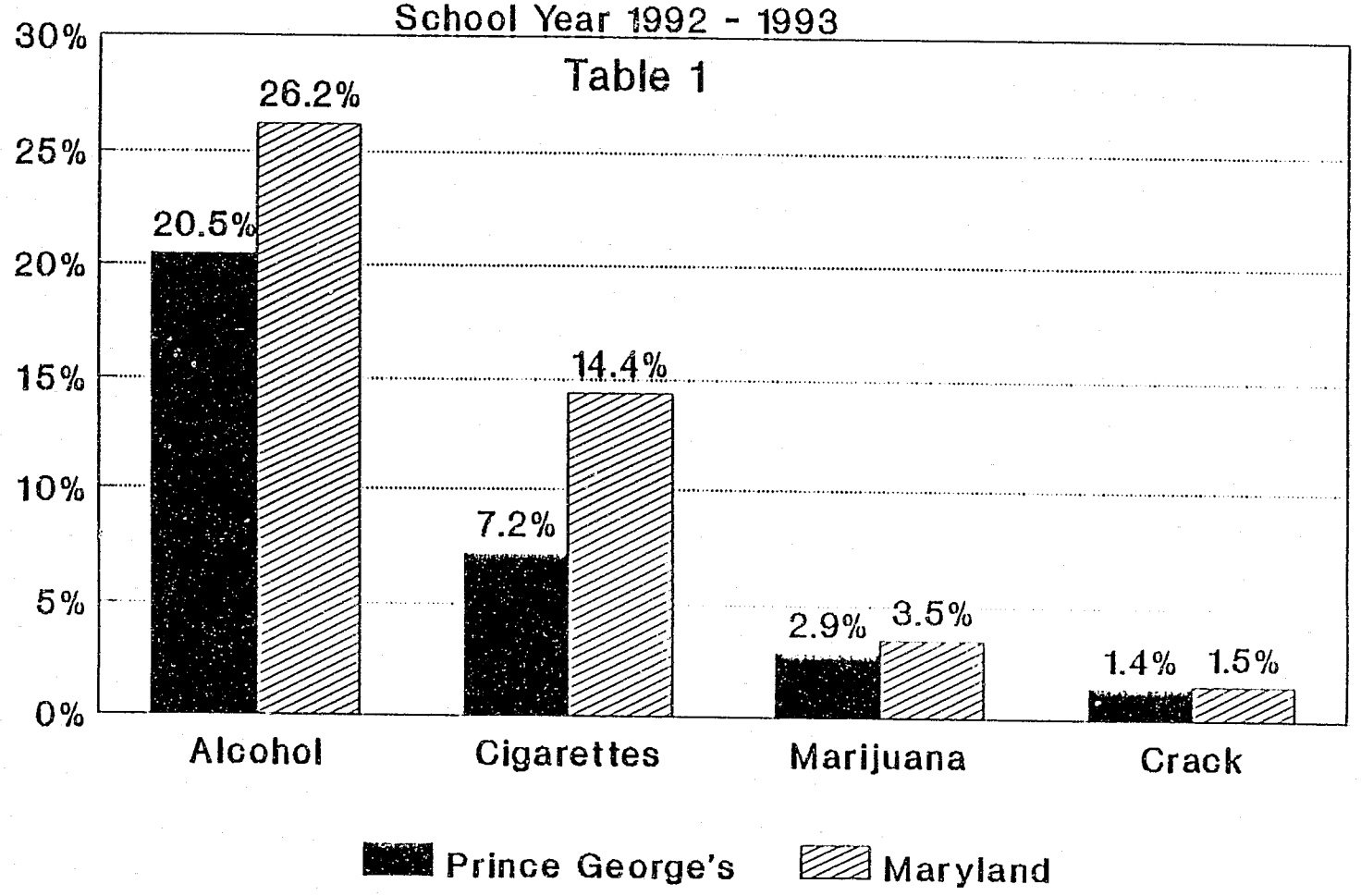
Data from the Infant at Risk program regarding drug use during pregnancy remains substantially unchanged from the previous years. Over 30% of the IAR referrals are pre-natal drug abusers and additional 30% received no prenatal care. IAR reported 25 HIV cases in 1992 and expect 26 cases in 1993.

Indicator #1: STUDENT SUBSTANCE ABUSE

Brief Remarks: The 1992-1993 Maryland Adolescent Survey revealed significantly lower use of drugs by County public school children in eighth, tenth and twelfth grades than the Maryland statewide average. Specifically, current use levels for alcohol, cigarettes, marijuana and crack were lower in Prince George's County. For twelfth graders current cigarette use is reported at 8.5% compared at 31.5% statewide and current alcohol use reported at 27.8% in the County compared to 52.9% in Maryland.

Technical Comment: The Prince George's County Adolescent Survey results are so low compared to statewide findings that the survey must be questioned. Students suspended, expelled or truant at the time of the survey may produce misleading results.

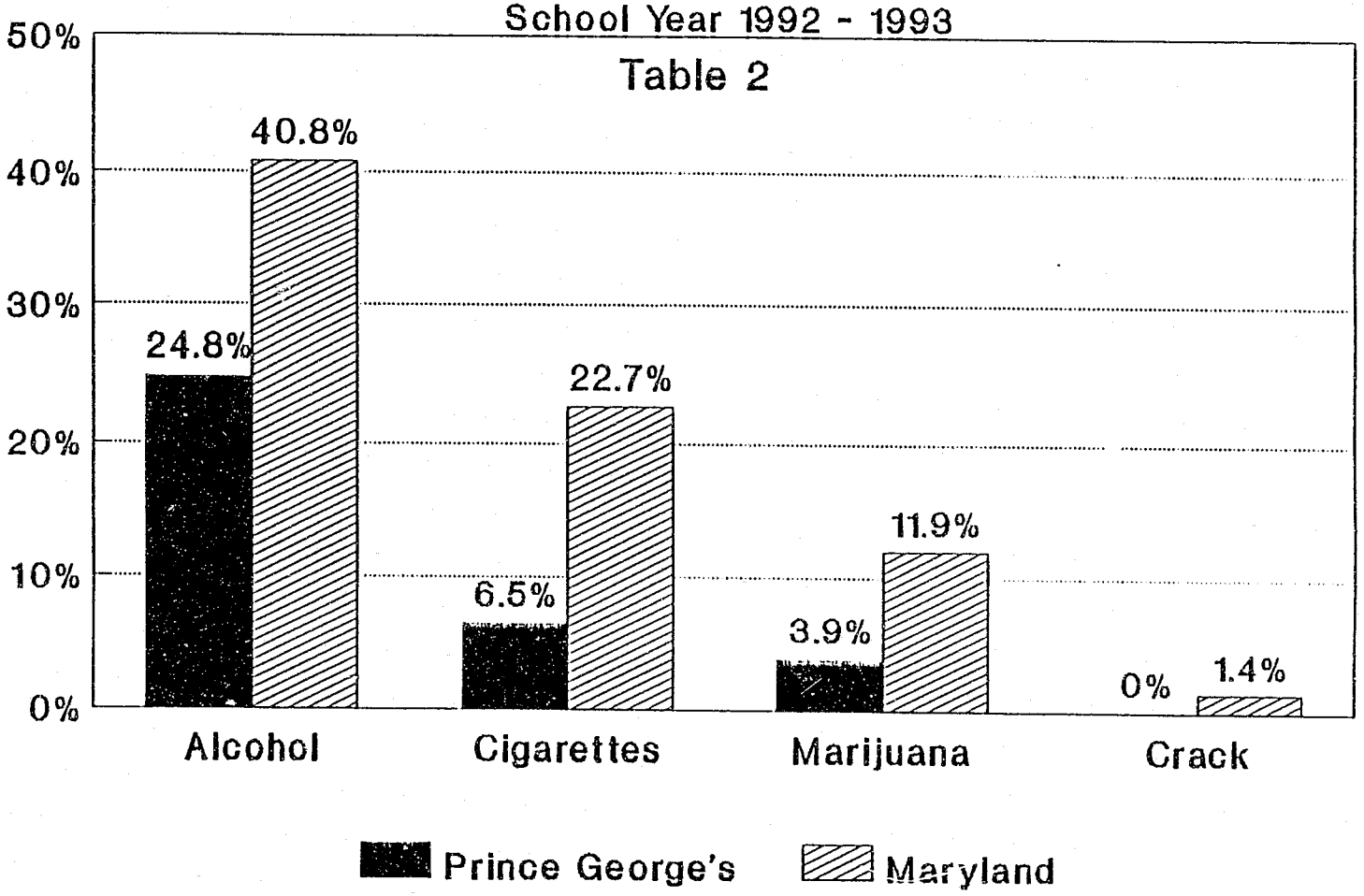
Percentage of Eighth Graders Reporting Current Use of Selected Substances in Prince George's County and Maryland, School Year 1992 - 1993



Source: 1992 Maryland Adolescent Survey'
Maryland Department of Education

Percentage of Tenth Graders Reporting Current Use of
Selected Substances in Prince George's County and Maryland
School Year 1992 - 1993

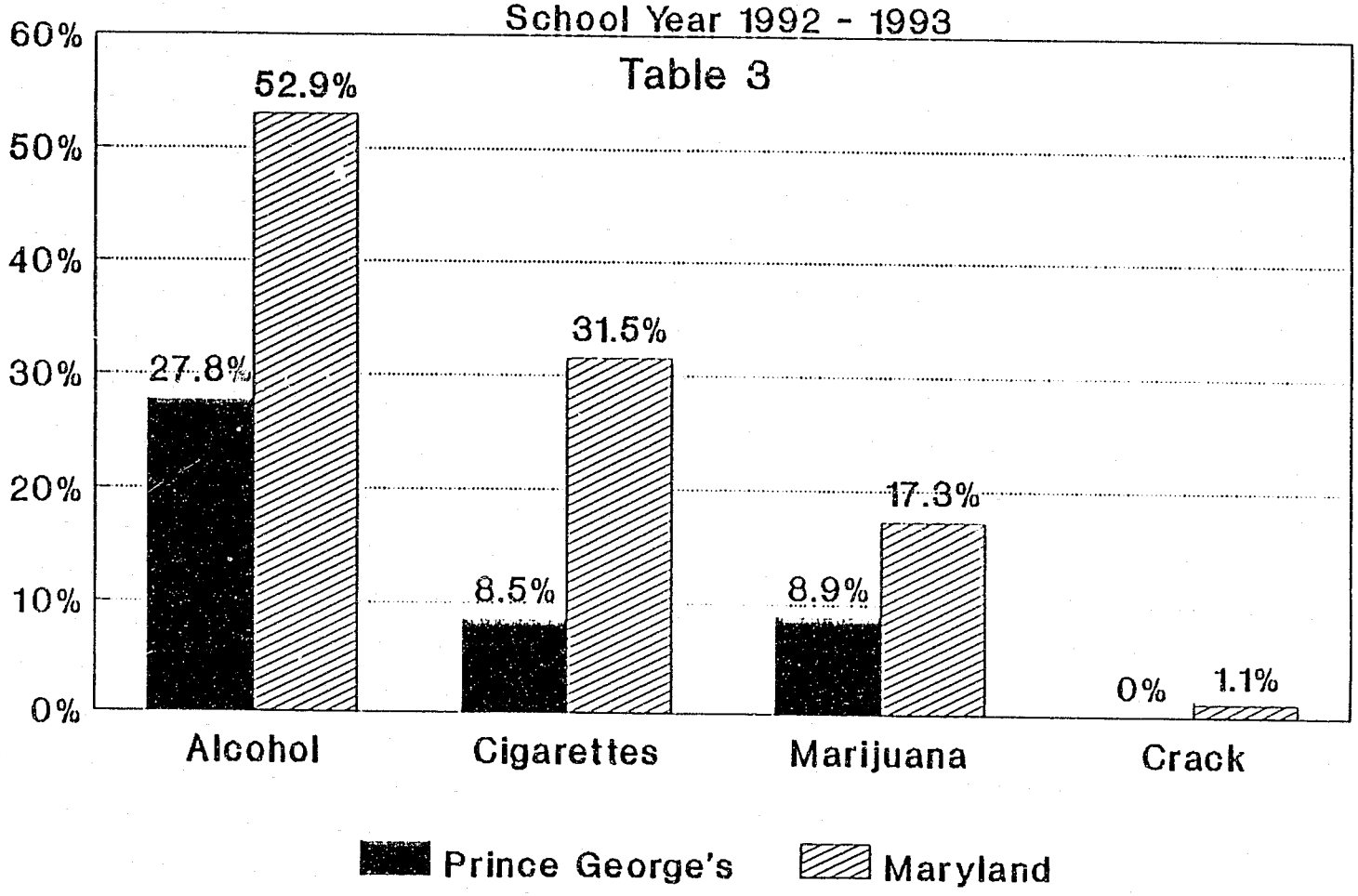
Table 2



Source: Maryland Adolescent Survey
Maryland Department of Education

Percentage of Twelfth Graders Reporting Current Use of
Selected Substances in Prince George's County and Maryland
School Year 1992 - 1993

Table 3



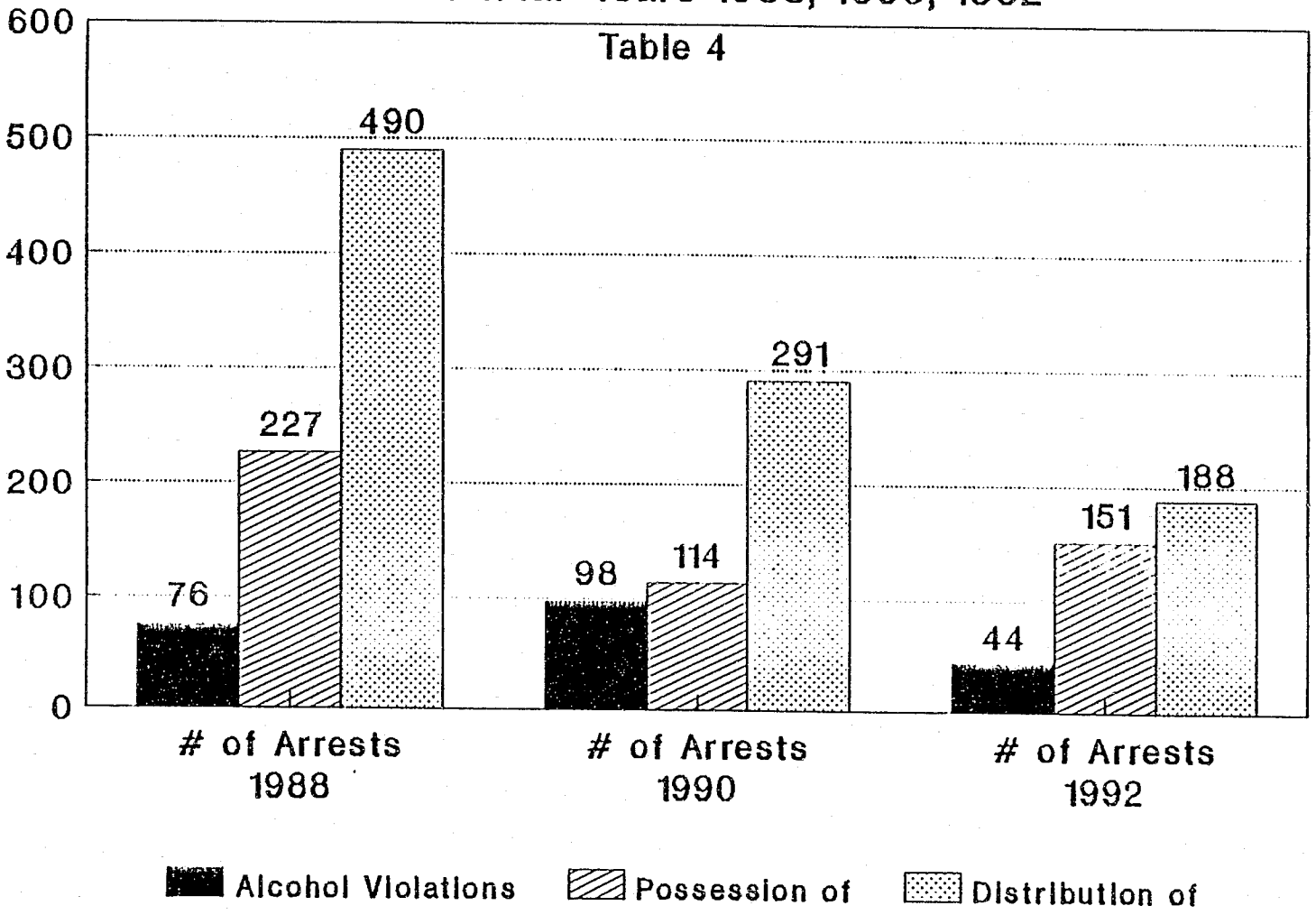
Source: Maryland Adolescent Survey
Maryland Deparment of Education

Indicator #3: JUVENILE ALCOHOL AND OTHER DRUG ARRESTS FOR CALENDAR YEARS 1988, 1990, 1992

Brief Remarks: Data provided by the Maryland State Police indicates a continuing decline in juvenile arrests for alcohol violations and illicit drug distribution. Juvenile drug possession arrests increased from 114 in 1990 to 151 in 1992.

Technical Note: Juvenile arrests in Prince George's County are comparatively lower than other Maryland jurisdictions. This low level of arrests may reflect enforcement priorities rather than actual levels of drug use and drug distribution.

Indicator #3: Juvenile Alcohol and Other Drug Arrests for Calendar Years 1988, 1990, 1992



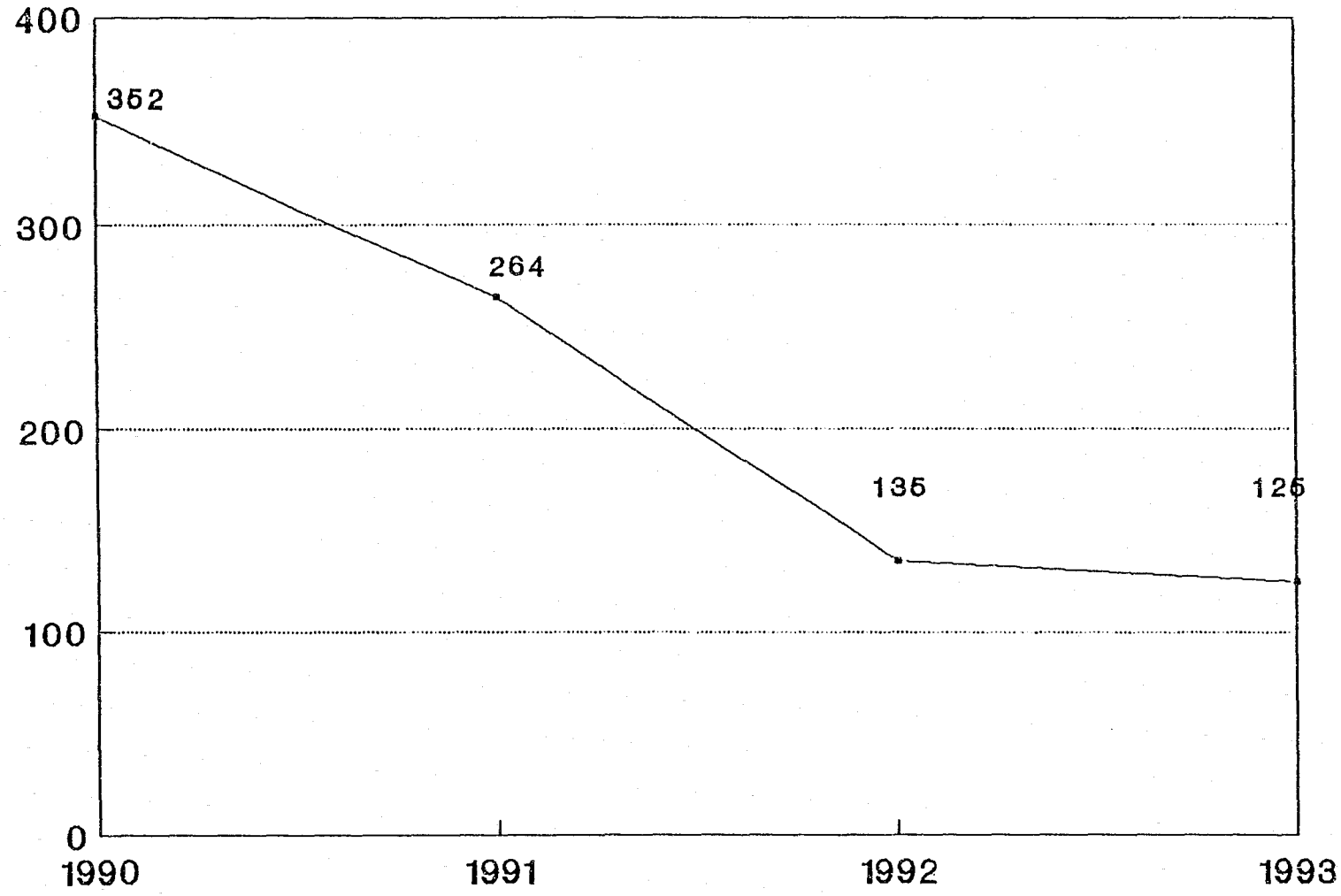
Source: Maryland State Police

Indicator #5: ADOLESCENT TREATMENT ADMISSIONS

Brief Remarks: Juvenile treatment program admissions continued on a downward trend that was first identified in calendar year 1990. Admissions for 1993 totalled 125, down from 135 a year earlier, and down from 352 admissions in 1990. Referrals from the Department of Juvenile Services and public Schools continue to decline.

Technical Note: Funding reductions for the Health Department's Student Assistance Program may explain a continued reduction in juvenile treatment admissions. In 1990 there were 10 student assistance teams operating in County high schools. At the beginning of school year 1993 there were only three functioning teams.

Indicator #5: Juvenile Treatment Admissions 1990-1993
Table 5



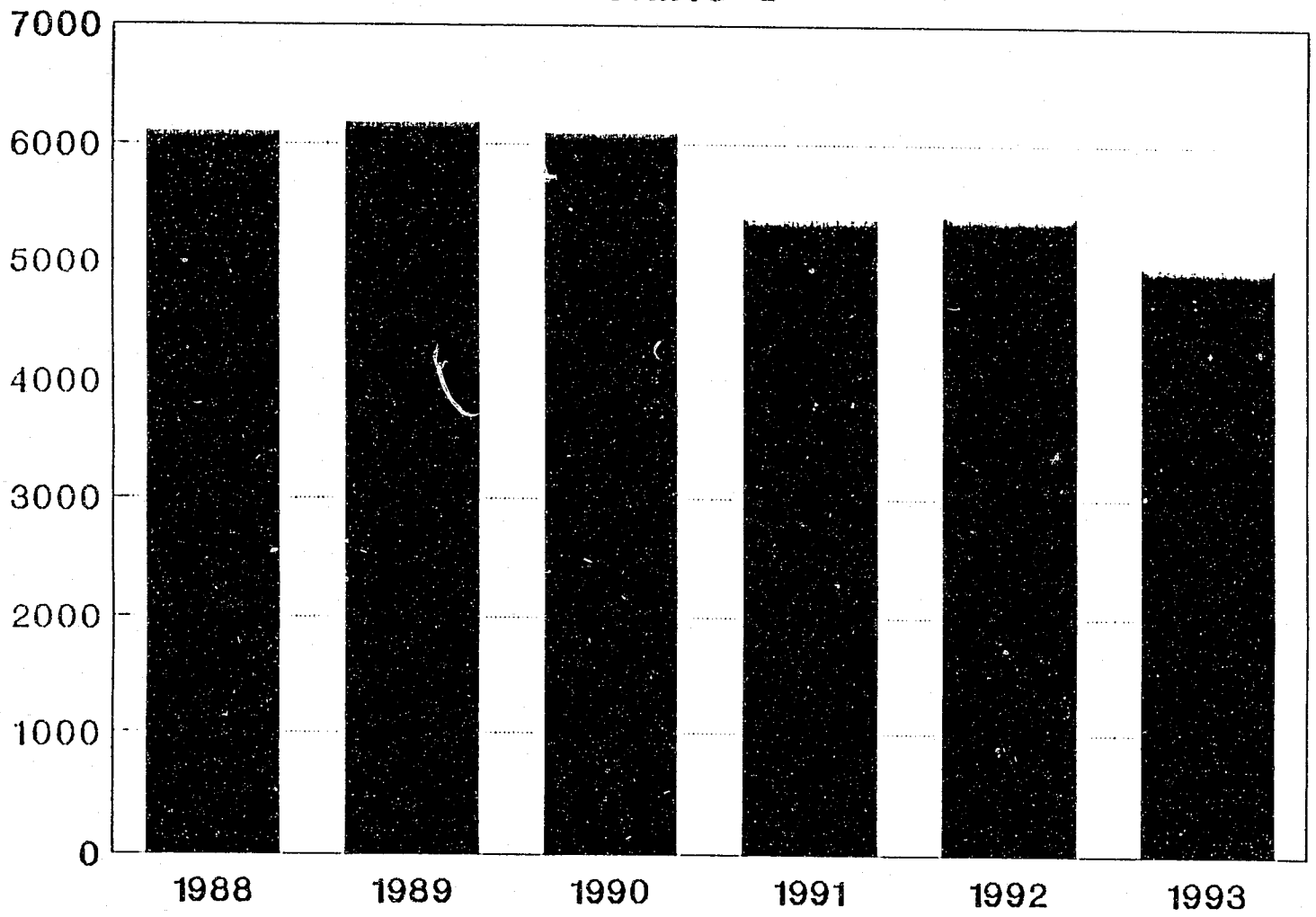
Source: Substance Abuse Management Information System

Indicator #7: ADULT TREATMENT ADMISSIONS FY 1988 - 1993

Brief Note: Prince George's County Health Department, Division of Addictions continues to experience a decline in treatment program resources. Staff positions have been reduced by 30% since FY 1989. The continued decline in treatment program admissions reflect a reduction in capacity not demand.

Technical Note: Adult admissions to treatment declined for clients with a primary problem of PCP, cocaine and heroin. Alcohol admissions remained unchanged from the previous year.

Indicator #7: Adult Treatment Admission FY'1988 - 1993
Table 6



Source: Substance Abuse Management Information System

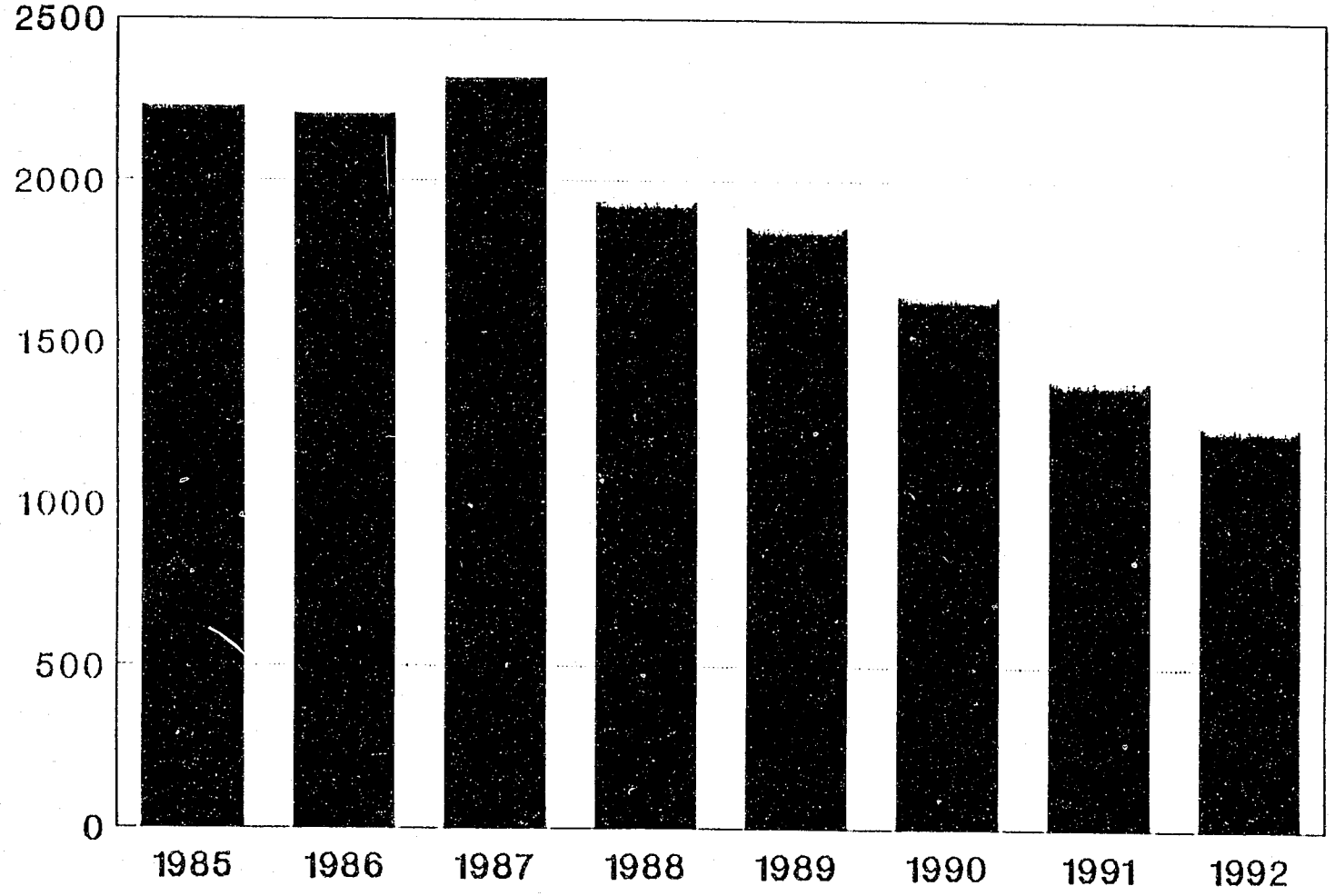
Indicator #9: ALCOHOL AND OTHER DRUG INVOLVED VEHICLE CRASHES 1985-1992.

Brief Note: The total number of vehicle crashes has gradually declined in Prince George's County during the past eight years. In 1985 the total number of vehicle crashes was reported by the Maryland State Police at 18,413. In 1992 the total number of vehicle crashes was reported at 17,002. The number and percentage of alcohol and drug related vehicle crashes has also steadily declined. In 1985 2,228 alcohol and other drug related crashes were reported in the County or 12.1% of all vehicle crashes. In 1992 1,243 alcohol and other drug related vehicle crashes were reported or 7.3% of all crashes. Alcohol and drug related vehicle crashes have declined by 46.4% from 1988 to 1992 according to the State Police.

Technical Note: During the last eight years various efforts have affected the drinking and driving behaviors of County residents. The Health Department in cooperation with the courts have provided training, offender assessments and outpatient treatment. The Health Department with the Department of Corrections established and operate a residential multiple DWI offender program. Volunteer groups such as the Mothers Against Drunk Driving have lobbied for stricter legislation and increased general public awareness. Car manufactures have improved the safety and handling of automobiles and trucks. All of these factors have contributed toward reducing alcohol and other drug related crashes.

Indicator #9: Alcohol and Other Drug Involved Vehicle Crashes 1985 - 1992

Table 7



Source: Maryland State Police

Indicator # 12: DRUG INVOLVED PREGNANCIES FOR CALENDAR YEARS 1991, 1992, 1993

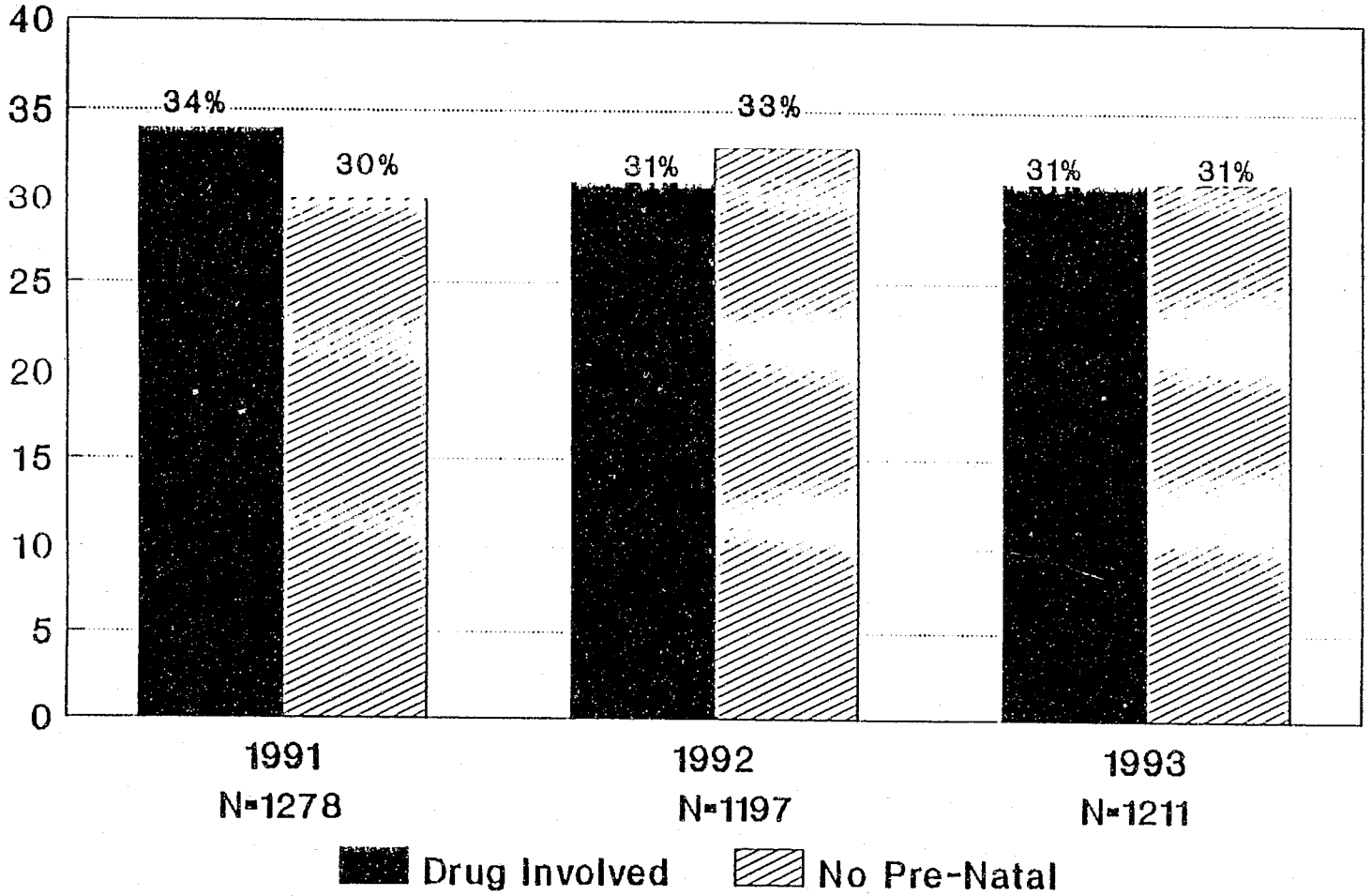
Brief Comment: Estimating prenatal drug complications, as no systematic studies have been completed in Prince George's County. National studies suggest 10% - 15% of pregnant women use illicit drugs during pregnancy, a higher percentage may use alcohol.

The Health Department provides an Infant at Risk program at Prince George's Hospital Center. The program receives approximately 1,200 referrals per year for a variety of reasons including maternal substance use, no pre-natal care, and HIV infections.

Technical Note: Data available on drug involved pregnancies was obtained from the Infant at Risk Program. The program reports the number and percentage of drug using pregnant women and women with no pre-natal care has remained constant over the last 3 years. HIV positive pregnant women increase in 1992 but remained constant in 1993.

Indicator #12: Drug Involved Pregnancies for Calendar Years 1991, 1992, 1993

Table 8



Source: Infant At Risk Program

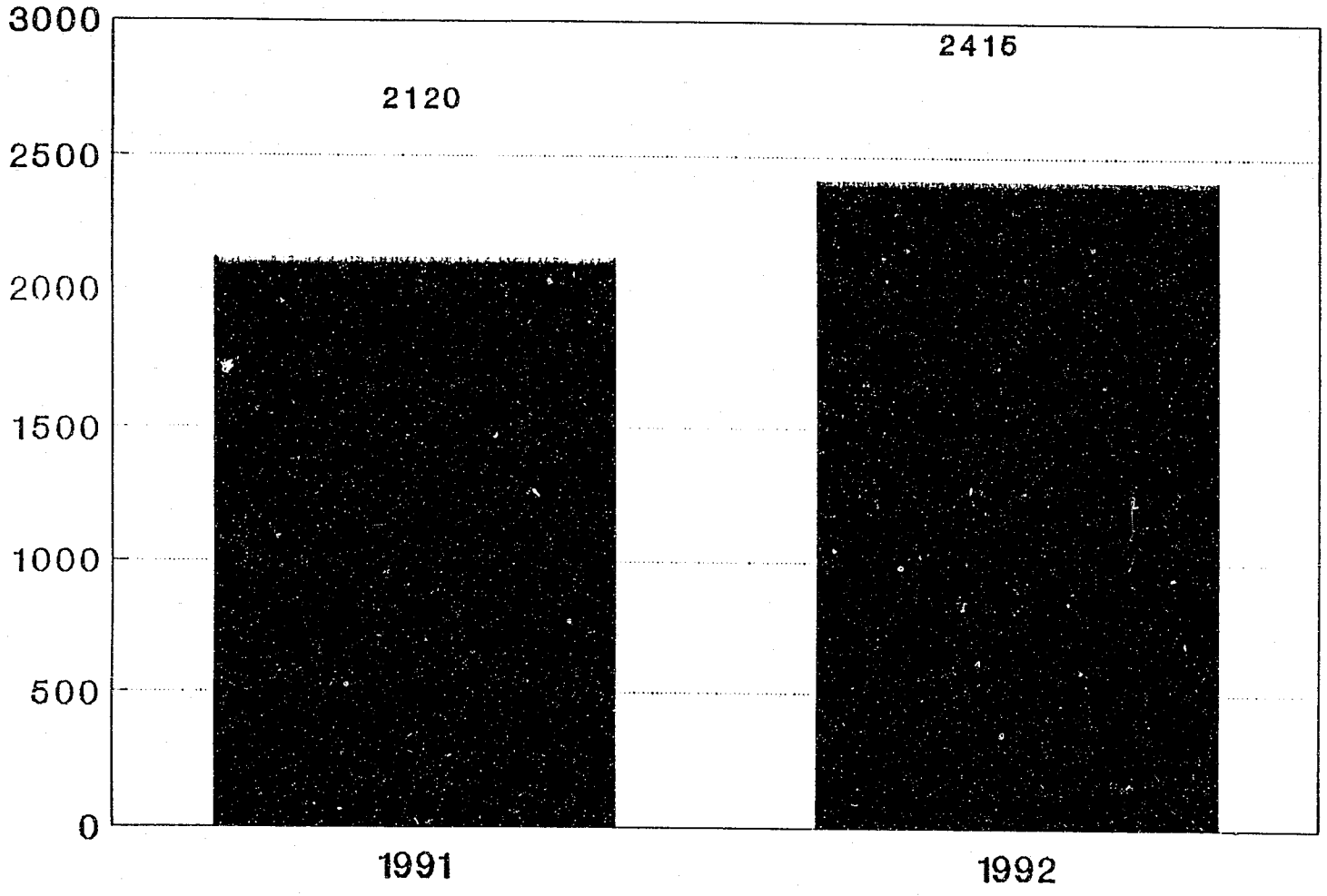
Estimate Based on 9 Months Data

Indicator #13: ADULT DRUG ARRESTS

Brief Comment: Adult drug arrests increased slightly during calendar year 1992 to 2,415 from 2,120 during the previous year.

Technical Note: Previous reports relied on Prince George's County Police data only. Adult arrests for sale or possession did not include reports from municipal police departments, State or Federal police agencies. Data for this report was received from the State Police and includes all county arrests for adults.

Indicator #13: Adult Sale and Possession Drug Arrests for 1991 and 1992
Table 9



Source: Maryland State Police

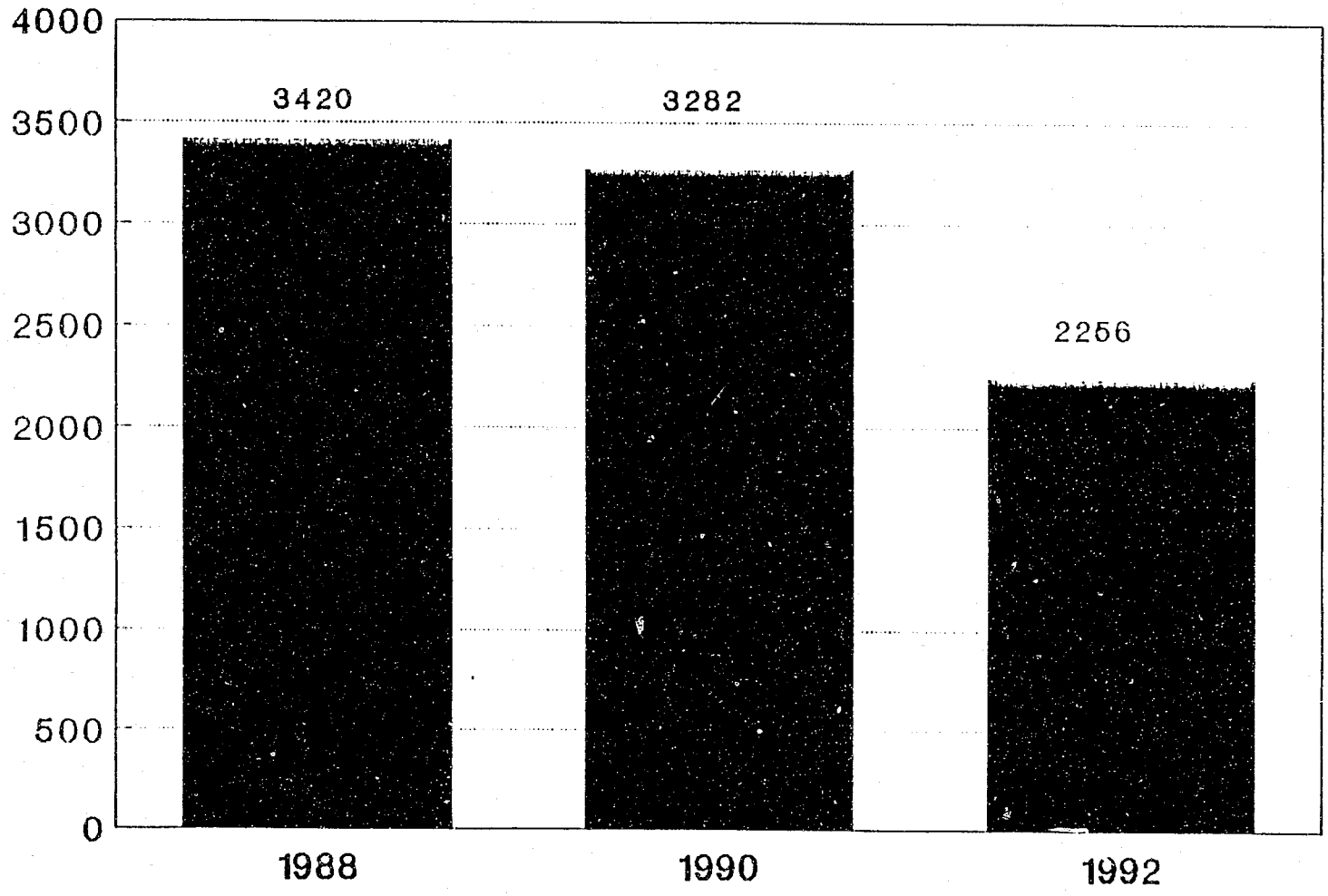
Indicator #14: DWI ARRESTS

Brief Comment: DWI Arrests continue to decline from 1988 through 1992. Arrests dropped from 3,282 in 1990 to 2,256 in 1992 or a 32% reduction in two years.

Technical Note: The decline in DWI Arrests maybe explain in part by changes in drinking and driving behavior and changes in enforcement strategies and priorities.

Indicator #14: DWI Arrests in 1988, 1990 and 1992 for Adults and Juveniles

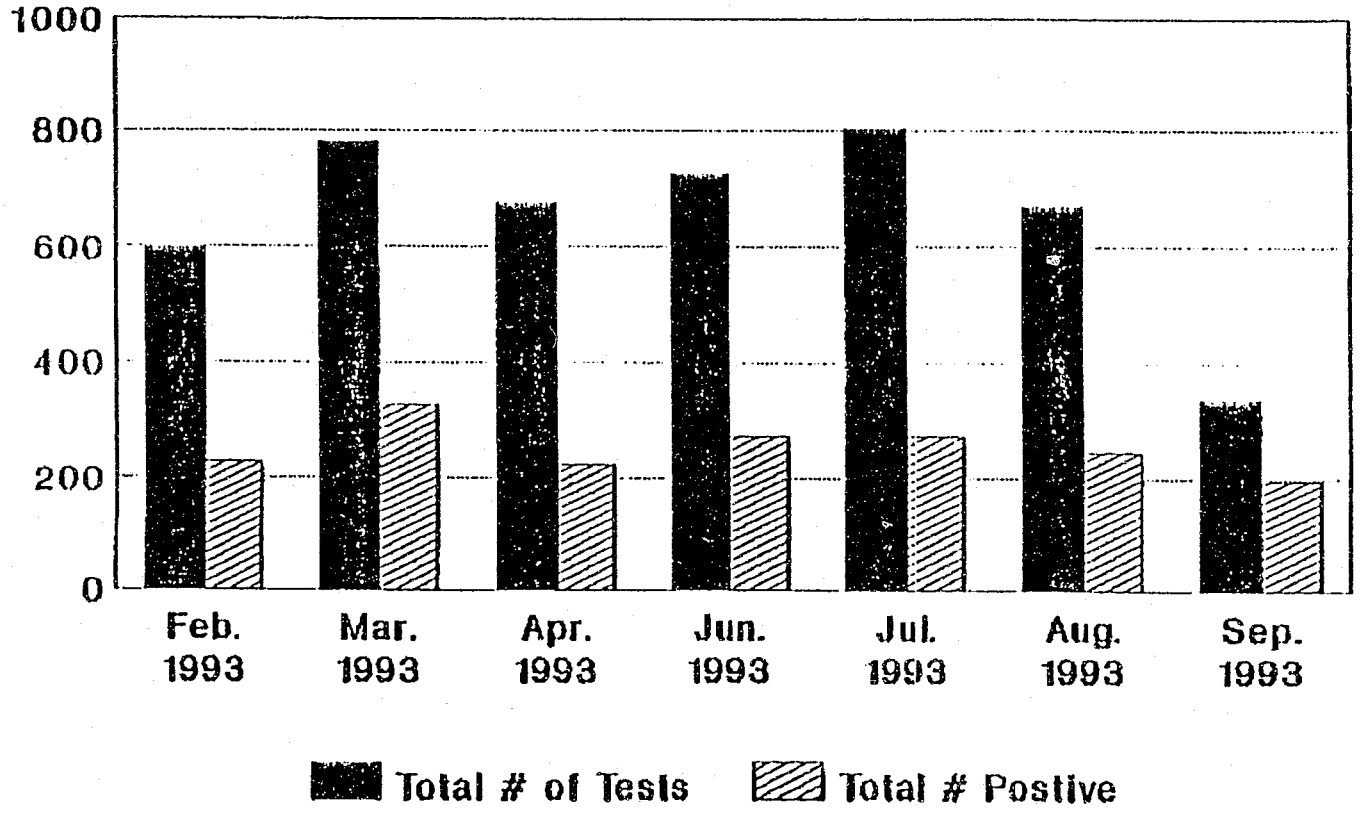
Table 10



Source: Maryland State Police

Indicator # 15: Post Arrest Drug Test

Table 11



Source: Department of Corrections

Indicator #15: Post-Arrest Drug Test

Brief Note: The Prince George's County Department of Corrections conducts drug toxicology testing on arrestees as part of their pre-trial release services. Results are consistently positive for 38% to 47% of arrestees tested. Women are more often positive than men. Cocaine is the drug most often identified.

APPENDIX B-4

Washington County

Demographic Description of Washington County, Maryland

Washington County Maryland is a major industrial and transportation center in the hub of Western Maryland. According to the 1990 census information, total population for Washington County is 121,393 persons with a 0.7% average annual growth rate.

6.2 of the population is in the age range of 0-4, 19.2% of age range 5-19, 40.8% in age range 20-44, 19.9% age range of 45-64 and 13.9% of age range 65 or older. 49% of the population is male, and 50.2% of the population is female. 93% of the population is white, 6% of the population is black and less than 1% of the population is Asian, Hispanic, American Indian or some other ethnicity. According to the 1980 Census of Population and Housing 96% of the population lives in a household and 4% of the population was therefore indigent, although more recent figures were not available.

Of the population 15 years and over, the following marital status information for Washington County residents is as follows: 24% are single, 61% are married, 2% are separated, 8% are widowed and 5% are divorced.

The birth rate per 1,000 population in Washington is 13.0%. According to the Washington County Environmental Scan, published in July of 1990, the total number of teenage pregnancies (age 19 or less) in 1987 was 223 out of 1,527 or 15%. Infant mortality rates for Washington County for the time period 1982-1989 ranged from a low of 6 to a high of 12 infant deaths per 1,000 live births. In 1987, the rate of infant deaths in Washington County was 11.8 per live births, and this is the most recent statistic.

The 1989 average unemployment rate for Washington County was 5.2%. According to the 1990 Survey of Buying Power, the median household income as of 1989 is 25,904. 21% of households are in $10,000-$19,000 income level, 28.4% in $20,000-$34,900 income level, and 15.2% are in $50,000+ level. Those living under the poverty level of $7,356 is 10.8% which is above the State average of 9.8%.

In Washington County there are the following number of public schools, 6 high schools, 7 middle schools, 2 combined middle/senior schools, 21 elementary schools, 3 combined preschool/elementary, and 1 preschool. There are 15 nonpublic schools in the County. We also have an Alternative Learning Center for students grade 6-12, who are found to be unable to function in a normal school setting as a result of various behavioral problems.

The Washington County Board of Education reported the following enrollment for 1990-91 to be 17,160 students. The dropout rate for that year was 4.3%. In 1991-92, the enrollment was 17,340. The dropout rate for that period was 3.3%. In 1992-93, the enrollment was 17,530; the dropout rate for that period was 3.6%.

As of 1989, families who receive AFDC funds in Washington County are 1,269 which is 1.1% of the total population. Food stamp recipients are 2,397 or 2.0% of the total population.

Scope of the Problem - Washington County, Maryland:

Substance abuse continues to have a negative impact on the quality of life in our County. The psychological, behavioral, spiritual and emotional growth development of our youth is impaired. Youth today view the use of alcohol and other drugs as a sign of adulthood. They have the perception that the use of chemical substances, especially alcohol, is their "rite of passage". Drug and alcohol use has become a norm among our youth rather an exception. The Maryland Department of Health and Mental Hygiene Addictions Services Administration 1988-1989 Survey of Substance Abuse Among Maryland Adolescents indicates that Washington County youth show higher averages of chemical use than averages of the State-wide estimate. Washington County also shows an alarming increase in the number of youth arrested for alcohol citations, DWI/DUI and possession of controlled and dangerous substances as shown in the following table:

	Alcohol Citations	DWI/DUI	Possession of Controlled Substances	Number of Arrests
1989	264	16	32	997
1988	221	16	30	973
1987	248	11	26	1,009

Percentages of arrests were as follows: FY 1987, 28% of all arrests were specifically for drug or alcohol offenses; FY 1988, 28% of all arrests were specifically for drug or alcohol offenses; and in FY 1989, 91% of all arrests were for drug or alcohol offenses. Alcohol arrests continue to account for the majority of all drug or alcohol offenses for our County's youth. It should be noted that the statistics cited above were specific drug or alcohol offenses. The data for drug or alcohol related crimes for our County's youth is difficult to obtain. Data for juvenile arrests comes from the Juvenile Services Administration of Washington County. Total indicated per capita for Washington County are higher than that State average. It should be noted that local Juvenile Court Judges

have estimated that the total of juvenile cases that come before them where the charges are alcohol or drug related is approximately 90%.

During the years 1986-1987, 1988-1989, 1990-1992 alcohol was the most commonly used drug among all school groups in Washington County. More recent trends and patterns of substance use for the County are included in the 1990-91 Maryland Adolescent Survey: Washington County Report and Table 7 comparing the 1990 Survey results with the 1992 survey results.

Other Problem Indicators

Indicator 1 - Perception by Maryland State Police that there were a growing number of juveniles ages 13 to 17 committing minor criminal offenses in which substance abuse was a contributing factor who were being released to parental/guardian custody with no information regarding opportunities to receive services/intervention.

Indicator 2 - Perception by local law enforcement that there were approximately 50 juveniles per month in Washington County who fit this profile.

Indicator 3 - Maryland Adolescent Survey Data, numbers of juveniles being processed through the Department of Juvenile Services, Adolescent Treatment Admissions, numbers of alcohol citations, DWI/DUI rates for juveniles.

Program Utilization Indicators

Indicator 1 - numbers of S.P.E.A.R. program admissions

Indicator 2 - Table 7; Maryland Adolescent Survey: Washington County Sample Reporting Tobacco, Alcohol and Other Drug Use Across Grade Levels - 1990, 1992 Comparison

Indicator 3 - Alcohol/Drug Related Accidents by Age (1992)

Indicator 4 - Number of intake cases; Department of Juvenile Services

Indicator 5 - S.P.E.A.R. Program Questionnaire

Indicator 6 - Adolescent Treatment Admissions

COMPARISON OF S.P.E.A.R. PROGRAM
MONTHLY REFERRALS

	1990	1991	1992	1993
June	4	7	5	4
July	8	7	4	2
August	28	24	2	3
September	11	10	4	8
October	11	13	7	5
November	8	12	4	*
December	7	4	7	*
January	n/a	8	4	3
February	n/a	11	7	9
March	n/a	17	2	14
April	n/a	14	2	6
May	n/a	15	4	10

TABLE 7

Percentage of Washington County Sample Reporting Tobacco, Alcohol and Other Drug Use Across Grade Levels - 1990, 1992

SUBSTANCE:	6TH GRADE			8TH GRADE						10TH GRADE						12TH GRADE					
	LIFETIME USE	PRIOR USE	CURRENT USE	LIFETIME USE		PRIOR USE		CURRENT USE		LIFETIME USE		PRIOR USE		CURRENT USE		LIFETIME USE		PRIOR USE		CURRENT USE	
	1992	1992	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992
Tobacco:																					
Cigarettes	15.8	11.4	2.4	37	50.3	26	38.9	11	21.9	53	52.0	32	36.7	17	23.4	61	62.3	42	40.2	26	28.7
Smokeless Tobacco	4.2	4.1	.5	17	23	10	14.1	6	7.7	17	23.2	22	13.6	14	8.4	30	31.8	20	14.7	14	7.4
Alcohol:																					
Beer, Wine or Wine Cooler	31.8	20.8	6.7	59	54.8	42	41.7	17	26.4	76	71.9	61	55.7	31	32.0	89	82.4	81	70.6	43	40.2
Liquor	9.3	7.4	2.9	36	33.3	22	23.6	8	14.1	52	52.3	38	39.6	15	23.1	71	68.6	53	49.6	27	26.3
5 or more servings/ one occasion	*	3.2	1.4	19	16.5	14	14.5	7	8.9	37	33.0	30	28.7	16	16.6	59	49.4	48	40.4	27	25.2
Marijuana:	*	1.4	1.0	10	7.9	4	7.5	1	3.8	17	14.8	10	12.4	5	7.8	31	25.7	20	21.6	11	11.1
Inhalants:																					
Glue, aerosols, etc.	6.5	3.2	1.4	21	14.3	15	14.0	8	6.9	22	8.0	10	6.2	4	2.2	17	9.8	10	9.4	3	4.6
Amyl or Butyl Nitrates	*	1.4	.5	2	*	1	1.4	1	1.0	5	2.5	4	1.9	1	.6	13	4.1	6	2.5	2	.8
Cocaine:																					
Crack	*	.9	.5	1	1.7	1	1.4	0	0	3	2.5	1	1.2	0	.6	5	3.3	4	2.4	1	1.2
Other Cocaine	*	.9	.5	3	2.0	2	1.7	0	*	3	3.1	1	2.8	0	.9	7	4.1	3	3.3	2	1.2
Steroids:	*	1.9	.5	4	1.4	3	1.0	3	1.0	2	*	1	1.2	0	.9	4	2.0	2	2.0	2	1.2
Amphetamines:	*	4.2	2.4	12	*	7	9.9	4	4.2	20	9.9	12	9.9	6	4.3	19	16.9	13	13.5	8	7.8
Barbiturates:																					
Tranquilizers	*	1.4	1.0	5	2.4	4	2.4	2	1.4	9	*	7	6.8	3	3.4	12	*	8	6.9	5	3.7
Methamphetamines:	*	.9	1.0	5	*	4	4.1	3	1.4	1	4.9	7	2.2	2	1.3	13	10.2	7	9.0	5	4.5
Narcotics:																					
Heroin	*	.9	.5	2	*	2	1.7	1	1.0	8	1.9	6	.9	3	.6	10	2.0	7	1.6	4	.8
Other (codeine, morphine)	*	4.6	2.4	6	*	5	5.5	5	2.1	3	*	1	8.0	0	3.4	2	*	2	8.6	2	4.5
Hallucinogens:																					
PCP	*	.9	.5	2	2.4	2	2.4	1	1.4	5	4.9	3	4.3	1	1.9	10	5.7	5	4.9	3	1.6
LSD	*	.9	*	6	3.4	3	3.1	2	2.1	8	7.1	6	6.5	1	4.1	15	13.1	10	11.0	5	4.9
Other Hallucinogens	*	.5	.5	2	*	2	1.7	1	.7	6	4.6	3	4.6	1	1.9	10	5.3	8	3.3	3	1.2
Designer Drug:	*	.5	.5	1	.7	1	.7	1	.7	1	1.2	2	1.2	0	.9	4	*	2	3.3	2	1.2
Needle Use:	*	.9	.5	2	.3	2	.3	1	.3	1	.9	1	.3	1	.3	3	1.2	2	1.2	2	.8

* State researcher did not provide data.

Alcohol/Drug Related Accidents by Age														
County	Ages 16-17	Row %	Ages 18-20	Row %	Ages 21-25	Row %	Ages 26-30	Row %	Ages 31-55	Row %	Ages 56-65	Row %	Ages >65	Row %
Allegany	8	4.0	26	12.9	45	22.3	34	16.8	73	36.1	8	4.0	8	4.0
Anne Arundel	37	2.7	128	9.3	283	20.6	274	19.9	575	41.8	44	3.2	35	2.5
Baltimore	30	1.7	132	7.4	322	18.1	337	19.0	800	45.0	89	5.0	66	3.7
Calvert	6	4.8	16	12.9	22	17.7	22	17.7	47	37.9	5	4.0	6	4.8
Caroline	3	3.8	9	11.5	14	17.9	17	21.8	26	33.3	3	3.8	6	7.7
Carroll	8	3.2	34	13.6	61	24.4	42	16.8	94	37.6	6	2.4	5	2.0
Cecil	13	3.9	46	13.9	59	17.9	66	20.0	131	39.7	11	3.3	4	1.2
Charles	19	4.3	47	10.5	90	20.2	83	18.6	182	40.8	18	4.0	7	1.6
Dorchester	4	5.1	7	8.9	13	16.5	16	20.3	31	39.2	6	7.6	2	2.5
Frederick	19	4.3	60	13.6	102	23.2	79	18.0	156	35.5	17	3.9	7	1.6
Garrett	3	3.8	11	13.9	27	34.2	12	15.2	21	26.6	0	0.0	5	6.3
Harford	18	3.4	62	11.8	91	17.3	84	16.0	228	43.3	27	5.1	16	3.0
Howard	10	2.5	36	9.0	80	20.1	74	18.6	169	42.5	21	5.3	8	2.0
Kent	0	0.0	6	13.0	11	23.9	5	10.9	21	45.7	2	4.3	1	2.2
Montgomery	38	2.6	132	9.0	307	20.9	275	18.8	617	42.1	67	4.6	30	2.0
Prince George's	26	1.2	128	5.9	429	19.7	379	17.4	1,068	48.9	106	4.9	46	2.1
Queen Anne's	3	3.0	14	14.0	12	12.0	17	17.0	43	43.0	8	8.0	3	3.0
St Mary's	4	2.2	20	11.2	35	19.6	34	19.0	76	42.5	6	3.4	4	2.2
Somerset	1	1.9	9	17.0	13	24.5	13	24.5	12	22.6	3	5.7	2	3.8
Talbot	3	3.0	14	14.1	16	16.2	17	17.2	45	45.5	4	4.0	0	0.0
Washington	12	3.3	42	11.4	84	22.8	63	17.1	147	39.9	13	3.5	7	1.9
Wicomico	5	2.1	28	11.5	38	15.6	45	18.5	107	44.0	13	5.3	7	2.9
Worcester	11	4.0	43	15.8	72	26.4	57	20.9	69	25.3	10	3.7	11	4.0
Baltimore City	8	0.5	85	5.4	228	14.6	295	18.8	784	50.1	109	7.0	57	3.6
Statewide	289	2.3	1,135	9.0	2,454	19.4	2,340	18.5	5,522	43.6	596	4.7	343	2.7

MARYLAND ADOLESCENT SURVEY

Washington County, Maryland

Comparison: Maryland State Sample and Washington County Sample

Positive Findings

*Washington County students report a decrease in the number of 10th and 12th graders who have lifetime and prior year use of beer, wine (other than for religious use) or wine coolers.

Areas of Concern

*Despite the above mentioned decreases, student reports of alcohol use is still alarmingly high. Two (2) out of every five (5) 12th graders have binged in the past year and one (1) out of every four (4) have binged in the last month.

*Tobacco use is significantly up in the 8th and the 10th grade. Life time use jumps form 15 to 30% between the 6th and 8th graces. Use patterns remain constant in the 8th, 10th and 12th grades.

Washington County: 1990/1992 Survey Comparison

Positive Findings

*Student reports of smokeless tobacco use have decreased significantly since the 1990 study.

*The 1992 Survey reflects a significant in lifetime use of inhalants in the 10th and 12th grades.

Areas of Concern

*Use of smokeless tobacco is high. The most significant increases occur between the 6th and 8th grade. This same trend is reflected in reported use of cigarettes.

*Rates of tobacco use remain fairly constant in the 8th, 10th and 12th grades.

NUMBER OF INTAKE CASES

DEPARTMENT OF JUVENILE SERVICES

WASHINGTON COUNTY, MARYLAND

1987	890 JUVENILES
1988	897 JUVENILES
1989	1001 JUVENILES
1990	987 JUVENILES
1991	904 JUVENILES
1992	947 JUVENILES

Washington County
DWI Arrests
Under 20 Years of Age

	Number of Arrests
1989	25
1990	30
1991	18
1992	24

* Please note: These statistics are from the Washington County Sheriff's Department

****

Washington County
DWI Arrests
Under 21 Years of Age

	Number of Arrests
1989	39
1990	45
1991	21
1992	7

Alcohol Citations

	Number of Citations
1989	234
1990	326
1991	261
1992	144

* Please note: These statistics are from the Hagerstown City Police Department.

S.P.E.A.R. PROGRAM OBJECTIVES

a. To ensure that drug/alcohol impaired individuals who commit minor criminal offenses are not inappropriately detained or committed.

b. To ensure that drug/alcohol impaired juveniles receive appropriate substance abuse education, prevention, treatment, counseling and intervention.

c. To ensure that family/siblings of drug/alcohol impaired juveniles and their families receive appropriate substance abuse education/prevention/treatment and family counseling services.

d. To provide drug/alcohol impaired juveniles and their families with substance abuse assessment and referral information during clinical and non-clinical hours, 7 days per week, 24 hours per day.

e. To provide ongoing case management component to ensure appropriate services are accessed and delivered to drug/alcohol impaired juveniles and their families.

f. To divert high-risk drug/alcohol impaired juveniles away from increased addiction and continued criminal behavior.

COOPERATING OR PARTICIPATING AGENCIES

COOPERATING AGENCIES	SERVICES TO BE PROVIDED
1. Alcohol and Drug Abuse Administration	1. Overall project supervisors, technical assistance, grant writing, consultation, and appropriate training for S.P.E.A.R. staff.
2. Washington County Health Department - Division of Addictions	2. Implementation and direct supervision of the S.P.E.A.R. Project, counseling services and mental health evaluations as needed.
3. Washington County local law enforcement agencies (Maryland State Police, Sheriff's Department, Municipal Police)	3. Referral of juveniles who fulfill S.P.E.A.R. project profile to S.P.E.A.R. Consultant(s).

S.P.E.A.R. PROGRAM REFERRAL CRITERIA

1. JUVENILES AGES 13 TO 17 YEARS OLD (THOUGH YOUNGER AND OLDER CHILDREN MAY BE ENCOUNTERED)

2. JUVENILES STOPPED BY AND/OR QUESTIONED BY LAW ENFORCEMENT OFFICERS

3. POLICE PERSONNEL SUSPECT HARMFUL INVOLVEMENT WITH ALCOHOL OR OTHER DRUGS

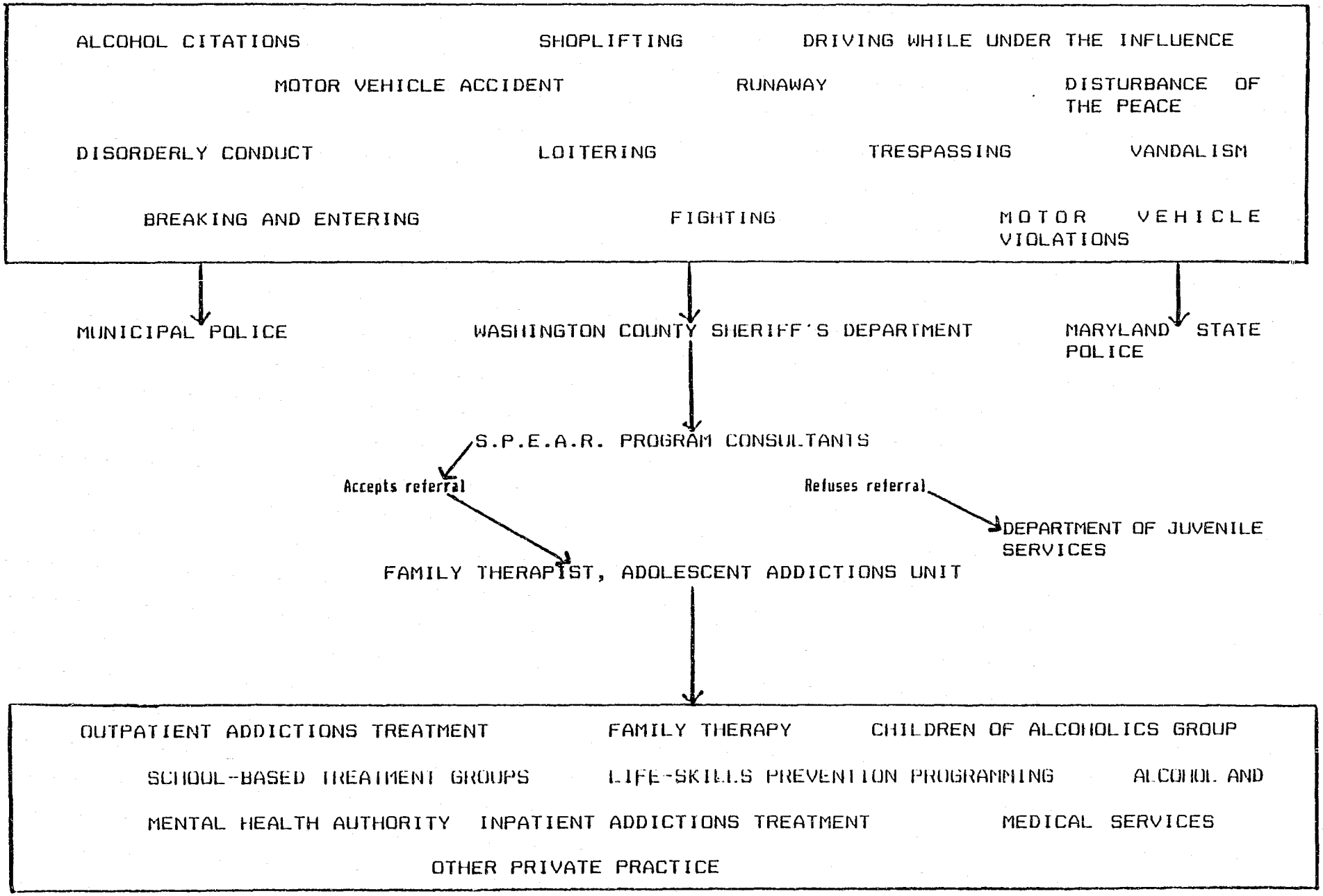
4. POLICE PERSONNEL SUSPECT THAT ALCOHOL OR OTHER DRUG USE IS A CONTRIBUTING FACTOR RELATING TO CRIMINAL BEHAVIOR

5. POLICE PERSONNEL ISSUE A NON-CRIMINAL OR VERBAL WARNING PRIOR TO RELEASE OF JUVENILE TO PARENTAL/GUARDIAN CUSTODY BUT OBSERVES THE NEED FOR SUBSTANCE ABUSE AND/OR FAMILY COUNSELING SERVICES INTERVENTION

5. JUVENILES HARMFUL INVOLVEMENT WITH ALCOHOL OR OTHERS DRUGS USE COULD BE AT ANY LEVEL INCLUDING COMPLICITY, EXPERIMENTATION, CASUAL USE, ABUSE, DEPENDENCY OR DISTRIBUTION

6. JUVENILE'S FAMILY SITUATION IS RELATIVELY STABLE AND FUNCTIONAL BUT INTERVENTION HAS NOT BEEN ACCESSED OR PROVIDED BECAUSE THE JUVENILE'S SITUATION OR BEHAVIOR HAS NOT YET REACHED CRISIS LEVEL

S.P.E.A.R. PROGRAM REFERRAL FLOW



SCREENING FORM
S.P.E.A.R. PROGRAM

DATE:

CLIENT INFORMATION
L. Name: F. Name: MI: Sex M/F:
SS# DOB: Race W/B/O: Phone #:
Street: City: CO: ST: In Schl:

FAMILY INFORMATION
Parent or Legal Guardian
L.Name: F. Name: MI:
Street: City: CO: ST: Phone #:

REFERRAL INFORMATION
MSP/CO/CTY:
Arstng Ofcr: Ntfyd By:
DWI/DUI/Civil/PosCDS/DisCDS/Other:
Screened-MSP/CO/CTY/Home/Office/Other:
Present at Screening

Presenting Problem

SUBSTANCE ABUSE HISTORY:
Current Use: Drug of Choice: Freq:
1st Use: Last Use:
Scnd Drug: Freq: 1st Use: Last Use:

In TX: Location (sa-op, sa-ip, mh-op, mh-ip, other):

FAMILY UNIT STRUCTURE:
In Tact: Functional:

DISPOSITION
Refrd To (Hospital, DSS, CASA, HD, Other): DSM IIIR:
Follow-Up Agreement:

Compl By:

REFERRAL TRACKING
Time Call Rcvd:
Time Fam Contc:
Time Fam Seen:
Time Spent:

S.P.E.A.R. PROJECT CONSULTANT(S) DUTIES AND RESPONSIBILITIES

1. Perform an initial psychosocial screening of impaired juvenile at barrack/police station to determine nature and extent of substance abuse involvement and mental health problems.

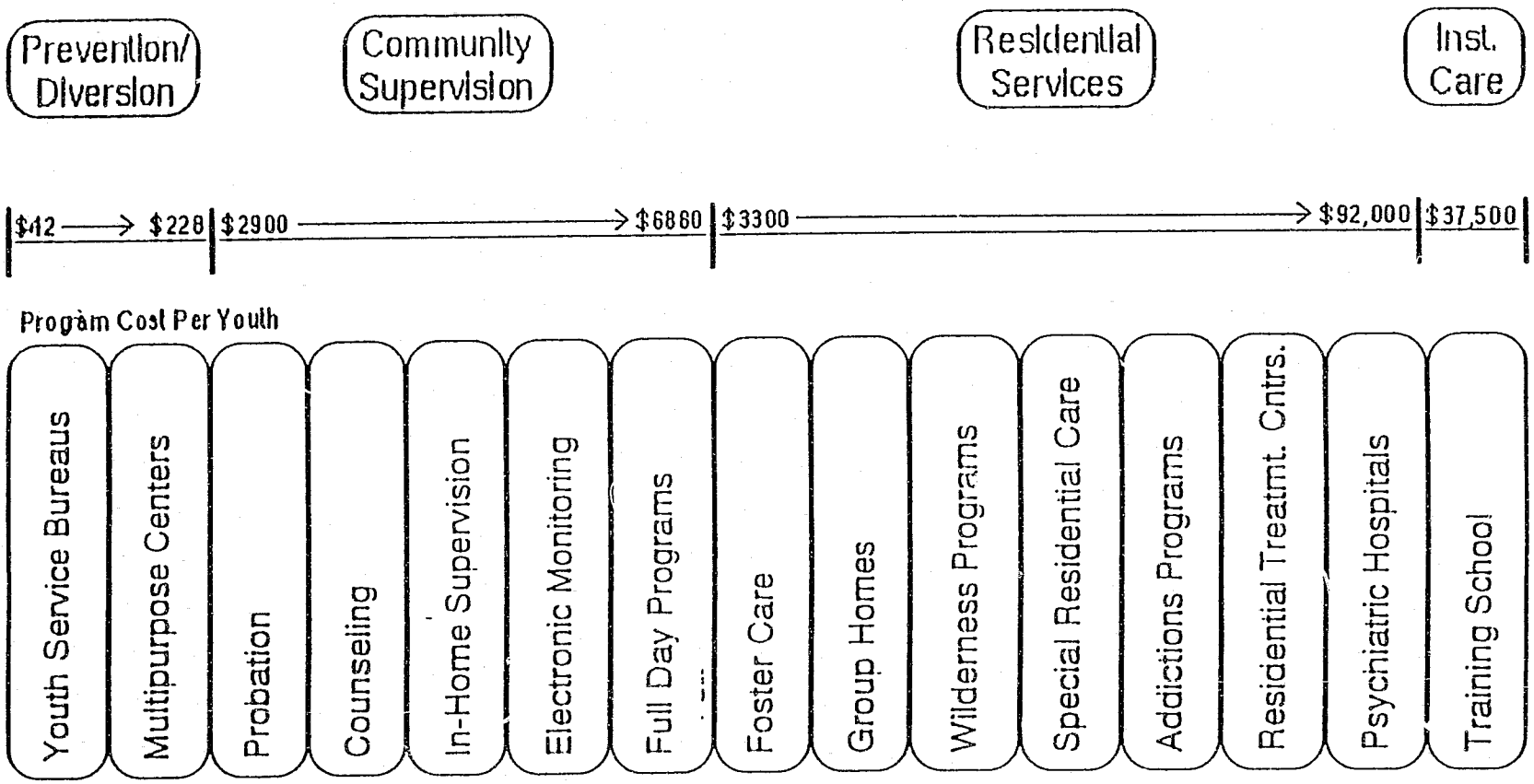
2. Obtain written and verbal commitment from juveniles parent/guardian to participate in scheduled follow-up visit with family therapist to perform a more indepth psychosocial assessment of juvenile and family members.

3. Provide appropriate referral information to individual/family for substance abuse education/prevention and/or treatment services as well as family counseling services.

4. Contact the Program Director within the Health Department, during traditional clinical hours, to report results of initial and follow-up assessments and referral options. The Program Director will function as the overall case manager to ensure appropriate services are being provided and accessed by client(s).

5. If the juvenile and/or family refuse to cooperate with S.P.E.A.R. Consultant(s) preliminary of follow-up assessments or refuse to access referred services, the Consultant(s) will notify local law enforcement personnel who may then process criminal charges for the initial offense in accordance with established law.

RANGE OF SERVICES



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