

INFORMATION NEEDS FOR DRUG ABUSE POLICY
IN THE WASHINGTON METROPOLITAN AREA

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GLOSSARY

ADASA	Alcohol and Drug Abuse Services Agency
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Agency
DUF	Drug Use Forecasting system
IV	Intravenous
PCP	Phencyclidine
PROMIS	Prosecution Management Information System
UCR	Uniform Crime Reports
WIC	Women, Infants, Children program

INFORMATION NEEDS FOR DRUG ABUSE POLICY IN THE WASHINGTON METROPOLITAN AREA

Driven by a record number of homicides, most related to drug selling, concern with drug problems in the Washington area has reached a new height. This concern has led to an interest in examining how adequately the area is served by the available public sector data systems concerning drug problems and programs.

There are three broad reasons for the public and private sectors to want information about drug use in the region: 1) to raise public awareness of the problem and create a constructive sense of urgency; 2) to help policymakers decide what to do; and 3) to track overall progress -- reduction of drug use in the population as a whole and in specific subgroups. What we have now in the Washington metropolitan area is probably sufficient to achieve the first purpose, but not the second and third. We used the available data in an earlier study.¹ This paper suggests how to build on what already exists to do a credible job for all three purposes, with the focus on the second and the third.

We assume, for the purpose of exposition, the existence of a regional authority charged specifically with monitoring the problem. This is not a recommendation that a new agency be formed for that purpose; instead an existing entity, such as the Council of Governments, might be given this responsibility.

There are substantial advantages to putting together data from the various agencies and programs involved in the drug problem (law-enforcement agencies, schools, hospitals, and treatment programs) and the different jurisdictions. All the sources of data discussed here have problems of reliability, coverage, timeliness, etc. But combining information from many sources increases both the reliability and usefulness of the information. Further, it is clear that jurisdictional

¹P. Reuter, J. Haaga, P. Murphy, and A. Praskac, *Drug Use and Drug Programs in the Washington Metropolitan Area*, R-3655-GWRC, The RAND Corporation, 1988.

boundaries have little relevance for many elements of the drug problem.

For some purposes, frequent and timely reporting is necessary. For others, less frequent reporting, or even a one-time special study, is more appropriate. Some indicators should be collected and reported by every jurisdiction in the Washington area, while others may not be needed on a regional basis. Though we will not attempt to estimate the costs of different activities, likely cost-effectiveness is a criterion by which proposed activities should be judged.

In the following sections, we discuss information about drug use in the general population, drug use by young people, enforcement strategies, treatment needs, and prevention programs. These sections mainly concern ways that agencies could expand information collection to reflect the state of the art, generally attained in at least one local jurisdiction. Next, we discuss proposals for a regional survey of drug use. Special studies of practices of intravenous (IV) drug users and drug use by pregnant women -- two populations of great concern for public health planners -- are also discussed. The final section of this paper lists our conclusions and main priorities for policy-relevant data collection and analysis.

DRUG USE IN THE GENERAL POPULATION

DAWN Data

The National Institute on Drug Abuse (NIDA) sponsors a Drug Abuse Warning Network (DAWN), which collects semi-annual reports from 26 metropolitan areas around the country. There are two main sources of DAWN data: reports of medical examiners (coroners) on the number of deaths for which drug use may have been a contributory cause and reports from selected hospital emergency rooms on admissions in which drug use was noted.

DAWN data are valuable as indicators of use in the general population because they are not colored by self-reports, by the types of people seeking treatment, or by law enforcement strategies, as the other sources of data on the general population all are. They are limited, however, by the fact that medical examiners' data only deal with the catastrophic endpoint of drug use, and thus do not provide any early

warning or much information about "softer" drug use, and by the fact that detection of drug use in emergency room admittees is somewhat haphazard.

The usefulness of DAWN data for policy purposes is also limited now by NIDA publication delay and by NIDA's limitations on identification of the participating emergency rooms. DAWN data are only published for the metropolitan area as a whole. Thus we were able to disaggregate only into central city (the District of Columbia) and suburbs. We were unable to determine the extent to which "suburban" trends were dominated by one jurisdiction, clearly an important matter for the allocation of treatment resources.

DAWN data would be more useful for local decisions if they were disaggregated by jurisdiction (or at least District, Maryland, Northern Virginia). Timely release could be obtained if local medical examers and emergency rooms were to send copies of their DAWN reports to a regional entity at the same time as they send them to NIDA.²

Urinalysis of Arrestees

The District has a program under which all arrestees in both the adult and juvenile systems are asked for a urine sample. The adult program, run by the Pretrial Services Agency, has been in operation for four years; the juvenile program began in 1987. For our research describing the Washington area's drug problems, this proved a very useful, objective indicator of trends in drug use, albeit in a restricted population. The urinalysis data showed, for example, the steady increase in cocaine and PCP use, despite the sustained law enforcement crackdown in the District. A unique quality of these data is their timeliness; monthly data from a large population of tests have been available within a few weeks of collection.

The urinalysis program is intended primarily to inform pretrial release decisions; newer elements of the program are intended to help in

²DAWN officials have been concerned with the accuracy of raw reports; the regional authority would have to acquire the data editing routines used by DAWN to test for data entry errors if it were to publish the data separately.

monitoring probationers and parolees. Data on trends are a by-product.

Prince George's County has received a grant to begin a testing program, but to our knowledge no other local jurisdictions currently have plans for urine testing of arrestees. Such programs might be instituted, perhaps on a sample basis, using the methods of the National Institute of Justice's Drug Urinalysis Forecasting (DUF system). If data from such a system were available for most jurisdictions in the Washington area, then they could serve as a timely check on the information about drug availability and trends in use that we propose to gather from interviews.

One note of caution about the urinalysis data. Neither in Washington nor in any other city have the data been systematically analyzed. We cannot say whether the trends in drug use by arrestees are a leading indicator for the population as a whole or for some important segment of the population. Indeed, it may be that the relationship varies across cities or drugs; different drugs appear to have different social paths of diffusion.

YOUTH

Before age sixteen, nearly all young people are in more or less regular contact with the schools. Surveys in the schools provide much of our current information about drug use and availability. Most of the jurisdictions in this area have had at least one such survey. Their usefulness both in delineating the problems here and in comparing reported use to national trends has been lessened by peculiarities of sample design and questionnaire construction and by noncomparability of questions. The Institute of Social Research at the University of Michigan has conducted annual nationwide surveys of high school seniors for over a decade, and their survey instruments have been refined and reliability of different question wordings tested. It would make sense for local school districts to standardize by using the Michigan instruments, perhaps dropping items relating to drugs known to be minor problems in this area and adding small modules dealing with issues of pressing concern to local school boards that are not adequately covered in the Michigan instruments.

As for the general population, self-report data from young people suffer from possible bias due to differences among racial and ethnic groups in the degree of underreporting. But again, they have the advantages that are not shared by administrative or other data. Detecting early use, occasional use, and use of soft drugs, and linking data about availability and antecedents of use, are all even more important for young people than for the older population.

It is important that surveys in different years, and so far as possible in different jurisdictions, use the same wording, be conducted at the same time of year, and be parallel in as many aspects as possible. The biannual school surveys in the State of Maryland, which Montgomery County kept up during recent years when state funding was not available, come closest to reaching this goal. It would be useful to have a staff-level working group bringing together all local school districts planning such surveys; at present, each goes off by its own, and the results are less valuable than they would be if they could be pooled.

Most local school districts collect data on the number of suspensions for drug-related infractions, referrals to treatment programs, and the like. These are of limited value as indicators of overall trends in drug use, since they also reflect school policies and the vigor with which they are being enforced. They could be useful as an indicator of what is being done in the schools, and of changes in the types of drugs being consumed by young people, the amounts bought and sold, markets, and other indicators. These data are published separately in annual reports by the Montgomery County Public Schools. A regional data bank should collect data from all local school districts to see if trends can be monitored and useful comparisons made; it might also attempt to provide model codes for collecting and presenting this information.

Urinalysis of juvenile arrestees in the District provides a timely indicator of drug use in a select population of considerable concern. These data were useful in showing the very high proportion of phencyclidine (PCP) use in this area and the continued widespread use of

cocaine despite intensified enforcement. As with adult arrestees, only the District tests juvenile arrestees. The suburban jurisdictions might well consider similar tests, at least on a sample basis. Besides providing an indicator of drug use in one high-risk population, urinalysis can help inform probation and treatment referral decisions.

ENFORCEMENT STRATEGIES

For enforcement policy it is important to obtain data that would permit measurement of the stringency with which drug laws are being enforced in the various jurisdictions of the region. That requires systematic monitoring not only of the number of arrests but also of the fate of those arrests, as well as the other sanctions that are applied against those involved with drugs.

Post-arrest Events³

Arrest data are currently produced on a timely basis by all jurisdictions.⁴ The weakness is in data on what happens after arrests. We do not have an adequate picture of what the criminal justice system is achieving in terms of the stringency of enforcement against dealers and users; similarly we do not know what strains are being put on the system as a result. What is needed is information on dismissals convictions, sentences, and time actually served in prison.

We were able to put together quite a complete picture of post-arrest events for the District, where the prosecutor's office collects data on the number of persons indicted and convicted on felony drug charges. Other D.C. agencies produce data on the numbers receiving sentences of incarceration and on the lengths of these sentences. These enabled us to broadly characterize the stringency of enforcement.

³Barbara Boland and Brian Forst provided valuable advice for this section.

⁴The inability to separate out cocaine from heroin in the arrest data should be mentioned as a significant problem in monitoring the stringency of enforcement. This is due to the conventions of the national Uniform Crime Reports (UCR), which is in the process of revision. It is not likely that local police agencies will develop a system for arrest data different from the UCR, so we make no suggestions on this matter.

The U.S. Attorney's Office has a data system that provides even more detail about the disposition of arrests referred to the prosecutors by the police department up to the point of sentencing. The PROMIS system (Prosecutor Management Information System) has been in operation in the District for about a decade and is used, in various forms, in about 65 large prosecutors' offices around the nation.⁵ Though it needs to be supplemented by police data on arrests that are not referred to the prosecutor and by court information about sentence length, PROMIS does provide an extremely good tracking of how the criminal justice system deals with each year's cases. We did not make use of these data when preparing our study, simply because we were unaware that the system was still in operation. Each year's data from a number of these offices are published in a Bureau of Justice Statistics publication called the *Prosecution of Felony Arrests*. The 1986 data will become available in published form in Spring of 1989.

PROMIS-type systems are also operating in at least two other prosecutors' offices, those of the State's Attorneys in Montgomery and Prince George's Counties. We are unaware of any publications from these systems.

It appears that PROMIS data could be provided on a much more timely basis if this were deemed necessary. Data entry for all cases closed in a calendar year can be completed within the first quarter of the following year and reports on particular classes of cases published by the middle of the year. This would mean that it would be possible by July of 1989 to ascertain the disposition of all 1988 cases referred to the prosecutors' offices in the District and Maryland.

As it was, we were only able to provide very fragmentary data for Montgomery County. For Virginia jurisdictions, we had to rely on sentencing data put together by dedicated volunteers from the "Court Watch" program of Parents Association to Neutralize Drug and Alcohol Abuse, a parents group.⁶ Since drug arrests are the major cause of the

⁵See Barbara Boland, *The Prosecution of Felony Arrests, 1986*, Bureau of Justice Statistics, forthcoming.

⁶The PANDAA program provided an interesting example of the fact that such information, if available, could be effectively used:

increased burden on the courts and prison system, criminal justice planners should at least have timely reports from all parts of the system.⁷

Our recommendation is that there be a substantial expansion of data collection by criminal justice agencies, in particular by prosecutors and courts. The Virginia, District, and Maryland prosecutors should be encouraged to disseminate their PROMIS data more rapidly and broadly. While our interest is primarily in the additional information that this would yield concerning the stringency of drug enforcement, it obviously would help criminal justice planning generally.

Prices and Availability

A good deal of attention has been given to occasional reports by local police agencies on the quantities of drugs and financial assets seized. Such reporting needs to be regularized to permit tracking of the pressure against drug markets created by such tactics.

In the long term, enforcement strategies will have an effect on drug abuse not solely by removing drugs and dealers from the scene; it has been sadly obvious in recent years that there are always plenty more of both to replace the lost ones. Enforcement will mainly affect future use by making it more difficult, risky, and thus expensive, to buy illegal drugs. Success should be measured not just by arrest and seizure indicators, but also by indicators of prices and availability of illegal drugs. There is no regular publication of such data in this area.⁸

following their first publication of average sentence length for different judges the most lenient judge brought his average up.)

⁷A former U.S. Attorney for the District of Columbia makes an interesting argument in this connection. Criminal justice planners have traditionally based their needs assessment on the numbers of reported crimes. Since drug distribution offenses are very rarely reported, he argues that there has been a systematic underestimation of the criminal justice system needs as distribution has become more visible and intense.

⁸Occasional bulletins are issued by the Drug Enforcement Agency (DEA) but report such wide ranges of prices that little information can be gleaned from them.

Undercover operations are an untapped potential source of price and availability data. As part of the standard reporting from such operations, officers could be required to provide summary information about the price paid, the extent of bargaining, and (more speculatively) the difficulty of obtaining the drugs. This amounts to a reconstruction and expansion of a federal system called STRIDE, which was used during the 1970s to track the price and purity of heroin seized or purchased by local agencies. The suggestion also represents an adaptation of a federal system for tracking the prices established in undercover operations by DEA for marijuana and cocaine; these data help provide guidance for undercover operatives in their negotiations.⁹

We have had some success collecting economic data on the drug trades by interviewing high-level dealers now in the federal prisons.¹⁰ It would be worth exploring whether economic indicators (prices for different quantities of drugs, where they were purchased, how difficult it was to make a connection) could be collected on a routine basis from arrestees in the District and the suburbs. An even better source of information is probably those entering treatment programs, whose motivation to cooperate is surely greater than that of the arrestees.

These economic indicators are intended to provide strategic intelligence, not tactical intelligence, to enforcement agencies. The enforcement agencies already collect tactical intelligence as part of their investigations; what is new about this proposal is that it would be routine, standardized, and published for use of policymakers rather than investigators.

⁹For an account of these latter data see P. Reuter, G. Crawford and J. Cave, *Sealing the Borders: The Effects of Increased Military Participation in Drug Interdiction*, R-3594-USDP, The RAND Corporation, 1988.

¹⁰P. Reuter and J. Haaga, *The Organization of High Level Marijuana and Cocaine Markets: An Exploratory Study*, N-2380-NIJ, The RAND Corporation, February 1989.

TREATMENT NEEDS

The major objective of gathering and analyzing treatment data is to inform difficult decisions that must soon be made about the allocation of public treatment resources among types of users. For example, does it make more sense to try to bring in reluctant young cocaine users for the first time or to provide the tenth treatment episode for an older heroin user? Are "walk-ins" being crowded out of the public treatment system by the "drag-ins"? Does it make sense to have hospital emergency rooms providing expensive detoxification that could be provided at less cost by specialized centers? Should local jurisdictions provide more residential treatment slots or better aftercare and halfway house facilities for graduates of residential programs? Is there an imbalance between residential and nonresidential programs? At the moment little of the relevant data is available, either in Washington or in other metropolitan areas.

Both the State of Maryland Alcohol and Drug Abuse Administration and the District's Alcohol and Drug Abuse Services Agency collect and analyze data on admissions to treatment programs. These reporting systems gather basic demographic data on clients, source of referral, major drug of abuse, employment status, and prior treatment history. Data on program "exits" are also collected, including length of time in the program, extent of drug use at the time of exit,¹¹ and whether the program was completed or the person was ejected.

The federal government used to mandate such data collection by the states (the CODAP system, which produced valuable data at the national level until 1982), and this requirement and funding for it have just been reintroduced in the 1988 Anti-Drug Abuse Act.

For Maryland, the system covers all certified programs, both publicly and privately funded admissions. For the District, the system covers all programs operated or contracted for by ADASA, which is said

¹¹The quality of the data on drug use at exit is highly variable. Some use self-report data only; some heroin treatment programs focus only on the extent of heroin use. Uniformity and completeness are both desirable and feasible.

to include 80 percent of all admissions to specialized drug treatment programs (the other 20 percent being admissions to privately financed programs). As of last year, the state of Virginia was trying to resurrect a similar reporting system.

The reporting systems currently refer only to state-certified programs (in Maryland) and ADASA-run or contracted programs (in the District). This leaves unanswered the question how much treatment (of what types, for what clients) is available outside the programs that report to these systems, how much they cost, and how people are paying for them. On the national level, a forthcoming report from the Institute of Medicine will collect and analyze available information for the first time. The National Institute of Alcoholism and Alcohol Abuse is collecting national data on the number of slots in licensed in-treatment facilities that are supported by private payments.

To provide similar information on a regional basis, we suggest the commissioning of a one-time regional treatment census, collecting basic information about private programs, including individual providers, nonmedical treatment programs, hospital emergency rooms, and detoxification facilities, coverage of which by current systems (and most likely, by the revived CODAP system) is sparse. Depending on the results, some regular updating of this census would be valuable.

The state reporting systems could be asked for regular computer runs similar to those that Maryland made available to RAND, breaking down by county of residence the state-level data on both admissions to and departures from licensed drug treatment programs.

People admitted to treatment programs, like arrestees, are a select population, and it is hard to infer much about drug use in the general population from intake data.¹² But the reports are valuable in their own

¹² Maryland produces county-level estimates of the numbers of "dysfunctional" drug and alcohol abusers by linking treatment admission records for the same person in different three-month periods, assuming that admissions are independent events, using a procedure similar to capture-recapture estimates of wild animal populations. We have not had an opportunity to review the methods in detail, but as we understand it, this procedure would produce substantial overestimates of the pool of drug and alcohol users from which individuals present themselves for treatment. The great uncertainty is the size of the drug- and alcohol-dependent population whose members never come into contact with the

right -- they tell us who the treatment system is reaching and how the caseload is affected by the growth of criminal justice and workplace referrals.

Useful program evaluation is expensive, and funding is probably to be sought from the federal government and foundations. The role of local governments is mainly to assign people to keep on top of the research literature and share information among themselves about which types of programs appear to work well, with which types of client. But a good database for program evaluation could be put together by trying to link records on the same person across programs, and interviewing those admitted about previous treatment episodes. It would then be possible to put together local information about treatment "careers," and the effectiveness of various types of programs in inducing periods of abstinence. It would not be necessary or even desirable to gather such data for every admission to every program on a continuous basis -- a well-designed sample with carefully supervised interviews might well produce better data than an attempt at complete coverage.

PREVENTION PROGRAMS

Especially outside the schools, prevention programs have been the neglected instrument of drug policy. This is made clear by a 1987 Montgomery County study that compared drug-related spending by all county agencies: enforcement dominated, followed by treatment, with prevention efforts receiving less than 5 percent of the total. A similar story could be told for every other local jurisdiction, but it is extremely difficult just to assemble and compare the figures on what is being spent now. A regional data bank should include indicators of what is being spent now by public agencies (and by private concerns as well, though it is even more difficult to produce those estimates). It

state-certified treatment programs. The assumption of statistical independence of the two events (treatment admissions) seems implausible. Nevertheless, these seemingly precise numbers are routinely quoted, e.g., in grant proposals, because they are the only such estimates available. Clearly there is an audience for prevalence statistics, since these very shaky numbers are so widely and often used, but we feel planners would be better served by a frank admission of our current ignorance.

will take some staff work to check with budget agencies and recast the figures in comparable terms, but the results can be relied upon to stimulate thinking.

The biggest problem in the prevention field is the paucity of information on what works. There are almost no evaluations of programs outside school settings. Workplace programs, media campaigns, and individual community programs are all going to be too small to support useful evaluation separately; moreover the barriers to effective evaluation are substantial. There is a clear need here for a regional body to serve as a clearinghouse of information, stimulating the sharing of information about materials, activities, format, and frequency of messages. Evaluations of mass-media smoking campaigns have shown the importance of coordinating efforts. At present, officials in different jurisdictions know almost nothing about what is going on or being planned in neighboring jurisdictions. A pressing information need is simply an inventory of local prevention programs (existing and in the works) and resources.

More ambitiously, we suggest consideration of a coordinated campaign in the District and the suburbs, perhaps directed at a characteristic local problem like PCP use, with local jurisdictions pooling their staff resources for planning and evaluation. Research support should also be sought from federal agencies. Most local jurisdictions have submitted numerous proposals for the Office of Substance Abuse Prevention high-risk group programs, but few of the activities proposed were large enough to have significant research or evaluation components. Given the wide variation in drug problems across metropolitan areas, and the current lack of information about what works in prevention, pooling limited local evaluation resources would make sense.

REGIONAL USER SURVEY

NIDA conducts an annual household survey that is the main source of information about the prevalence and frequency of drug use in the general population. The sample is designed to be representative of households in the entire nation, and not to be representative of any

smaller region. An entirely separate sample would be required to produce estimates valid for a state or metropolitan area. The state of Maryland is reportedly considering funding a statewide survey designed to produce county-level prevalence estimates. Given the metropolitan character of so much of the drug problem it is appropriate to consider a survey that covered the metropolitan area, including both household and nonhousehold populations.

The main advantage of a regional household survey would be comprehensive coverage. All other indicators refer to select populations: youths in school, arrestees, those who are taken to emergency rooms, those who enter treatment programs, the dead. Another advantage (shared with school surveys) is that data can be gathered on early and infrequent drug use and use of "soft drugs" -- very important for policy purposes, but not well covered by DAWN data, treatment data, or arrestee data. Lastly, a household survey can include questions on a wide variety of background characteristics and other behaviors that would be burdensome to include in the routine reporting required of the courts, hospitals, medical examiners, and treatment programs.

The major problem with a household survey is that socially disapproved behavior, such as use of illegal drugs, is typically under-reported. This in itself would not be so troublesome, if the amount and direction of bias were fairly constant over time and among subgroups of the population -- analysts could still follow trends and compare different regions and groups, even if all the prevalence estimates should be increased by, say, 25 percent. But several methodological reports suggest that data provided to drug use surveys by young blacks is less reliable than that provided by young whites, for whatever reasons. This would be a serious problem for planners in the Washington area, because the majority of the population in the largest jurisdiction (D.C.) is black. I know of no studies that have examined whether there has been a deterioration over time in the quality of self-reported drug use data, which would vitiate the comparison of data from different years, the main use to which survey data are put.

This problem of bias probably does not outweigh the advantages of a household survey. But it does suggest that any local survey should try to incorporate question wording and formats similar to the NIDA surveys so that local researchers can "piggy-back" on any nationally funded studies of data reliability and validity in different groups.

This does not mean that Washington agencies should just take over a NIDA instrument in its entirety and replicate it on a local sample. (NIDA has not used the same questionnaire administered at the same time of year in all its surveys, which could cause problems for the study of national trends.) The NIDA instruments cover virtually every drug -- the major illegal ones (heroin, cocaine, and marijuana) and a host of other illegal and legal substances (inhalants, amphetamines, hallucinogens, etc.). The interview usually takes an hour to an hour and a half, which is about the outside limit of what can be expected from respondents in the general population without severe problems of fatigue and breakoffs. If local officials and researchers wanted to add any questions to a Washington area survey, some of the questions on the current NIDA instruments would have to be dropped.

SPECIAL STUDIES

A survey efficiently designed to provide information on drug use in the general population would not produce reliable data on high-risk groups that only constitute a small portion of the population, such as IV drug users. Also, there are questions that can be studied most efficiently by methods other than the periodic household survey, such as case-control designs using hospital or treatment program records and follow-up of clients discharged from treatment programs. Because of serious health consequences of their drug use, and because of the current uncertainty about how to motivate them to change their behavior, we can identify two groups about which new information is particularly needed: pregnant women, and IV drug users.

Pregnant Women

Until recently, there was little evidence about the effects on the fetus of the use of drugs other than opiates during pregnancy. Now that cocaine use has been widespread among young women for several years, there are more and more disturbing reports of behavioral and physiological effects of maternal drug use on children. The effects of PCP use on the fetus, uniquely common in the Washington area, are likewise ominous but little known. (There are anecdotal reports of pregnant teenagers using PCP as a way to lose weight.) There is no regular reporting system for "fetal withdrawal syndrome" or the better known "fetal alcohol syndrome" (FAS). Both problems are likely to grow, and to require special efforts to reach pregnant women. It would be useful to have a reporting system from District and suburban hospitals. Hospital obstetric and maternity ward staff, and antenatal clinic and WIC (Women, Infants, Children program) staff, are by now well aware of FAS, but it is likely that training in recognition of drug use by pregnant women and its effects on the fetus would be needed. Special studies to produce a descriptive epidemiology of drug use in pregnancy in the Washington area would be especially valuable. One design would be a case-control study using data from hospital charts; another would involve following up referrals to drug abuse treatment from antenatal clinics or WIC programs.

IV Drug Users

The best current sources of data on IV drug users are the DAWN data on heroin-related deaths and emergency-room admissions and ADASA and Prince George's County treatment intake data. In its regular contribution to NIDA's Community Epidemiology Workshop, ADASA also includes data on the number of AIDS cases in the District and the proportion of those attributed to IV drug use. The AIDS crisis has brought into focus the continuing need for information about IV drug users. The RAND Washington study presented indirect evidence that heroin users in the Washington area are mainly the aging cohort of Black men born in the late 1940s and 1950s, among whom there was an epidemic

of heroin use in the late 1960s and 1970s. Anecdotal reports from local treatment professionals also suggest that there is not much new recruitment into heroin use in recent years. But "not much" new use can still represent an enormous public health problem if it is sufficient to create a conduit for the spread of AIDS infection to previously low-risk populations. And besides heroin, there are drugs increasing in popularity (cocaine and PCP, to a lesser extent amphetamines) that are also injected by some users. IV drug users as a group are of concern, and some special education programs are starting to be aimed at them. It would be useful to have in place a system for monitoring changes in behavior that these programs are intended to produce. IV drug users are rare enough in the household population to make it not worth trying to follow them through surveys. But heroin users come into frequent contact with public treatment programs, emergency rooms, and law enforcement agencies. A special local study of needle-sharing and other high-risk behavior by IV drug users might be possible relying on short intake interviews.

CONCLUSIONS

For the purpose of designing "demand reduction" programs, the greatest information needs are probably those that could be met by (1) a user survey, (2) coordinated school surveys, (3) regular collection of data from treatment programs, (4) a treatment census, and (5) a regional prevention program clearinghouse. (All are discussed in preceding sections.) Of these, only sporadic school surveys and the treatment program reporting in Maryland and the District now exist.

Health planners in this area are likely to need more and better information to deal with problems arising out of drug use -- such as IV drug use and use of cocaine and PCP (and alcohol and tobacco) by pregnant women. We have argued that these call for special studies, but these may then lead to a recommendation for some continuous data collection for monitoring the problems.

For law enforcement strategies, more data are needed in some jurisdictions on post-arrest events to measure the degree to which arrest statistics measure real and sustained "crack-downs." In other

jurisdictions all that is required is better and earlier reporting from existing data systems. Data are also needed on prices and availability of drugs, which in theory should be affected by supply reduction. The District has a program for urinalysis of arrestees, that provides a measure of (among other things) the utilization of drugs; the surrounding jurisdictions could consider adding such programs, at least on a sample basis. No jurisdiction reports systematic collection, let alone analysis, of data on drug prices, expenditures, and methods of purchase; we believe that a number of potential sources of such information, described above, should be explored.

For evaluation both of targeted prevention programs and the overall effort, policymakers should consider regularly repeated core questions on a household survey, as well as continuing and the current DAWN reports. The most useful single source of drug-related data in this area at present is the semi-annual submission from ADASA to NIDA's Community Epidemiology Workshop. A Regional Drug Report might adopt the same schedule, expand the list of topics to include information from the other current and new sources discussed above, and expand coverage to the whole metropolitan area.

