Drug Use in the Detroit Metropolitan Area

Problems, Programs, and Policy Options

John G. Haaga, Richard Scott, Jennifer Hawes-Dawson
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John G. Haaga, Richard Scott, Jennifer Hawes-Dawson
with Elizabeth A. McGlynn, Katheryn Russell

Supported by the Skillman Foundation
PREFACE

This study analyzed recent trends in drug use and drug-related problems in the Detroit metropolitan area (Wayne, Oakland, and Macomb counties), assessed the programs currently in place to deal with drug use and its problems, and proposed priorities for future efforts. The major emphasis was on drug abuse prevention and treatment, though drug law enforcement was also studied. The research effort involved analyzing existing data; interviewing local and state officials, treatment providers, and community leaders; and visiting selected program sites. The scope of the study did not allow collection of new primary data or detailed evaluation of individual programs.

This research was funded by a grant from the Skillman Foundation to RAND and a subcontract from RAND to the Addictions Research Institute of Wayne State University. Additional funding came from RAND's Drug Policy Research Center, which is supported by the Ford and Weingart foundations. The findings should interest officials of public agencies responsible for drug programs, managers of prevention and treatment programs, and leaders of community groups active in drug prevention—both in Detroit and other metropolitan areas.
SUMMARY

OVERVIEW

National concern about drug problems was ignited in the latter half of the 1980s by a sudden and dramatic increase in cocaine use. Rock cocaine, or "crack"—a new, cheap, smokable form of the drug—swept through the nation's major metropolitan areas, quickly becoming the drug of choice among inner-city youth. The Detroit metropolitan area was no exception. Between 1985 and 1987, the number of hospital emergency room episodes mentioning the presence of cocaine increased nearly sixfold (see Fig. S.1). Arrests for narcotics violations in the metropolitan area grew from 9000 in 1986 to nearly 16,000 in 1988. In the last several years, the drug epidemic appears to have diminished somewhat, both nationally and in the Detroit metropolitan area. However, levels of drug use and drug trafficking still remain well above their 1985 levels, and substance abuse is continuing to create severe problems for individuals and communities alike.

![Emergency Room Episodes Mentioning Cocaine](image-url)

*Fig. S.1—Emergency Room Episodes Mentioning Cocaine (Detroit Metropolitan Area: 1983–1989)*
Because local governments and community organizations are the entities that have to deal most directly with these problems, it makes sense to analyze the situation at the local or metropolitan level. This report documents a study of the three-county Detroit metropolitan area. The study's purpose was to analyze recent trends in drug use and its consequences in the Detroit metropolitan area, assess the range of existing programs designed to deal with the problems, and suggest policy options and future priorities. This research relied on existing data; interviews with public officials, treatment providers, and community leaders; and site visits to selected programs.

SUBSTANCE ABUSE IN THE DETROIT METROPOLITAN AREA

The Drug Abuse Warning Network (DAWN) is a national database containing information on hospital emergency room (ER) episodes involving drug abuse and on drug-related deaths reported by county medical examiners. The ER data show how quickly crack took hold in the Detroit metropolitan area. In 1983, only 3 percent of the reports that noted the route of administration for cocaine indicated that it had been ingested by smoking. But by 1989, mentions of cocaine had quadrupled, and the proportion of patients who ingested the drug by smoking had soared to 76 percent.

As for ER mentions of heroin, they have declined substantially in the Detroit metropolitan area since the early 1980s, in contrast to a rising national trend. This apparent decline of heroin use in the Detroit metropolitan area may be illusory or temporary, however; there have been reports of high-purity, inexpensive heroin reaching the streets of eastern and midwestern cities. And there is great concern connected with the fact that 95 percent of the heroin ER cases have reported injection as the route of administration. Intravenous drug use has been identified as the likely route of transmission in 22 percent of the state's Acquired Immunodeficiency Syndrome (AIDS) cases.

In the early 1980s, methods of drug distribution changed in the city of Detroit as heroin sales moved outdoors and more and more adolescents were recruited for "crews" of sellers, touts, and guards, loosely organized into larger gangs. The arrival of crack seems to have accelerated this trend toward more visible and competitive street dealing.

Detroit has one of the highest homicide rates of all American cities, and in 1987, half the homicide victims in Wayne County tested positive for cocaine. While the homicide rate has remained fairly stable in recent years, an ominous trend has emerged—more teenagers are
involved, both as killers and victims. The legacy for the 1990s is that large numbers of young men are well armed and accustomed to resolving even petty disputes with extreme violence. This violence can take on a momentum of its own. In Detroit, as in other cities throughout the nation, there has been no decline in homicide rates comparable to recent declines in indicators of drug use. Many analysts fear that a declining overall drug market could lead to increasingly violent competition among the large numbers of people deriving their incomes from drug sales.

Although the current wave of illegal drug use and its attendant violence did not create Detroit’s economic decline, it will certainly hinder the efforts of residents, especially those in poorer neighborhoods, to overcome the effects of an adverse economy. In addition, the cocaine epidemic of the 1980s has left a cohort of heavy users who will require a good deal of help from the medical, drug treatment, and social service systems for many years to come.

**DRUG PREVENTION IN THE SCHOOLS**

To date, the most effective prevention programs appear to be those based on the social influence model. This model includes (1) resistance training to help students develop skills to identify and resist situational pressures (e.g., peer pressure) to use drugs and (2) activities designed to correct distorted beliefs that students often have about the prevalence and acceptability of drug use among their peers.

The health education programs in Detroit area schools include the key elements of the social influence model, and substance abuse education modules are used at all grade levels from kindergarten through the seventh or eighth grade, depending on the program. Nonetheless, there is some concern as to whether children are actually receiving the amount of prevention education called for in the curriculum. Substance abuse education is also provided in health courses at the secondary level. However, since these courses are offered as electives, it is likely that relatively few high school students “get the message.”

In addition to the health education programs, Michigan is implementing a promising new approach that has been adopted by a number of other school districts throughout the country—Student Assistance Programs (SAPs). Specially trained teachers and administrators from each school make up the SAP teams, and efforts to reduce drug use are tailored to meet the needs of individual schools.

SAPs may be designed either as primary prevention efforts aimed at the elementary level or as secondary prevention programs aimed at
older adolescents who have begun to use alcohol or drugs. Michigan has elected to emphasize primary prevention efforts, at least for the time being, and has mandated the implementation of SAPs in elementary schools. There are very few SAPs in junior and senior high schools, especially in the inner city. Given the considerable harm that can come from progression to harder and more frequent drug use, the evidence that primary prevention programs do not affect use among those who have already begun regular tobacco or drug use, and the lack of affordable formal treatment for young drug users, higher priority should be given to developing new interventions to help young people in the early stage of drug use to quit. This is an area in which private funding may be needed as a catalyst, since the major emphasis in the public sector is elsewhere.

PREVENTION EFFORTS IN THE COMMUNITY

Federal aid for drug and alcohol prevention and treatment programs is channeled through Michigan's Office of Substance Abuse Services (OSAS) in the Department of Public Health. OSAS in turn contracts with eighteen regional coordinating agencies (CAs) that distribute funds for community prevention and treatment efforts.

There is a good deal of prevention activity in the Detroit metropolitan area, much of it organized by churches and community groups without significant government funding. In addition, several nonprofit organizations provide technical assistance, sponsor small grant programs, and encourage the formation of networks among prevention groups. Most of these community prevention activities rely heavily on volunteers. Many are fairly small in scale but incorporate a wide variety of efforts directed partly against crime and violence and partly against drug use.

It is not possible to measure the specific effects of community prevention efforts, due to the inherent difficulty of conducting a controlled study of the decentralized activities that generally characterize such efforts. Organizations and neighborhoods mobilize in many different ways against drug problems in their various forms. It is often difficult to specify how success should be defined or measured, and the benefits of such efforts are generally diffuse and long term. Diversity and local experimentation should be encouraged, simply because there is no single proven model for successfully preventing substance abuse in the community. Given the absence of a formula for community prevention, the important criteria for funders should be whether groups have (1) evidence of local support and involvement and (2) a
record of working successfully on social issues in the target neighborhoods.

The CA staff and other prevention professionals are probably in the best position to identify groups or agencies with effective programs, to point to those that can benefit most from financial and technical assistance, and to stimulate proposals and monitor progress. Most of the prevention groups are not experienced in dealing with large-scale funders, so the current small grant programs are an important and useful vehicle for providing assistance.

TREATMENT PROGRAMS

Currently, just over 270 programs are licensed by OSAS to provide drug abuse treatment in the Detroit metropolitan area. The number of admissions funded by the CAs has been fairly constant, around 27,000 in recent years. Alcohol is still the primary drug of abuse, accounting for the largest number of admissions (46 percent in 1989). However, between 1986 and 1989, the percentage of cases in which cocaine was named as the primary drug rose from 12 to 33 percent. Since the total number of admissions was constant during those years, it is possible that the increasing number of persons treated for cocaine dependency "crowded out" from public programs persons who needed treatment for alcohol or heroin dependence.

There is a need for more subsidized treatment in the Detroit metropolitan area. Programs funded by the city's Bureau of Substance Abuse Services are all operating at full capacity, and many people seeking treatment are turned away. However, the first priority of the public system in the next few years should be to improve the effectiveness of existing services and to expand services to special populations, rather than to simply expand uniformly. Although the growth in federal grants has been helpful, the city and the state face fiscal crises among the worst in the nation, a fact that underscores the need to improve the effectiveness of existing resources and to expand treatment services selectively.

In Detroit, as in other large metropolitan areas, there is a critical shortage of appropriate treatment facilities and services for women. For example, child care is an important ancillary service that is seldom available in the treatment programs.1 There is also a need for

1Since 1988, the federal block grants have included a requirement that states set aside at least 10 percent of their total award to provide treatment and prevention services for women. OSAS and the Detroit area CAs are planning to implement that
intermediate treatment options. One of the weakest links in the continuum of care is the scarcity of day/night treatment programs and halfway houses, particularly for women and young people. The CAs should promote the development of such programs as a cost-effective alternative to intensive residential treatment when outpatient counseling alone is insufficient.

It is also important to maintain the network of treatment services for intravenous drug users. Methadone therapy should be provided as an option for addicts who cannot succeed in other types of treatment. And finally, there is a need for better coordination between social service agencies and the drug treatment system. Agency staff should be trained in client assessment so that they can better match the needs of the client and the treatment services to which clients are referred. Current efforts by one of the CAs\(^2\) in the Detroit metropolitan area to improve case management should be evaluated and, if successful, replicated elsewhere in the area.

**LAW ENFORCEMENT**

The current drug problems in the Detroit metropolitan area are not due to a failure on the part of the criminal justice system to "get tough" in enforcing drug laws. On the contrary, enforcement efforts by police, prosecutors, and judges increased steadily throughout the latter half of the 1980s as cocaine markets spread through the area and drug problems worsened. Michigan has mandatory minimum sentencing laws for drug offenses that are among the most severe in the nation; three-quarters of the inmates in the Wayne County jail have been incarcerated for drug offenses.

Two strategies that appear to be effective in dealing with local drug problems are already in place in the Detroit metropolitan area and should be continued and expanded: community policing and retail enforcement. Community policing involves the visible and continuous presence of police in a neighborhood, rather than patrol cars suddenly appearing on the scene in response to a crime report. The Detroit Police Department maintains a community presence through decentralized ministations and through its Crime Prevention Division, which works with neighborhood anticrime groups. Retail enforcement involves ongoing and specifically targeted crackdowns on street sales and crack houses. Initiatives against street sales should be di-

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\(^1\)requirement by developing four new programs that will provide services specifically to women.

\(^2\)Southeast Michigan Substance Abuse Services (SEMSAS).
rected against buyers as well as sellers, thereby spreading the policing network outward to include those who come into a neighborhood from other areas. The Detroit Police have tried a number of innovative sanctions for punishing drug buyers, including confiscating cars used in drive-up purchases.\textsuperscript{3}

Local law enforcement agencies should continue to focus on neighborhoods where self-help efforts are under way and should help organize such efforts in other neighborhoods damaged by drug selling and its attendant violence. Community policing and retail enforcement may do more to reclaim neighborhoods (and ultimately to help the Detroit metropolitan area cope with its drug problems) than more ambitious efforts to break up drug organizations or capture high-level dealers.

**DRUG POLICY IN THE 1990s**

Greater efforts should be made to address problems on a metropolitan as well as a local basis. Drug problems often overrun city and county boundaries, and increased cooperation among prevention, treatment, governmental, and law enforcement entities would help to establish a more united front.

A larger share of local discretionary resources should be devoted to prevention efforts, and the increase in funding should be accompanied by an increased effort to evaluate programs and to foster activities that look sustainable and effective.

Attention should be focused on the larger problems of substance abuse, rather than on single drugs. The cocaine crisis helped to motivate public concern, but the danger now is that improvements in indicators of cocaine use may be seen in nonurban areas as evidence that the problem has been solved or is not “our” problem anyway. Public and private organizations dealing with substance abuse can help maintain its prominence on the public health agenda by emphasizing the need for broad-spectrum efforts, rather than by defining the problem in terms of a currently popular drug.

The changes proposed in this study must be considered in a context of overall retrenchment in government services. Although federal funding for drug programs has grown in recent years, this funding will most likely be reduced, along with discretionary spending on domestic programs generally.

\textsuperscript{3}Informal estimates by department officials suggest that the majority of people arrested for purchasing drugs in Detroit while in their vehicles have come from outside the city.
At the state level, Michigan faces a projected 1991 deficit larger than that of any other state but one. At the metropolitan level, Detroit has had to deal with the cocaine epidemic at a very difficult time, following years of economic stagnation, depopulation, declining tax revenues, and cutbacks in the police force. The Detroit metropolitan area has fared less well than many other areas in obtaining funds under competitive grant programs. Given the fiscal crises at the state and local levels, it is important that more effort be focused on grant proposals.

Finally, public officials and community leaders must understand the long-term nature of the many drug-related problems facing the Detroit metropolitan area. Unrealistic expectations about quick and complete solutions could lead to frustration and the abandonment of many promising programs. To a large extent, the success of prevention and treatment efforts can only be measured by monitoring their effects through the next decade and beyond.
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ACRONYMS AND ABBREVIATIONS

AA  Alcoholics Anonymous
AAP  American Academy of Pediatrics
AIDS  Acquired Immunodeficiency Syndrome
ALERT  Adolescent Learning Experiences in Resistance Training
BABES  Beginning Alcohol and Addiction Basic Education Studies
CA  coordinating agency
CDC  Centers for Disease Control
DARE  Drug Abuse Resistance Education
DAWN  Drug Abuse Warning Network
DEA  Drug Enforcement Agency
DHHS  Department of Health and Human Services
DUF  Drug Use Forecasting
EAP  Employee Assistance Program
ER  emergency room
FBI  Federal Bureau of Investigation
FSA  Family Service America
GAO  General Accounting Office
GIG  Governor’s Incentive Grant
GM  General Motors
HIV  Human Immunodeficiency Virus
IOM  Institute of Medicine
MADD  Mothers Against Drunk Driving
ME  medical examiner
NIAAA  National Institute on Alcohol Abuse and Alcoholism
NIDA  National Institute on Drug Abuse
NIJ  National Institute of Justice
ONDCP  Office of National Drug Control Policy
OSAP  Office of Substance Abuse Prevention
OSAS  Office of Substance Abuse Services
PCP  phencyclidine
PREVCO  Prevention Coalition of Southeast Michigan
SAAM  Substance Abuse Awareness Month
SADD  Students Against Drunk Driving
SAI  Special Alternative to Incarceration
SAP  Student Assistance Program
SEMSAS  Southeast Michigan Substance Abuse Services
TASC  Treatment Alternatives to Street Crime
THTM  Teenage Health Teaching Modules
1. INTRODUCTION

In 1985 and 1986, a new form of cocaine appeared in the Detroit metropolitan area and most other large metropolitan areas in the United States. Known as “crack,” this cheap, smokable, powerful stimulant led to a sudden increase in cocaine use in inner cities, suburbs, and even many rural areas. The outcome was what one historian called a “wave of fear that resulted in enormous media and public attention to the drug problem” (Musto, 1987, p. 274).

The new popularity of cocaine added greatly to the already existing burden on the health, social service, and criminal justice systems. In the Detroit metropolitan area, as elsewhere, a large illegal economy founded on the cocaine trade grew rapidly. Enforcement of the drug laws produced growing numbers of arrests, adding to the already overcrowded jails and prisons and the workload of probation agencies. Cocaine users appeared in increasing numbers in hospital emergency rooms (ERs) and on waiting lists for treatment programs. In addition to the direct damage to users and their relatives, there was significant collateral damage caused by drug trading and the violence surrounding it, compounding the problems of poor neighborhoods and degrading the sense of public order and trust for everyone.

The response of both public and private sectors to the crisis brought on by the use of cocaine in the late 1980s was one of improvisation. Partly because of decades of neglect in basic drug-related research and program evaluation, there were important gaps in the available information on the range of measures appropriate for controlling drug problems.

Now, in the early 1990s, the air of crisis has diminished somewhat. Indicators such as hospital ER reports of cocaine use have declined slightly, as have the numbers of persons admitting to cocaine use in nationwide surveys (though all cocaine indicators remain well above their precrisis levels). However, even though these drug issues may have lost some of their political salience, the problems created by drug use and drug trafficking are lasting ones. The recent upsurge in the popularity of cocaine added to, rather than replaced, the continuing health and social problems caused by heroin use. The Detroit metropolitan area, like other large metropolitan areas, now has a legacy of thousands of residents dependent on cocaine and heroin. And the abuse of alcohol and drugs other than cocaine and heroin
continues to affect a much larger population, not at all confined to the big cities where drug problems have received the most publicity.

At this point, past the initial stages of the cocaine crisis, institutions in both the public and private sectors have begun new programs or adapted existing ones to cope with drug use and its ramifications. It is a good time to take stock of what has been done, evaluate the long-term problems, and set priorities for a sustained response. Because the agencies that have had to deal most directly with substance abuse problems are the local governments and civic groups, these are the levels of the Detroit metropolitan area governments that are emphasized in this study.

RESEARCH GOALS

The specific goals of our research were to (1) analyze recent trends in drug use and the consequences of drug use in the Detroit metropolitan area, (2) assess the programs now in place to deal with drug use problems, and (3) propose priorities for new drug use prevention and treatment efforts.

Our research dealt with the full range of responses to drug problems; we looked at both public- and private-sector efforts. Our major emphasis was on prevention and treatment (often called demand reduction) efforts. Law enforcement was also considered, partly because it has accounted for most of the resources devoted to controlling drug use throughout the nation, and partly because law enforcement can reinforce demand reduction efforts.

METHODS AND FOCUS

Our research relied on existing data; interviews with local and state officials, community leaders, and treatment providers; and site visits to selected programs. Data sources included the national Drug Abuse Warning Network (DAWN), which collects reports of drug use detected in patients at hospital ERs and in autopsies; the Drug Use Forecasting (DUF) system, which collects data from urine tests of samples of arrestees; Michigan's Department of Public Health, which provided cause-of-death statistics; and Michigan's Office of Substance Abuse Services (OSAS), which provided budget and treatment admission data. Special tabulations of DAWN data were prepared for this report. The collection of new primary data and the detailed evaluation of individual programs were beyond the scope of our study.
The project covered the three-county Detroit metropolitan area. These counties—Wayne, Oakland, and Macomb—include the jurisdictions of four of the eighteen coordinating agencies (CAs) that receive funds for public drug and alcohol prevention programs from Michigan's OSAS. Figure 1 shows the Detroit metropolitan area and lists the regions covered by the four CAs.

The advantage of treating the Detroit metropolitan area as a whole is that it forms a natural “market area” for the selling of illegal drugs and for many types of prevention programs. Treatment programs also frequently serve clients from several jurisdictions. Though drug problems present different faces in different parts of the Detroit metropolitan area, there are enough similarities and potential gains from coordinating policies within that area to make the larger scope better than focusing solely on the city or on one county.

This report deals specifically with problems of illegal drug use, rather than with problems associated with the abuse of other addictive substances such as tobacco and alcohol that are legal for most users. The legal classification of an addictive substance matters in that it governs whether law enforcement agencies are involved in controlling that substance and affects not only the degree of neighborhood disorder and violence caused by sales, but also the priorities for prevention efforts aimed at different age groups, the content of prevention messages, and many other factors. Nevertheless, because this report emphasizes treatment and prevention, the programs for which typically deal with the abuse of both legal and illegal substances, the distinction between the two forms of substance abuse is not always sharp.

REPORT OUTLINE

Section 2 of this report highlights some of the trends in drug use and the consequences of drug use in the Detroit metropolitan area. The next two sections then deal with prevention programs: Sec. 3 discusses those conducted primarily in the schools, and Sec. 4 describes those conducted outside the schools (i.e., in the community at large). In both of these sections, we describe the range of existing programs, assess what our review found to be the main policy concerns, and recommend ways to address the most pressing needs.

Section 5 discusses the public and private treatment systems; Sec. 6 describes trends in drug law enforcement, particularly in relation to community self-help efforts. The final section, 7, returns to some themes that cut across the different program areas: the need to de-
Fig. 1—Detroit Metropolitan Area
vote more resources to prevention, to build coalitions across geographic and administrative boundaries, and to experiment and give current efforts a realistic amount of time to succeed. The Appendix provides details on our sources of drug use data.
2. DRUG USE AND RELATED PROBLEMS

This section describes drug use trends and drug-related problems in the Detroit metropolitan area. We first discuss the increase in cocaine use that began in the mid-1980s and has motivated nationwide concern with drug problems since that time, including the problem of cocaine's effects on newborns. We then discuss the continuing problem of heroin use and the growing problem of Human Immunodeficiency Virus (HIV) transmission through intravenous drug use. Next, we widen the perspective by considering other addictive substances, after which we turn from indicators of substance abuse to the neighborhood violence and desolation that have accompanied drug trafficking. The concluding subsection gives our assessment of the current drug use problems and what their resolution will require in terms of public commitment in the years ahead.

COCAINE

The indicators available for tracking trends in the use of illegal drugs in the Detroit metropolitan area are limited. The best sources are (1) the Drug Abuse Warning Network (DAWN) data collected from hospital emergency rooms (ERs) and medical examiners (MEs) by the National Institute on Drug Abuse and (2) data from the Drug Use Forecasting (DUF) program sponsored by the National Institute of Justice. Both systems reflect drug use in the population as a whole only imperfectly, but they do present broadly consistent pictures of recent trends.

Figure 2 (top portion) shows the number of “mentions” of cocaine reported to the DAWN system by hospital ERs in the Detroit metropolitan area for the years 1983–1989.1 As can be seen, cocaine mentions rose gradually in the early 1980s, rose sharply in 1986 and 1987 (coinciding with the introduction of crack into the area), and have since declined from the 1987 peak. This pattern of cocaine mentions

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1 Staff members of participating hospitals compile monthly reports for DAWN, examining the records of all ER visits to ascertain the number of times drug use was detected by laboratory tests or reported orally. Each drug listed in the records for a visit counts as a mention. (See the Appendix for a more complete description of the DAWN system.)
Cocaine-related ER mentions, Detroit metropolitan area

Index of cocaine-related ER mentions, total DAWN system

SOURCE: NIDA, Series G (RAND calculations).

Fig. 2—Cocaine-Related Emergency Room Mentions Reported to DAWN, 1983–1989
in the Detroit metropolitan area closely parallels the pattern seen nationwide in metropolitan ERs (Fig. 2, bottom portion). The reports from MEs in the Detroit metropolitan area for cocaine detected in corpses show a similar trend: a sharp rise in 1986 and 1987, with a subsequent leveling off and slight decline from the 1987 peak (NIDA, Series G, 1988 and 1989). The nationwide ME data have not yet shown a decrease in the number of cocaine-related deaths comparable to that seen in Detroit, Washington DC, and a few other metropolitan areas.

Of the cocaine ER mentions for which the route of administration was known in 1983, only 3 percent were attributed to smoking. At that time, only complicated and dangerous methods for extracting smokable free-base cocaine were widely known. By 1989, the total number of cocaine ER mentions per year had quadrupled, and the proportion of cocaine mentions for which the route was smoking had risen to 76 percent. This change illustrates how quickly crack took hold in the Detroit metropolitan area.

In 1989, approximately 67 percent of the people involved in cocaine ER mentions in the Detroit metropolitan area were males; 76 percent were black. The percentage of cocaine mentions involving blacks had grown since 1985 in the Detroit metropolitan area, as in the rest of the nation, but substantial numbers of whites were also using cocaine in the late 1980s (see Table 1).

Though crack is reported to be popular among teenagers, this trend was not seen in the DAWN ER data for the Detroit metropolitan area. Less than 2 percent of the cocaine mentions in 1989 involved persons under age 18. The age distribution of patients shifted between 1985 and 1989, with the proportion of users aged 30 or over growing from 49 to 56 percent. (A similar but less pronounced shift can be seen in the national data shown in Table 1.) This shift, combined with evidence of a recent decline in the total number of cocaine mentions, suggests that in the metropolitan area as a whole, fewer young people are starting cocaine use than were doing so in the late 1980s (see Table 1).

The age distribution of DAWN ER reports need not be representative of the age distribution of all cocaine users in the area. Hospital ERs may admit a disproportionate number of older users, since they are more likely than neophytes to suffer from the health consequences of long periods of use. But we see no plausible reason for considering the change in the age distribution between 1985 and 1989 to be an artifact of changing patterns of ER use or changes in the likelihood of detection of cocaine use by young people. The publicity about crack use by adolescents should, if anything, have made ER staffs more alert to the possibility that young patients had
Table 1
Cocaine Mentions in Emergency Room Admissions by Age, Sex, and Race for Detroit Metropolitan Area and Nationwide, 1985 and 1989

<table>
<thead>
<tr>
<th></th>
<th>Detroit Metropolitan Area</th>
<th>Nationwide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>2.2</td>
<td>1.4</td>
</tr>
<tr>
<td>18–29</td>
<td>48.6</td>
<td>42.6</td>
</tr>
<tr>
<td>30 and over</td>
<td>49.1</td>
<td>56.0</td>
</tr>
<tr>
<td>Sex (in percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68.3</td>
<td>67.8</td>
</tr>
<tr>
<td>Female</td>
<td>31.7</td>
<td>31.9</td>
</tr>
<tr>
<td>Race (in percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>70.1</td>
<td>78.7</td>
</tr>
<tr>
<td>White</td>
<td>29.8</td>
<td>20.7</td>
</tr>
<tr>
<td>Other</td>
<td>0.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Total number of mentions(^a)</td>
<td>1083</td>
<td>4091</td>
</tr>
</tbody>
</table>

SOURCE: NIDA, Series I.

\(^a\)These Detroit metropolitan area and nationwide data are from separate samples of reporting hospitals. The ratio of the Detroit area and nationwide numbers cannot be used as an estimate of the Detroit metropolitan area's share of national cocaine problems.

Cocaine use is common throughout the Detroit metropolitan area, but we have only imperfect indicators for estimating where it is most prevalent. The DAWN data tapes contain reporting facility and patient zip codes, which we tabulated for the years 1987–1989. By either measure (facility or patient zip code), the city of Detroit, with just over 25 percent of the metropolitan area's population, accounts for about 75 percent of the cocaine-related ER visits in the area.\(^3\)

This disproportionate percentage may be caused by city residents having a greater propensity to use ERs as their primary-care facilities, but even when the number of cocaine mentions is compared to the total number of ER visits for any reason, the resulting ratio for the city is almost four times the ratio for the surrounding areas.\(^4\) As Fig. 3 shows, the zip codes most heavily represented in the cocaine patient population lie in the central portion of the city of Detroit. The

\(^3\)The 1990 Census recorded a population for the city of Detroit of 1,027,974, which is 26.3 percent of the total for the three counties in the Detroit metropolitan area.

\(^4\)Cocaine use was mentioned in records for 7.0 of every 1000 ER visits in the city of Detroit, compared to 1.8 per 1000 in the rest of the metropolitan area.
- Zip code boundaries do not conform exactly to political boundaries
- Zip code areas were placed in the county containing their geographic center

SOURCE: NIDA data (RAND tabulations).

Fig. 3—Distribution of Patients' Home Zip Codes for Cocaine-Related Emergency Room Episodes, 1989
rest of the city (along with Dearborn, Pontiac, and Mount Clemens) also had many of its residents recorded as cocaine users in ERs throughout the metropolitan area.

The DUF system collects interview and urinalysis data from samples of adult arrestees in the central booking facilities of 26 large cities, including Detroit. The DUF program began in Detroit in 1988, so it cannot be used to investigate the first few years of increased cocaine use. There was a decline in the proportion of arrestees testing positive for cocaine in the last quarter of 1989 (see Fig. 4). Before that, the proportion hovered around 50 percent. Again, one or two data points are not enough evidence for concluding that the growth phase of the cocaine epidemic has clearly passed, but the DUF data do tend to give this impression, thus corroborating the DAWN indicators. The DUF data, of course, pertain only to arrestees, but studies sponsored by the National Institute of Justice suggest that drug use pat-

![Graph](image)

**NOTE:** Shaded area represents imputed values for missing observations.

**SOURCE:** NJI, 1990.

**Fig. 4—Drugs Detected in Urine of Adult Arrestee Sample, City of Detroit, 1988–1989**
terns and trends in this group are useful as forecasts for the general population (Harrell and Cook, 1990).\footnote{The recent decline in cocaine indicators for the city of Detroit is sustained, DAWN will have provided the leading indicators. Despite the forecasting in DUF's name, the DUF data appear to be following the DAWN data in the downward trend.}

One particular concern with relation to cocaine use is crack's popularity among young women, since cocaine has great potential for causing prenatal harm to their children. The proportion of women among those recorded as cocaine users in ERs has been no higher than the proportion of women among those recorded as users of heroin and other opiates. However, the absolute numbers of women using cocaine are considerably larger than those of woman using heroin, so the cocaine-use threat to infant health is much greater. Though there is still uncertainty about the effects of cocaine on the fetus, cocaine does appear to cause a greater incidence of premature abruptions and deliveries, fetal growth retardation, and neonatal seizures. Maternal cocaine use has also been associated with attention deficit disorder and other behavioral problems of infants. The consequences of maternal cocaine use for infant health could thus be both severe and long lasting.\footnote{The American Academy of Pediatrics Committee on Substance Abuse (1990) provides a brief review of recent research on the consequences of maternal use of cocaine and other drugs. As the committee points out, most of the studies of cocaine's effects on women and their infants have used "recognized substance-abusing populations," so little is known about the effects of low or infrequent doses of cocaine. The committee cautions that the "long-term effects on learning and school performance of children exposed to illicit drugs in utero have not been well documented" (p. 640). Until such issues are clearer, it is difficult to forecast the problems with which the health, child protection, and educational systems will have to deal, though they are likely to be serious.}

Pediatricians at Hutzel Hospital, one of the largest obstetric facilities in the metropolitan area, have pioneered the testing of meconium (the fecal discharge of a newborn) to detect maternal drug use during pregnancy (Ostrea et al., 1990). Of a sample of 1000 infants born at Hutzel, 42 percent showed traces of at least one of the drugs tested for (cocaine, heroin or other opiates, cannabis). Cocaine was found in 21 percent, opiates in 24 percent, and cannabis in 12 percent. All told, 38 percent had been exposed to either cocaine or opiates.\footnote{These figures are much higher than the 11 percent of mothers in the sample who admitted to drug use in their medical histories.} The women and infants in whom drugs were detected in the Hutzel study had a range of outcomes, from uncomplicated pregnancies and deliveries to fairly severe problems.\footnote{Estimates of fetal exposure to drugs have to be distinguished from estimates of the prevalence of health and behavioral problems caused by such exposure. Not all drug-}
branes, premature abruptions, low-birth-weight babies, and newborns with small head circumferences were all more common for cocaine users than for users of other drugs or nonusers.

Hutzel's population cannot be taken as representative of the city of Detroit, still less of the whole metropolitan area. The program is unique and, although it receives referrals from a wide area, its clients are heavily drawn from poor neighborhoods of the inner city. Moreover, Hutzel is the delivery hospital for most of the women who participate in a program for pregnant drug users at the Eleanor Hutzel Recovery Center (across the street from the hospital). Still, such high rates of drug exposure among babies born at one of the largest hospitals in the city of Detroit do serve to indicate the size of the potential problem.

Admissions to the neonatal intensive care unit at Hutzel Hospital rose by over 50 percent in three years, from 691 in 1987 to 1063 in 1989. There is no way to determine how much of the increase is due to fetal exposure to alcohol and drugs, but hospital staff and public health officials reported to us that the cocaine epidemic has seriously worsened the infant health situation in the Detroit metropolitan area.

HEROIN

ER mentions of heroin reported to the DAWN system have substantially declined over the 1980s (see Fig. 5). The number of positive findings for heroin in autopsies performed by MEs in the Detroit metropolitan area rose during the first half of the 1980s, perhaps because many of those who began using heroin during the 1960s and 1970s died from the compounded effects of years of addiction. Since 1987, however, the number of heroin mentions in reports from MEs in the Detroit metropolitan area has also declined (NIDA, Series G, 1988–1990). In both cases (ER and ME data), the declines apparent in recent data from the Detroit metropolitan area are steeper than those seen nationwide for metropolitan areas covered by the DAWN system (see Fig. 5). ER admissions and autopsies reflect, in varying proportions, the cumulative results of long drug-using careers, as well as the harm caused to some new users. Increases or declines in these figures partly reflect the consequences of heavy use by experienced users.

Exposed infants show severe problems, and severe problems are found in infants who have not been exposed to drugs, though at lower rates.
Heroin-related ER mentions, Detroit metropolitan area

Index of heroin-related ER mentions, total DAWN system

SOURCE: NIDA, Series G (RAND calculations).

Fig. 5—Heroin-Related Emergency Room Mentions Reported to DAWN, 1983–1989
DUF urine testing of arrestees also provides data on trends in heroin use. As Fig. 4 shows, the proportion of adult male arrestees testing positive for heroin and other opiates has held steady at about 10 percent since 1988.

Over 80 percent of the Detroit metropolitan area heroin mentions reported to the DAWN system came from ERs located in the city of Detroit, which has only slightly more than 25 percent of the metropolitan area’s population. The average age of heroin ER patients has continued to rise in recent years. As Table 2 shows, 85 percent of these patients were age 30 and over in 1989, up from 70 percent only four years earlier. Both the aging and the decline in numbers are consistent with the epidemiologic picture of heroin use as worst among the cohort of men born in the 1950s who, for the most part, became involved with heroin in the 1960s and 1970s.

The apparent decline of the heroin threat may be illusory, however. There have been several reports of inexpensive heroin of high purity

![Table 2](image)

**Heroin Mentions in Emergency Room Admissions by Age, Sex, and Race for Detroit Metropolitan Area and Nationwide, 1985 and 1989**

<table>
<thead>
<tr>
<th>Age (in percent)</th>
<th>Detroit Metropolitan Area</th>
<th>Nationwide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>18–29</td>
<td>30.3</td>
<td>15.0</td>
</tr>
<tr>
<td>30 and over</td>
<td>69.6</td>
<td>84.9</td>
</tr>
<tr>
<td>Sex (in percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>67.1</td>
<td>67.7</td>
</tr>
<tr>
<td>Female</td>
<td>32.9</td>
<td>31.8</td>
</tr>
<tr>
<td>Race (in percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>77.5</td>
<td>67</td>
</tr>
<tr>
<td>White</td>
<td>22.0</td>
<td>32</td>
</tr>
<tr>
<td>Other</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Total number of mentions (^a)</td>
<td>3061</td>
<td>1184</td>
</tr>
</tbody>
</table>

**SOURCE:** NIDA, Series I.

\(^a\)These Detroit metropolitan area and nationwide data are from separate samples of reporting hospitals. The ratio of the Detroit area and nationwide numbers cannot be used as an estimate of the Detroit metropolitan area’s share of national cocaine problems.
reaching the streets of eastern and midwestern U.S. cities. Increasing percentages of heroin users admitted for treatment through the Central Diagnostic and Referral Service (CDRS) of the city of Detroit's Health Department report that they began heroin use before age 20 (Gaines, 1991). Heroin still has the potential to appeal to young drug users.

Heroin is sometimes considered a man's drug, but in Detroit in 1989, nearly 33 percent of the heroin ER mentions involved women. This figure is close to the nationwide figure of 30 percent (NIDA, Series I, 1989). The proportions of women involved are thus about the same for cocaine and heroin, though there are far more cocaine episodes.

The vast majority (over 95 percent) of heroin incidents have injection recorded as the route of administration (NIDA, Series I, 1989). Smokable heroin is feared by public health authorities, because it may make heroin attractive to young people averse to needle use. There are some reports from New York that smokable heroin is being sold along with crack (Treaster, 1991). However, given the overwhelming prevalence of injection as the route of administration for heroin, the increased risk of Acquired Immunodeficiency Syndrome (AIDS) is a concern.

Intravenous drug use has always posed severe health risks, such as the spread of hepatitis, tetanus, and heart infections via unsterilized needles. However, the rise of the HIV, which leads to AIDS, a fatal disease, has greatly increased the dangers associated with intravenous drug use. The HIV infection can be passed through blood or semen, so intravenous drug users who share needles are at high risk for infection, as are their sexual partners. The route of transmission in most cases of AIDS has been sexual contact between males, but the fastest growing number of cases is associated with transmission among intravenous drug users and their sexual partners.

Through September 1990, 1271 cases of AIDS had been reported to the Centers for Disease Control (CDC) for Wayne, Oakland, and Macomb counties (799 for the city of Detroit alone). Intravenous drug use was identified as the likely route of transmission for 22 percent of Michigan's cases (CDC, 1991). AIDS cases reported to the CDC represent only the advanced stages of the disease caused by the HIV in-

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9Samples collected by the Domestic Monitoring Program of the Drug Enforcement Administration (DEA) showed a decline from an average price in Detroit of $1.65 per pure milligram of heroin in 1988 to $1.19 in 1989 (DEA Office of Intelligence, 1989). The Domestic Monitoring Program also reports data on the purity of samples, but the wide range of purities among the individual samples (e.g., from 4.8 to 27.6 percent in 1989) makes it hard to compare trends from year to year.
fection, which can appear some years after the original infection. Hence, the number of persons in the Detroit metropolitan area infected by the HIV and thus capable of passing it to their sexual partners and, in the case of women, to their newborns is no doubt much larger than the number of reported AIDS cases. The incidence of AIDS in the Detroit metropolitan area is still lower than the nationwide average for metropolitan areas: 7.9 new cases during the 12 months prior to September 1989 per 100,000 residents, compared to 19.7 new cases per 100,000 residents nationwide.

The prevalence of the HIV infection among intravenous drug users varies greatly across cities. In New York, over 60 percent of intravenous drug users tested positive for presence of the HIV in 1988, compared to 2 to 3 percent in Los Angeles (Schuster and Pickens, 1988, Table 3). We did not find comparable figures for Detroit, but Detroit’s relatively low proportion of AIDS cases due to intravenous drug use suggests that Detroit has been on the lower end of this scale so far.

In addition to the direct link between intravenous heroin use and HIV transmission, there may be indirect links between the use of cocaine and HIV transmission if cocaine use leads to high-risk sexual behavior or involves high-risk drug-taking behavior. There was a nationwide increase in the prevalence of sexually transmitted diseases other than AIDS in the same years and places (large metropolitan areas) that crack use took hold. The prevalence of syphilis, for example, began increasing for both black males and females in 1985 after years of steady decline (Rolfs and Nakashima, 1990). This connection has been ascribed to the promiscuity of and lack of precaution taken by men and women using crack (Goldsmith, 1988). Moreover, some studies have concluded that cocaine users who inject cocaine are even more likely to share needles than are heroin users (e.g., Chaisson et al., 1989). A related point is that cocaine may even act directly to suppress the immune response of users (Weiss, 1989). Cocaine users, their partners, and their children may thus be joining the ranks of those at risk for sexual and perinatal transmission of the HIV and AIDS.

**ALCOHOL, MARIJUANA, AND DRUGS OTHER THAN COCAINE AND HEROIN**

The recent epidemic of cocaine use, the continuing problem of heroin use, and the ominous possibility of increases in HIV transmission rightly occupy a good deal of public attention. But a full discussion of drug problems needs to account for the persistent use of other addic-
tive substances. Alcohol, it is worth remembering, is the most com-
monly abused substance throughout the United States and in every
racial and age category of the American population (NIAAA, 1990).
Marijuana has received less attention in recent years because of the
sudden appearance of crack, but marijuana is illegal, can lead to
dependence, and has detrimental consequences (albeit less dramatic
than those of cocaine) for the user's health. Nationally, nonmedical
abuse of psychotherapeutic drugs is about as common as cocaine use.
The types and amounts of drugs ingested determine the acute and
chronic health problems that can result.\footnote{Kleiman (1989, Chap. 1) provides a good review of the evidence about health
problems created by marijuana use. The American Academy of Pediatrics has
published a very useful guide for health professionals that contains a summary of
evidence on the psychological and physiological consequences of use of the popular legal
and illegal drugs (AAP, 1988, Chap. 8).}

Table 3 shows the percentages of all 1989 ER episodes reported to
DAWN in which individual drugs (and alcohol when detected in com-

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problems created by marijuana use. The American Academy of Pediatrics has
published a very useful guide for health professionals that contains a summary of
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Table 3

Drugs Mentioned in Emergency Room Records in Detroit, Chicago, and New York, 1989

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percentage of ER Episodes in Which Substance Was Mentioned in:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Detroit</td>
</tr>
<tr>
<td>Cocaine</td>
<td>41</td>
</tr>
<tr>
<td>Heroin, morphine, methadone</td>
<td>12</td>
</tr>
<tr>
<td>Marijuana, hashish</td>
<td>7</td>
</tr>
<tr>
<td>Amphetamines, methamphetamine</td>
<td>0.3</td>
</tr>
<tr>
<td>Phencyclidine (PCP)</td>
<td>0.3</td>
</tr>
<tr>
<td>Diazepam</td>
<td>3</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>1</td>
</tr>
<tr>
<td>Codeine and codeine combinations</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol in combination with drugs</td>
<td>35</td>
</tr>
</tbody>
</table>

SOURCE: NIDA, Series I.

NOTE: Because of omitted substances and multiple substances detected in one episode, totals do not add to 100 percent.

uncommon in the Detroit metropolitan area. The most common legally prescribed drug with abuse potential is diazepam (much of which is sold under the trade name Valium); it was detected in about 3 percent of all ER episodes for which drug use was recorded.

Among the most serious problems created by drug use are the increased morbidity and risk of mortality for the users. Unfortunately, medical statistics based on hospital admission records, discharge reports, and death certificates are not organized in a way that allows easy calculation of the total amount of morbidity and mortality caused by the use of addictive substances. A relatively small proportion of the deaths in which excessive alcohol use was an underlying cause have acute alcohol intoxication listed as a proximate cause. Most of the toll taken by alcohol shows up in the form of excess numbers of deaths due to heart disease and trauma caused by vehicle crashes. Ravenholt (1984) devised a method to translate the "cause-of-death" distributions reported in vital statistics into numbers of
deaths attributable to excessive use of alcohol, tobacco, and drugs (both illegal drugs and abused prescription drugs).\footnote{We did not attempt to update estimates of the proportions within each category of death attributable to various substances. Some of these proportions, like the proportion of all lung cancers caused by tobacco use, probably changed little over the course of the 1980s. The proportion of vehicular crash deaths in which alcohol was implicated has fallen somewhat, however, most likely because of stricter enforcement of laws against alcohol-impaired driving. A major source of uncertainty is the proportion of homicides and trauma deaths that should be attributed to the use of illegal drugs. This proportion has probably also risen somewhat, though it is still likely that alcohol use is a larger factor than other substance use. Ravenholt's method is still valid, in our view, for making broad estimates of the relative burden of mortality ascribable to different substances.}

We applied Ravenholt's methods to death statistics for the three counties for the years 1986–1988, the most recent years for which data were available from the Michigan Department of Public Health. What we found was that, on average, about 7500 deaths per year in the three-county region can be attributed to the effects of tobacco use. Just under 2000 deaths per year can be attributed to the effects of alcohol use. All other substances, both illegal drugs and legal drugs abused or used accidentally, account for about 575 deaths per year.

Mortality related to the use of addictive substances is more common among residents of the city of Detroit (relative to their numbers) than among residents of the metropolitan area. Residents of the city suffer tobacco-related mortality rates 1.5 times as high as those for residents of the rest of the metropolitan area, and their mortality rates related to alcohol and drug consumption are nearly three times as high as those for residents of the surrounding areas. These comparisons do not necessarily show that residents of the city use addictive substances that much more than residents of the other jurisdictions; rather, they show that city residents are more likely than others to suffer the most severe consequences of addiction-related health problems.

Two implications can be drawn from these comparisons:

• Of the policies aimed at curbing illegal drug use, those that also try to reduce mortality from tobacco and alcohol use (i.e., that provide many types of prevention and treatment or self-help programs) are likely to have the most long-term effect on public health.

• If resources for substance use control programs are allocated according to where the public health (not to mention public order) problems are greatest, the city of Detroit will get a considerably
larger per capita share than the rest of the Detroit metropolitan area.

VIOLENCE AND NEIGHBORHOOD DESTRUCTION

The harm caused by the illegal drug trades reaches many people other than drug users and their families. Residents of neighborhoods where open drug sales take place obviously suffer, most directly from the violence that accompanies the trades and drug-law enforcement, and indirectly from the process of economic and social deterioration to which the violence contributes. One of the most important consequences of the drug trades and their attendant violence is the destruction of the civic bonds, i.e., residents' feelings of safety and ownership. Such effects are hard to quantify, but vital.

Detroit has for years had one of the highest homicide rates of all American cities. The relation of the homicide rate to the increase in the drug trades is unclear; there are no precise ways to estimate how many homicides are drug related. The city of Detroit had the highest homicide rate in the country during the 1970s. Then, after a dip in the late 1970s, the homicide rate climbed to a peak in 1987. This climb began several years before the cocaine epidemic (see Fig. 6). In 1987, however, half the homicide victims in Wayne County tested positive for having used cocaine shortly before death (Hood et al., 1990). The homicide rate has been fairly stable in recent years, but there has been an ominous trend—more teenagers are involved, both as killers and as victims (see Fig. 7).

Methods of drug distribution changed in the city of Detroit in the early 1980s: heroin sales moved outdoors and more and more adolescents were recruited for “crews” of sellers, touts, and guards, loosely organized into larger gangs. Mieczkowski (1986) describes the beginning of this process in the heroin trade of the early 1980s; Taylor (1989) provides a graphic description of the growth of Young Boys, Inc., and its successors and their work in the crack trade. The arrival of crack seems to have accelerated a process, already begun in Detroit, in which drug sales became more visible and competitive. The legacy for the 1990s is that large numbers of young men are well armed and accustomed to resolving even petty disputes with extreme violence. This violence can take on a momentum of its own; in Detroit, as in other cities throughout the nation, there has been no decline in homicide rates comparable to the recent declines in indicators of drug use. In fact, many analysts fear that a declining overall market could lead to increasingly violent competition among the large numbers of people deriving their income from drug sales.
Fig. 6—Homicide Rates in Selected Cities, 1970–1990

Fig. 7—Percentage of Teenagers Among Homicide Victims and Killers in Detroit Metropolitan Area, 1980–1988
The consequences of drug use and drug selling for the area's economy are manifold. Among the most important costs other than those borne directly by users and their families are the lost-opportunity costs because of resources being diverted to drug distribution and attempts to suppress distribution or discourage use. And a great cost is imposed on many neighborhoods when the loss of public order further reduces the dwindling number of nearby job and business opportunities for residents. The current wave of illegal drug use and its attendant violence did not create Detroit’s economic decline, but it can only hinder residents’ efforts to overcome that decline.\(^\text{12}\)

The size of the underground economy created by the drug trades is not known precisely. The DEA Office of Intelligence (1990) reports cocaine prices in the form of a national range, with separate prices reported only for the largest cities and major ports of entry. Of these cities, Chicago has usually shown price ranges closest to those reported for Detroit. The wholesale price for a kilogram of cocaine was $30,000 to $45,000 in 1986 and fell to $17,000 to $24,000 in 1988. The most recent reports are $19,000 to $25,000. Calkins (1990) reports a range of Detroit area prices in 1990 between $26,000 and $40,000 per kilogram for cocaine of high purity. Retail-level prices were constant at $100 per gram of diluted street cocaine for several years in the mid-1980s; the range reported in 1988 was $50 to $100, and most recently $60 to $125. So even with the more recent increases, prices are still generally lower than they were in 1986, when the large increase in cocaine use began. This finding suggests that prices (which may be higher because of enforcement pressure at all levels) are not yet at a point that will significantly reduce consumption.

A substantial proportion of the income derived from drug sales in the city of Detroit accrues to the importers and high-level dealers, many of whom live outside the city and thus recycle little if any of their income into the city’s economy. But for drug markets as a whole, incomes of retail dealers appear to constitute the larger part of the illegal revenues, even though importers and wholesale dealers typically receive greater per capita incomes (Reuter and Kleiman, 1986; Reuter and Haaga, 1989). For individual retail dealers, typical incomes, though often better on an hourly basis than those generated by legal alternative occupations, are not very high. Collectively, however, they can add up to a major diversion of resources and income from the

\(^{12}\)For a discussion of the causes and effects of economic decline and depopulation, see Darden et al. (1987), especially Chap. 2.
legitimate economy. Reuter, MacCoun, and Murphy (1990) used data from a sample of Washington DC dealers to calculate that the net drug-sale earnings of young black men engaged in the trades in 1988 were about one-quarter as large as all earnings of the same population from legitimate work.\textsuperscript{13} Perhaps most important, the drug trades divert many young people from building experience in and work habits suitable for the legitimate economy.

**ASSESSMENT**

It is easier to elicit concern about a social problem when the indicators of its harmful effects are all clearly increasing. Then the difficulty regarding priorities—How much of this can we live with, given all our other problems?—is muted by uncertainty—How much worse is this going to get? It is too soon to declare that the cocaine epidemic is over, but it is not too soon to start asking what the steady state will look like, what the long-term problems caused by this epidemic will be, and how best to deal with those problems.

The indicators reviewed in this section can easily give rise to one of two perceptions: (1) the “drug problem” has been solved or (2) the drug problem has not been solved, but has been revealed as yet another urban problem and thus not a major threat to those who live outside the inner city. These perceptions are mistaken and thus would be misleading as a guide to policy.

With regard to the first perception, there is no one “drug problem”; there are many related drug problems. Though it was a sudden increase in cocaine use that heightened public awareness and made drug abuse a salient political issue in the 1980s, the decrease in cocaine indicators does not promise an end to problems with alcohol, tobacco, prescription drugs, and other illegal drugs. It does not even presage a quick end to cocaine problems, since cocaine use is still a major public health problem.

The second perception, that drug abuse is uniquely a problem for the inner city, is also inaccurate. The data on health consequences of substance abuse, as for many other health issues, show greater problems for blacks and the urban poor, and there are differences in patterns of abuse for particular drugs, including alcohol, both over time and among subgroups of the population. But no part of the American

\textsuperscript{13}The same study also found that a large percentage of those dealers in fact used drug selling as a higher-paid supplement to other work, not as their exclusive source of income.
population has ever been “drug free,” and the drugs of greatest current concern are abused throughout the Detroit metropolitan area. The violence and disorder associated with drug use and open drug sales pose problems for all members of the metropolitan area. Moreover, although the focus of our research was on the use of illegal drugs, the larger context of health consequences related to the use of all addictive substances, including alcohol and tobacco, should be kept in mind. Many of the measures discussed in the remainder of this report are designed to reduce dependence on both drugs and alcohol. The visibility of alcohol problems helps prevent substance abuse from being defined as strictly an urban problem, rather than a problem affecting the entire Detroit metropolitan area.

One legacy of the cocaine epidemic, even if its growth phase ends soon, is going to be the large number of Detroit metropolitan area residents whose lives have been seriously disrupted by regular cocaine use. We should not think of this group as a stable pool of heavy cocaine users. Even if the overall numbers of cocaine users no longer appear to be rising, some heavy users will turn to other drugs, moderating or quitting their cocaine use. Other people, currently infrequent or even nonusers of cocaine, will progress to heavy, dependent cocaine use. The total number of persons whose cocaine use hurt them in the past and who might return to cocaine use in the future is larger than the current number of frequent or recent binge users. There is still much uncertainty about the course of cocaine dependence, particularly about what will happen to the many who began using it in the form of crack. Only four years have passed since large numbers of people were first exposed to crack; treatment professionals are still in the process of adapting their methods to clients dependent on this new drug form. Our best guesses come from extrapolation, both from previous generations’ experience with cocaine in other forms and from the experience of users of other addictive substances.

Many people will continue to use cocaine, which is still readily available and, despite recent price rises, cheap. The prognosis for those who persist is not good. Long after the phase of dramatically rising incidence was over, the heroin epidemics beginning in the late 1960s left behind a hard core of addicts concentrated in the inner cities. These people, drifting in and out of jail and treatment programs, were unable to put their lives back together for more than short periods.

Many other people will make more or less determined efforts to quit using cocaine. Some might achieve this goal by switching to dependence on a legal drug, alcohol, or another illegal drug. Others will achieve a more positive success, both with and without formal treat-
ment. If past experience with those trying to quit the use of tobacco and drugs is a guide, most of those who quit using cocaine will do so only after more than one attempt. The experience following the heroin epidemics of the 1960s and 1970s might be taken as a fairly optimistic projection for the aftermath of the 1980s cocaine epidemic: few new users and a gradually shrinking cohort of heavy users. This latter outcome will require a good deal of effort on the part of the medical, drug treatment, and social service systems for years to come. Benign neglect will leave behind a residue of unsolved problems and a Detroit metropolitan area vulnerable to the next surge in popularity of one drug or another.
3. PREVENTION IN THE SCHOOLS

From the individual’s point of view, it is always better not to get a disease than to get it and try to deal with the consequences. From society’s point of view, it is usually more effective to devote available resources to preventing a disease outbreak than to treating the disease, except when the disease is very rare, treatment is easy and effective, or the prevention measures are risky or expensive relative to treatment. None of these exceptions holds for drug abuse.

There has been a special importance attached to primary prevention in the drug abuse field because of a lack of faith in the long-term effectiveness of alternative measures.1 As early as 1972, in the beginning years of the Nixon administration’s “War on Drugs,” the situation was expressed clearly in a report to the Ford Foundation:

Law enforcement has failed to stem the supply of illegal drugs, and rehabilitation efforts have thus far failed to reclaim many abusers. Everyone now talks of pouring money into education to stop the problem before it begins. (Wald and Abrams, 1972, p. 123)

Some advances have been made in both law enforcement strategies and treatment methods in the last two decades, but this early statement still summarizes the imperative of primary prevention. It has to work, because nothing else offers a satisfactory long-term solution.

Though much of the promising new work in drug abuse prevention involves activities outside the schools (see Sec. 4), most prevention work is likely to continue to be done in the schools or at least initiated by the school system for the foreseeable future. In the Detroit metropolitan area, as in the rest of the country, the lion’s share of prevention resources has been invested in school-based programs. As stated in the National Drug Control Strategy, “After parents, school is probably the most powerful influence on children’s lives” (ONDCP, 1989, p. 49). Schools are more directly suited to prevention programming than many other channels of influence. Like churches, they are spread over the entire territory that needs to be reached, in the city and suburbs alike. However, they have an advantage over

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1Primary prevention has as its goal prevention of any use of harmful substances, including tobacco and alcohol. The goal of secondary prevention is to get those who are experimenting with gateway drugs to quit or not move on to heavy drug use. The distinction between primary and secondary prevention programs is commonly made but not always clear cut; many programs aim both at deterring or delaying any use and at preventing the transition from experimental to regular use.
churches in that nearly everyone in the age ranges targeted for most primary prevention programs attends school (if only sporadically), whereas the churches have relatively worse attendance and dropout problems and occupy less of most young people's time. Radio and television have nearly universal reach but relatively low direct involvement compared to face-to-face encounters.

In the next subsection, we review the state of knowledge in the schools about preventing the use of addictive substances. We then describe the major school-based prevention activities in the Detroit metropolitan area and discuss how these initiatives compare with what research shows (or experts assert) are the most promising strategies for reducing substance abuse. Finally, we present our assessment of how to support, expand, and improve the existing school-based prevention efforts.

LESSONS LEARNED FROM PAST RESEARCH

Substance abuse prevention is a relatively new field for research. Few programs have been evaluated in more than one setting or in large-scale implementations.²

Program evaluations in the 1970s succeeded mainly in establishing which approaches do not work. Such approaches included the information-only programs, which either use scare tactics or simply convey pharmacological knowledge based on the assumption that well-informed people will not use drugs. Indeed, there was some evidence that information programs could be counterproductive (Blum, Blum, and Garfield, 1976). The general skills approach used in the 1970s, largely in reaction to the failure of scare tactics, produced only moderate success at best. It attempted to make children more aware of how they make decisions in general, often avoiding any mention of drugs to remove any appearance of lecturing or preaching. General principles, however, do not automatically provide guidance to young people facing immediate perceived pressure to use addictive substances; the teacher's posture of neutrality was impractical and confusing, and those adolescents at greatest risk tended not to have acquired values conducive to sobriety from their families and the culture at large (Ellickson and Robyn, 1987).

There is more support in the research literature for programs based on social influence models. These programs typically include (1) re-

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²Ellickson (forthcoming) and the Office of Substance Abuse Prevention (OSAP) (1990a) summarize previous research on prevention programs.
sistance training to help students develop skills to identify and resist situational pressures (e.g., peer pressure) to use addictive substances and (2) activities to correct the distorted beliefs that students often have about the prevalence and acceptability of drug use among their peers.

Most young people have no strong views in favor of drug use; they drift into it because it is what they think others are doing. Adolescents often believe that more of their peers are using drugs than is the case. Adolescents’ time horizons are short, and they tend not to worry about the long-term consequences of their actions. They also tend to have unrealistic views about their own chances of suffering the bad consequences of drug use, even if they know about them. Thus, messages in many of the social influence programs emphasize the user’s loss of control, inability to function, and immediate health risks rather than future dangers or relatively rare catastrophic health consequences.

Classroom activities typically focus on open discussions and role playing to help students identify social pressures to use drugs and practice ways of resisting pressures from peers, friends, and relatives. Older, socially adept teenagers are the counselors in some of the recent programs. Some programs enlist parents to help in encouraging the children to develop positive friendships with nonusers and to provide alternative activities for youth (such as recreational programs, religious programs, peer leadership workshops, academic clubs, and community service programs). Various other elements are typically added to the resistance skill training activities—for example, stress management, programs to assist students in setting goals and becoming achievement motivated, self-worth enhancement programs, and values clarification.

Much of the research in this area deals with programs for early adolescents, those making the transition to middle or junior high school. Sixth-, seventh- and eighth-graders are at the ages at which significant numbers will start using tobacco, alcohol, and drugs. Many in the field now call for comprehensive drug education starting with the early elementary grades and continuing through high school. But the evidence on the effectiveness of school programs targeting earlier

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*The Alcohol Misuse Prevention Study of the University of Michigan's medical school deals with alcohol use among junior high school students.*
(and later) grades is much weaker than the evidence on the effectiveness of junior high school programs.⁴

Early studies of the effectiveness of the social influence approach produced mixed results and generated skepticism about whether the approach worked well for all drugs, all students (particularly high-risk students, minorities, and the poor), and in a variety of school settings (inner-city and suburban communities). Recent studies have shown modest but encouraging results. Two large-scale programs based on social influence models—Project ALERT (Adolescent Learning Experiences in Resistance Training) and Project STAR (the Midwestern Prevention Project)—have been the subjects of well-designed evaluations (Pentz et al., 1989; Ellickson and Bell, 1990).

ALERT was tested in 30 junior high schools in California and Oregon. After two years of follow-up, it proved effective in preventing marijuana use among both high- and low-risk students. It also curbed cigarette use, including regular and daily use, among students who had previously experimented with smoking. However, early gains in preventing alcohol use during the seventh grade eroded by the time the students reached the eighth grade, suggesting that the social influence model is more likely to prevent the use of substances of which society disapproves. The ALERT program was not effective for children who were already heavy smokers. In fact, confirmed smokers in schools using the program were less likely to quit or cut down than those in nonparticipating schools, possibly due to a backlash against the prevention messages. Notably, the program was at least as effective in schools with substantial minority populations as in predominantly white schools. Booster sessions appeared critical for maintaining the effects (Ellickson and Bell, 1990).

Project STAR used an addictive substance education curriculum for junior high school students (including refusal skill training), as well as parental and community outreach activities. This program also produced a substantial reduction in student use of tobacco and marijuana after two years of follow-up. However, of all the substances researched, alcohol was the least consistently affected. These initial findings were generally consistent with the Project ALERT results at a similar point in the experiments. However, it is too early to say

⁴Growing Healthy, the curriculum used in Oakland County, is one of the few comprehensive health education programs for elementary students that has been evaluated. It did produce some evidence of success at reducing cigarette use, but those results have not been widely replicated (OSAP, 1990b, p. 15).
whether the positive results from the junior high program will hold through high school and beyond (Pentz et al., 1989). For our purposes, the most important points that have emerged from these evaluations are as follows:

- Prevention programs based on the social influence model have had some success in a wide range of schools for diverse student populations. It is not true, as many had feared, that only suburban, middle-class, and majority-culture students can learn and practice the resistance skills taught in these programs. There is no case for triage—that is, for concentrating resources on groups presumed by decision makers to be most amenable to prevention messages.
- The long-term effectiveness of these programs is still unknown. A key but unproven assumption is that delaying or preventing the first use of gateway drugs will reduce the numbers of young people who progress to more harmful patterns of drug use.
- The evidence of effectiveness mainly concerns programs for early adolescents (11- to 13-year-olds). Plausible claims have been made for programs aimed at younger school children, but these claims should be treated as unproven, and experimentation with alternative types of programs should be pursued.
- Resistance skill programs appear to have less influence on, or even to backfire with, young people who are already involved with one or more addictive substances.
- Resistance skill programs have had less success with alcohol than with any of the other targeted substances. This finding suggests that the social and legal environment matters for these programs: When use of a substance is broadly tolerated, and even promoted, within the community, isolated classroom efforts to discourage use by young people may not be effective.

CURRENT PROGRAMS

Funding for drug prevention in the schools has increased nationwide since passage of the Drug-Free Schools and Communities Act of 1986. Under that act, federal grants are distributed to the states via a formula that takes into account the size of the school-age population,

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6Project ALERT conducted a six-year follow-up survey in the spring of 1990, when former participants were in the twelfth grade, to determine current substance use attitudes and behaviors. Project STAR is also continuing to monitor long-term effects. Published results are not yet available.
making some adjustment for the proportion of the population living in urban areas. Seventy percent of the funds are earmarked for the state education agency, primarily for distribution to local school districts for prevention programs, and thirty percent are for a fund to be used at the state governor’s discretion. In Michigan, these discretionary funds are used by the state Office of Substance Abuse Services (OSAS) for the Governor’s Incentive Grant (GIG) program, which has been used to fund some school programs. Federal funds for both types of grants are supplemented by state funds.

The state agencies set conditions for use of these grant funds and have promoted substance abuse prevention by providing funding and training for a common health curriculum. But, as is true for most aspects of educational policy, there is considerable discretion in the selection and implementation of programs at all levels: the intermediate school districts, the school districts, the individual schools, and the individual teachers. School systems are not so highly centralized that higher levels of administration can simply mandate changes in classroom activities and expect those changes to occur. Principals have a great deal of control over the speed and intensity with which reforms are adopted in their schools. And even when a curriculum is set, individual teachers have much control over what actually happens in the classroom.6

Most school-based prevention programs and activities currently operating in the Detroit metropolitan area have incorporated the major lessons from the first two decades of substance abuse prevention research. The majority of students passing through the area’s public schools have at least some exposure to substance abuse education via mandatory health courses that go from the elementary grades through junior high school.

The two curricula most commonly used in the Detroit metropolitan area are the Michigan Model for Comprehensive School Health Education, which is the state-mandated health curriculum taught in Wayne County and Macomb County schools, and the Growing Healthy School Program, which is a state-approved comprehensive health curriculum taught in Oakland County schools. These two curricula are somewhat similar in content and structure, the Michigan Model program having been derived in large part from the Growing Healthy program. In both programs, substance abuse education

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6 A current study in the Troy Public School District is dealing with the neglected question of measuring how much of the intended curriculum is actually covered in the classrooms.
modules are included for all grade levels from kindergarten through eighth grade. Of the 83 school districts serving public school students in the area, 54 use the Michigan Model, 24 offer Growing Healthy, 4 have their own locally developed substance abuse curricula, and 1 does not have a substance abuse education curriculum.7

At the secondary level, substance abuse education is also provided in health courses, typically as elective rather than required courses. Most are derived from popular health curricula such as Teenage Health Teaching Modules (grades 9 through 12), QUEST: Skills for Living (grade 9 through 12 enhancement), and Here's Looking at You: 2000. The state education department has a contractor upgrading the Teenage Health Teaching Modules to produce a Michigan Model health curriculum for grades 9 through 12. Many schools also use additional programs to enhance their core substance abuse curriculum.

We next discuss the content and implementation of the two major curricula. We then turn to the less common programs, the add-ons, and the extracurricular substance abuse prevention activities in the schools.

Major Curricula

Michigan Model for Comprehensive School Health Education. The Michigan Model, initiated in 1985, is a statewide health and substance abuse curriculum for kindergarten through eighth grade. The curriculum is designed to include age-appropriate activities to influence student health attitudes, practices, and cognitive skills. One of the model's major areas of emphasis is drug education and resistance training for school-aged children and their parents.

The Michigan Model is used in 33 of 34 districts in Wayne County, 18 of 21 districts in Macomb County, and 3 of 28 districts in Oakland County. Federal and state funds are used for local coordination, teacher training, and necessary materials.

The Michigan Model in the Detroit metropolitan area is implemented through three intermediate school districts and the large school districts in the city of Detroit. Each has a Michigan Model coordinator who serves as liaison between the local school district(s) implement-

7The five districts that do not offer either Michigan Model or Growing Healthy substance abuse education classes are Lincoln Park in Wayne County; Lanse Cruz, Centerline, and Warren Consolidated in Macomb County; and West Bloomfield in Oakland County.
ing the Michigan Model, classroom teachers, community resource agencies and personnel who support the model, trainers who provide in-service training for the model, and the state department of education.

The classes are taught by regular classroom teachers at the elementary level and usually by health or science teachers at the middle and junior high school levels. Teachers must participate in special in-service training. Initial training for new teachers is about 30 hours per grade level for instruction on all ten health modules, plus one-half day of additional training for teachers who switch grade levels.

The Michigan Model curriculum covers ten areas of health: (1) safety and first aid education, (2) nutrition education, (3) family health, (4) consumer health, (5) community health, (6) growth and development, (7) substance abuse, (8) personal health practices, (9) emotional and mental health, and (10) disease prevention and control. The complete model consists of between 40 and 50 lessons in each grade from K through 8. Students receive about 15 minutes of instruction per lesson at the elementary grade levels and about 50 minutes per lesson in grades 7 and 8.

Each district signs a participation agreement with its intermediate school district agreeing to incorporate the ten content areas of the health curriculum into its courses. Schools and teachers have a good deal of discretion in deciding whether a particular course objective is already covered in an existing program. Given the large number of participating schools and teachers, the staff of the intermediate school district cannot effectively track implementation in the local schools. There appears to be much mixing and matching of the Michigan Model courses with existing school health programs. At least one coordinator reported to us that it is not always clear whether districts are using all, some, or none of the curriculum materials provided.

Although we were not able to get precise breakdowns of the time usually allocated within the health curriculum to substance abuse prevention education alone, local education officials estimate that between four and eight lessons per grade are typically devoted to the substance abuse education module. As Table 4 shows, the Michigan Model, as designed, provides about as much time for substance abuse prevention in the junior high years as do the ALERT and STAR programs.
Table 4
Substance Abuse Prevention in the Michigan Model and Other Drug Prevention Curricula

<table>
<thead>
<tr>
<th>Curriculum</th>
<th>Grade Level</th>
<th>Classroom Time Spent on Substance Abuse Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan Model</td>
<td>K-6</td>
<td>4–8 15-minute sessions/grade</td>
</tr>
<tr>
<td></td>
<td>7–8</td>
<td>4–8 50-minute sessions/grade</td>
</tr>
<tr>
<td>ALERT</td>
<td>7</td>
<td>8 50-minute sessions</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>3 50-minute sessions</td>
</tr>
<tr>
<td>STAR</td>
<td>6–9</td>
<td>12 45-minute sessions/grade</td>
</tr>
<tr>
<td>for Adolescence</td>
<td>6–8</td>
<td>11 45-minute sessions/grade</td>
</tr>
</tbody>
</table>

SOURCE: training manuals for each program.

The Michigan Model curriculum contains elements similar to those that have been shown effective in other substance abuse education programs based on social influence models. A major focus is on identifying pressures to use addictive substances and developing resistance skills. The program also includes discussions of short-term health and social consequences of substance use, training in identifying and resisting media and advertising influences to experiment with addictive substances, decision-making and problem-solving training, stress management, values clarification activities, training in strategies for setting personal goals and becoming achievement motivated, self-worth enhancement activities, and training in ways to avoid situations conducive to drug use.

Substance abuse education begins in kindergarten with the introduction of general concepts of health and wellness, including definitions of different types of addictive substances, how they affect the body, and reasons that people do and do not use them. These early classes are intended to provide accurate information without piquing too much curiosity or frightening the children.

Programs in grades 5 through 8 move away from this information-only approach to develop decision-making skills and peer resistance techniques. Peer resistance training is first introduced at grade 5 and is reinforced in more sophisticated situations in grades 6 through 8. Students are taught and get to practice techniques for identifying and responding appropriately to pressures from people and social situations to use cigarettes, alcohol, and drugs. The curriculum also deals with media and advertising influences on addictive substance use and ways to resist such influences.
Another goal of the Michigan Model program is to encourage parental support for and participation in their child’s health and substance abuse education. The model has an accompanying parent manual for each elementary grade, K through 6, that gives information about the health topics being taught in the classroom and suggests activities to be done at home to reinforce classroom instruction.

School districts in the Detroit metropolitan area started phasing in the Michigan Model during the 1984-1985 school year on a small scale in a few target elementary schools. Since then, the Michigan Model has expanded rapidly to new districts and new schools. Most districts initially gave first priority to phasing in the elementary school curriculum; most of them then turned their attention to the junior high school program.

Most participating districts have not yet fully implemented the curriculum at all grade levels in all schools. Complete information on the extent of program implementation in the Detroit metropolitan area was not available, but our conversations with local coordinators indicated that participating districts are in varying stages of implementing the curriculum and that the process is slow. In the current (1990-1991) school year, most districts are still phasing in the curriculum for the early primary grades. Some districts opted initially to teach the curriculum in grades K through 3 or K through 6 only; others implemented the junior high curriculum, but not necessarily in all schools.

Program implementation for the city of Detroit began in 1984 with only six target elementary schools. By the 1989-1990 school year, approximately 60 percent of the city’s elementary schools (117 of about 200) and all 40 junior high schools were teaching the Michigan Model at one or more grade levels. For that same school year, the Wayne County intermediate school district staff estimated that over 85 percent of the elementary schools and close to 70 percent of the middle schools were teaching the Michigan Model at one or more grade levels. Most elementary schools in that county are teaching the model for grades K through 3, K through 4, or K through 6; over 3000 teachers have been trained so far.

The availability of Michigan Model training staff is a key factor limiting the speed of the program’s implementation. Training resources vary greatly within the Detroit metropolitan area. The Detroit public school system, which includes over 260 schools, seems to have the most limited staff resources for implementing the Michigan Model. The Michigan Model coordinator for the city of Detroit serves as the master trainer for the city with limited assistance from a couple of
part-time teacher trainers. In the 1989–1990 school year, six teacher training workshops were conducted for about 150 teachers from the city. These workshops were difficult to organize because all training had to take place after school hours or on Saturdays. Many teachers opted for the Saturday-only training, which meant that the 30 to 35 hours of training was often spread over a month rather than conducted in three or four consecutive days, which is the method preferred by most trainers.

By comparison, the Wayne County intermediate school district has many more trainers to assist in implementing the Michigan Model in areas outside the city of Detroit. In addition to a full-time Michigan Model coordinator, there is one full-time health educator for every five districts in the region working on program implementation.

Implementation of the program seems to have proceeded more rapidly and smoothly in the elementary schools than in the junior high schools. Local education officials attributed this difference in part to the fact that the curriculum for grades K through 6 is the responsibility of a single classroom teacher who can figure out how the Michigan Model program maps into the existing school curriculum and can make appropriate adjustments. At the junior high level, it is reportedly a more difficult task for schools to fit together the Michigan Model and their current curriculum and to find a suitable pool of seventh- and eighth-grade teachers who are available and willing to teach the program.

**Growing Healthy School Program.** First introduced in the Detroit metropolitan area in 1978, Growing Healthy is now the main health and substance abuse program in 24 of Oakland County’s 28 public school districts (and 29 private schools). In the 1989–1990 school year, 183 public schools, 1771 teachers, and 66,000 students were involved in the program. On average, the Oakland County intermediate school district conducts about 25 teacher training workshops per year. Over the past six years, the Growing Healthy program has expanded substantially into new grade levels and new schools and districts in Oakland County.

Growing Healthy emphasizes the same ten health content areas as the Michigan Model, with a special module on substance abuse and use that is taught at each level from kindergarten through seventh grade. Like the Michigan Model, it starts in the early grades by providing simple information about drugs of all types, and then moves to more focused training on peer pressure and resistance skill development in grades 5 through 7. Teacher training time and requirements are roughly the same as for the Michigan Model.
The Oakland intermediate school district staff did note several differences between the Growing Healthy and Michigan Model programs. Growing Healthy is designed for grades K through 7; the Michigan Model continues through grade 8. This difference suggests that, on average, students exposed to Growing Healthy probably receive less substance abuse prevention instruction at the junior high level. However, some teachers have divided Growing Healthy's seventh grade substance abuse education curriculum into two classes, one for seventh graders and one for eighth graders, to give students more time to practice a range of prevention-oriented activities. The Michigan Model modules on addictive substances and mental health have been updated recently; the older, Growing Healthy program is due for a major curriculum update and revision in these areas. Many teachers using Growing Healthy are using supplemental curriculum materials to fill in the information gaps that will be addressed by the updates and revisions.

Unlike the Michigan Model, Growing Healthy does not include a separate manual for parents. Growing Healthy was able to obtain limited funding for small-scale longitudinal evaluation of the program's effect on student substance use and attitudes; the Michigan Model has not yet been subject to rigorous process or outcome evaluations.

Other Curricula

Some schools in the Detroit metropolitan area use various other curricula, usually to supplement the core health and substance abuse education classes in the Michigan Model or Growing Healthy program. Most of these curricula include elements on such subjects as peer resistance skills, decision making, and self-esteem building.

The enhancement programs that are used on a limited basis in some schools in the region include Project DARE, QUEST: Skills for Living, BABES, Paper People, Children Are People (self-esteem classes), Here's Looking At You: 2000, Guided Group Interaction, and Merrill-Health: A Wellness Approach. They reach a smaller proportion of the total student population and use little or no technical or training assistance from the intermediate school districts.

Some state and local officials have expressed concern that these programs compete with or supplant the core education curriculum in the Michigan Model and Growing Healthy programs. Proponents of the Michigan Model argue that the state's emphasis on a comprehensive addictive substance curriculum for grades K through 8 keeps individual school efforts from becoming sporadic and fragmented. When the
state shifted attention to the comprehensive health curriculum approach of the Michigan Model, some local prevention programs were displaced or received lower funding priority—for example, the Substance Abuse Education programs now operate on a small scale with limited funding from the Michigan legislature. Nevertheless, most officials we interviewed felt that implementation of the Michigan Model need not crowd out experimentation with other approaches.

The most popular alternative prevention programs used by schools in the Detroit metropolitan area are as follows.

**Project DARE (Drug Abuse Resistance Education).** This police-sponsored program, developed in Los Angeles, targets fifth- and sixth-grade students. It is used in several elementary schools in Wayne and Oakland counties. With uniformed police officers as instructors, it emphasizes four areas: (1) providing accurate information about alcohol and drugs, (2) teaching decision-making skills, (3) showing how to resist peer pressure, and (4) giving ideas for alternatives to substance use. A police officer visits the school once a week for about 17 weeks.

Some local officials maintain that some schools use the limited DARE program to avoid offering the more comprehensive education curriculum in the Michigan Model (or Growing Healthy) program. The DARE curriculum has not received much evaluation to date, and there are many unanswered questions about its effectiveness. Well-designed evaluations of DARE in North Carolina and Kentucky have found no differences between schools that use DARE and comparison schools in terms of student substance use or student intentions to use addictive substances, although DARE did appear to affect attitudes toward such substances (Ringwalt, Emmet, and Holt, 1990; Clayton et al., 1991). No evaluations have compared whether police officers or regular teachers are more effective for delivering the prevention messages. School officials have concerns about the potential problem of losing control over the content and quality of substance use prevention education if schools rely exclusively on police-sponsored programs such as Project DARE.

**BABES (Beginning Alcohol and Addiction Basic Education Studies).** A few districts in Oakland County are offering the BABES program in some elementary schools. This program provides basic information on addictive substances for the early grades (as well as preschoolers). The presentation format is puppetry. Each classroom teacher is involved in a six-week program designed as an enhancement (not a replacement) for the Growing Healthy program.
Sometimes parent volunteers are trained to present the BABES pro-
gram to elementary students.

**Paper People.** Similar to the BABES program, Paper People is a school-based substance abuse prevention program for children in the primary grades. It is used in a few schools in Wayne and Oakland counties, along with the core drug curriculum in the Michigan Model or Growing Healthy program. The Paper People curriculum is used as a supplemental program for high-risk students in a small sample of elementary schools in Wayne County that have Student Assistance Programs funded by the Southeast Michigan Substance Abuse Services (SEMSAS). It derives its name from the paper-bag puppets used by the children. Paper People consists of eight lessons designed to address various kinds of families and family problems, including substance abuse, and to assist children in making healthy decisions regarding general safety and substance abuse. Teachers participate in a one-day training program.

**Teenage Health Teaching Modules.** The Teenage Health Teaching Modules (THTM) program for grades 9 through 12 is a comprehensive health education program for junior and senior high school students. Developed by the Education Development Center, Inc., and funded by the CDC, it was designed as an extension to Oakland County's Growing Healthy program (Hubbard and Young, 1988).

The THTM program consists of sixteen modules, each covering a task such as protecting oneself and others from smoking, drinking, and drugs; handling stress; living with feelings; having friends; promoting health in families; and other traditional health topics. Each module provides 4 to 15 hours of instruction on a designated health topic. The modules can be used as a complete set or separately to supplement the health education already in place; most schools use the second option.

THTM is among the most common secondary programs offered as an elective course in the Detroit metropolitan area. In Oakland County, nearly half of the school districts have used parts of the THTM, particularly the drug prevention modules, to supplement the Growing Healthy program.

The state education department currently has a contract under way to upgrade the modules to produce a comprehensive grade 9 through 12 health and substance abuse education component for the Michigan Model, but it will be several years before such a program is ready for local implementation.
QUEST. A few schools in the area use one or more components of the QUEST program either as enhancements to their core district health and substance abuse education curricula for grades K through 8 or as elective courses for senior high school students. QUEST has three components: Skills for Growing, for grades K through 5; Skills for Adolescence, for grades 6 through 8; and Skills for Living, for grades 9 through 12. Materials for the elementary programs include texts for parents, who are requested to work with their child and teacher. At the secondary level, the classes instruct students on how to say no to drugs and other pressures. By the fourth grade, students from middle and high schools are sometimes used to lead discussions on peer pressure. The sixth- through eighth-grade curriculum explores many topics surrounding changes during adolescence and relations with peers and parents, including specific information about addictive substances. The ninth- through twelfth-grade curriculum includes units promoting healthy life-styles. Students are meant to learn skills for communication, decision making, goal setting, and career planning.

In Oakland County, about 60 percent of the school districts indicated that they were using one or more components of the QUEST program during the 1989–1990 school year. QUEST is not strongly supported by the Wayne County intermediate school district.\(^8\) The few QUEST classes in operation in Wayne County are primarily elective courses on decision making for high school students. During the 1989–1990 school year, the Wayne County intermediate school district conducted only one teacher workshop on the QUEST program for high school teachers and none for elementary school teachers, suggesting that the current demand for QUEST teacher training is relatively modest.

**Student Assistance Programs**

Student Assistance Programs (SAPs) have become increasingly popular in recent years in the Detroit metropolitan area as well as in the nation as a whole. SAPs may be designed either as primary prevention efforts aimed at the elementary level or as secondary prevention programs with an intervention and treatment orientation aimed at older adolescents who have begun to experiment with (or are abusing) alcohol, tobacco, and drugs.

\(^8\)Sometimes principals obtain funding from local foundations or community groups to support implementation of special educational programs such as QUEST. For example, the Birmingham Families in Action parent group has supported the QUEST program in selected schools in Oakland County, and the Kellogg Foundation has funded at least one high school in Wayne County to offer QUEST as an elective to its high school students.
In the Detroit metropolitan area, there has been a strong push from the state for primary prevention SAPs targeted at high-risk elementary school students and their parents. Although there are a few SAPs in place in secondary schools, the state department of education has mandated (at least during the 1989–1990 school year) that SAPs focus on the elementary level. Like many of the supplementary programs for elementary students discussed above, SAPs are not uniquely aimed at substance abuse. Instead, they focus on personal and family problems that might put students at risk for substance abuse—e.g., family violence, child abuse, alcoholic or drug-abusing parents, being a latchkey kid, low self-esteem, and lack of positive role models.

SAP activities can include a variety of in-class or after-school programs and services aimed at teachers, administrators, parents, students, and health care providers. Programs are often directed at improving overall school and class climate; training school staff on effective intervention, assessment, and referral procedures for students who exhibit behavioral problems related to substance abuse; educating parents on effective ways to reduce stress in families with high-risk youth and to reduce substance abuse; setting up support groups for students who have been identified as living in an alcohol- or drug-abusing family; organizing parental education and support groups; increasing student self-esteem and coping skills; and providing tutoring and remedial assistance for students.

A prerequisite for state funding of SAPs is that schools have a comprehensive alcohol and drug policy. Many schools have fairly vague or inconsistent policies, so the contractor or intermediate school district staff helping to organize a SAP must provide technical assistance to the school staff to develop policies for dealing with student drug use.

SAPs are meant to be locally designed and adapted to meet the needs of individual schools. A major objective is to provide individualized assistance and services to students when they first begin to engage in or show early signs of high-risk behaviors that warrant close attention and monitoring. This objective is accomplished by using a core team of specially trained teachers and administrators to plan and deliver services to high-risk students or by paying an outside (nonschool) professional (e.g., a mental health professional) to provide intervention services to target schools.

During the 1989–1990 school year, the school districts received funding to begin SAPs in a small sample of elementary schools in each county. Most of the SAPs are only beginning to form core support
teams in participating schools. A major difficulty in setting up SAPs has been recruiting teachers and administrators who are willing to participate as volunteers. Wayne County intermediate school district staff members observed that recruitment is often hampered because teachers are not compensated for any extra time they spend working on the SAP core support team, which typically requires a substantial after-school commitment.

During FY 1990, Macomb County responded to the state's mandate to initiate elementary-level SAPs by identifying a small number of target elementary schools that were feeder schools to junior high schools where SAPs already existed. The elementary SAPs were modeled after the Maplegrove Concept of in-school support groups for children of alcoholics. The Oakland County intermediate school district also received a small state grant to work with four school districts to plan and develop elementary SAPs in 1990.

In the spring of 1990, the Wayne County intermediate school district staff conducted a substance abuse awareness/student assistance policy conference for school administrators. During the 1989–1990 school year, that intermediate school district received about $43,000 in state funding to begin working with 17 elementary schools from six districts to help them plan and pilot test SAPs. The first year of program operation focused on identifying volunteers to serve on the SAP core teams. During the 1990–1991 school year, core team members are to be trained and implementation is to begin. The intermediate school district also submitted a grant application to OSAP for additional funding for SAPs in Wayne County. If this supplemental funding is received, there are plans to expand SAPs to roughly 59 elementary schools over the next three years and to add an evaluation component to measure the effect of SAP activities.

In 1990, SEMSAS allocated its total prevention budget of about $200,000 to put SAPs in place in nine Wayne County school districts. SEMSAS hired an outside contractor to help schools plan and implement SAPs in a small sample of target schools in Wayne County. The process of phasing in SAPs has been very slow because of the long lead times needed to gain school-level cooperation from teachers and administrators to mount such programs. Like SAPs in

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9SEMSAS is one of four coordinating agencies (CAs) for public drug and alcohol treatment and prevention programs in the Detroit metropolitan area. The geographical areas covered by the four CAs are indicated in Fig. 1 (see Sec. 1); the role played by the CAs is described in more detail in Sec. 4.
other parts of the region, the SEMSAS programs have only recently been implemented and are still in the early experimental stages.

The objective of the SEMSAS-funded SAPs, when fully implemented, is to provide seven core components for participating schools:

1. A district student assistance team to help oversee and coordinate programs in the district.
2. School student assistance teams in each target school to generate a detailed set of activities and timetables for implementation using a structured planning process.
3. A drug education enhancement curriculum for high-risk elementary students (e.g., Paper People).
4. Educational support groups for elementary students who have been identified as living in an alcohol- or other substance-abusing family or who are experiencing other types of family problems that cause stress and interfere with the ability to learn.
5. The use of external assessment, referral, and treatment providers to assist in referring students to outside agencies as needed.
6. Parental education and support groups such as PARENT PLUS, which is an eight-session education program for parents of high-risk elementary students.
7. A student assistance information system, i.e., a computerized student tracking system to permit analyses and follow-up for individual schools and districts.

Extracurricular Programs

Schools often supplement their core substance abuse education curriculum with school-wide activities or services, student-group activities, or community activities. One such program is Project Graduation, a high school prevention program to warn students about the dangers of drinking and driving. It is usually presented at a student assembly near graduation. (The mass media components of Project Graduation are discussed in Sec. 4.) Although this program's initial focus was limited to drinking-and-driving messages at the time of high school graduation, it now includes a range of activities aimed at preventing alcohol and other substance use, such as biannual student workshops and spring rallies. Regional student workshops for high school students from a six-county area are held twice a year.

Some schools mount special prevention activities during Substance Abuse Awareness Month (SAAM), an annual statewide public aware-
ness campaign. Activities include T-shirt days, rallies, seminars on effective parenting and on substance abuse, red ribbons worn to show support for drug-free life-styles, and SAAM Sunday, on which sermons in local churches deal with drug prevention.

In the inner city, there have been some ambitious reform attempts in which substance abuse prevention is embedded in a larger context of motivating school achievement and avoidance of destructive behaviors. One example is an experimental program for minority students funded by the Kellogg Foundation and designed by Creigs Beverly of the Wayne State University School of Social Work. The idea behind the program is that disadvantaged minority students need culturally sensitive help to get over feelings of hopelessness and vulnerability, since many of these students lack strong church, family, and school ties. Each of the two targeted high schools has committed one class period per month for grades 9 through 12 to mentor training, guest speakers, peer leadership training, and related activities. Another component is a six-week summer institute for eighth graders from the junior high schools that feed into the two targeted high schools, the objective being to provide remedial instruction in reading and math to better prepare these students for high school. Ten weekend sessions of training are provided to high school peer counselors who can go to local junior high schools to motivate younger students to stay in school and out of trouble. There is also a high school graduation requirement that students must volunteer at least 250 hours to community service.

A health clinic has been set up in each participating school, and health professionals visit each school once a week to provide on-site assistance with a range of health problems, including substance abuse concerns. As in other cities, school-based health clinics have proved controversial, with significant numbers of parents and others fearing the provision of advice on contraception.

Local community groups occasionally offer special activities for high-risk students in particular targeted schools. For example, Mumford High School students from Detroit have access to programs offered by the Northwest Activities Center, a community group that sponsors the KIND (Kids in Need of Direction) program to provide after-school care services and alternative recreational programs along with anti-drug messages.

Many schools in the area have active Students Against Drunk Driving (SADD) groups, which sponsor peer leadership workshops, training on peer resistance skills, drug awareness programs, special SADD assemblies, and other support activities for drug-free life-
styles. Various peer leadership training workshops are offered to students, such as Teenage Alcohol and Tobacco Education Training, a two-day leadership program (sponsored by the Wayne County intermediate school district's Drug Abuse Reduction Through Education program) that trains high school students in alcohol and tobacco education and prevention. Upon completion of the training, students work together to make presentations and lead discussions about alcohol and tobacco in both elementary and secondary classes within their districts.

Parent groups, such as Parent to Parent, Concerned Parents Coalition, and Families in Action, also sponsor student leadership training workshops, such as PRIDE and Youth to Youth. Volunteer parent groups and local community groups also adopt individual schools and help fund special school programs and activities, such as paying guest speakers, organizing school fund-raising efforts to support curriculum efforts, and giving scholarships to students to attend special workshops or conferences aimed at preventing the use of addictive substances.

The programs just described are but a few of many. Our intent was to convey the breadth and diversity of activities in both urban and suburban schools in the Detroit metropolitan area. In secondary schools, where few students are enrolled in health education, such programs are often the only source of substance abuse counseling.

ASSESSMENT

It was beyond the scope of our project to conduct detailed evaluations of the individual prevention programs being used in the Detroit metropolitan area schools. Our review did show, however, that the major prevention programs being used—the Michigan Model and the Growing Healthy curricula—include the main elements that evaluations of similar programs in other parts of the country have shown to be effective in reducing tobacco and illegal drug use among young adolescents. The Michigan Model and Growing Healthy are both based on teaching specific resistance skills. They represent a clear advance over older methods that provided information alone or provided general motivation against drug use without specific practice in realistic social settings. For the most part, substance abuse prevention is embedded in health curricula. In elementary and middle schools, this approach probably strengthens drug use prevention both substantively and administratively by making it part of the normal work of the school rather than an isolated extracurricular
activity. In the high schools, however, health courses are electives that reach few students.

Proponents of the Michigan Model argue that many schools and teachers, facing numerous other pressures for educational reform, will be reluctant to devote teaching time to substance abuse prevention if there is not a strong mandate for a comprehensive approach covering all districts and schools. The major problem with the Michigan Model so far has been slow implementation. The crucial bottleneck appears to be the lack of trainers, especially for teachers in the city of Detroit. No curriculum is likely to work if teachers are not well acquainted with its purpose and design and comfortable using it in the classroom. Once a curriculum is well established, some diffusion can take place through informal, teacher-to-teacher training, but a new effort requires that more resources be devoted to formal training.

One concern with the Michigan Model is whether it provides enough time for the topic of substance abuse prevention. If delivered as designed, the Michigan Model course involves about as much classroom time in the junior high grades as ALERT and STAR, the resistance skill programs that have shown evidence of effectiveness in recent evaluations.

The statewide curriculum does not appear to be incompatible with other special-purpose prevention programs that have been adopted by some Detroit area schools. Given the diversity of problems addressed along with substance abuse prevention in these programs, it would probably be worth continuing to experiment rather than attempting to impose uniformity through the Michigan Model alone.

Programs such as those discussed above often provide a good way for local foundations, businesses, and community groups to add their funding and volunteer time to what the schools can provide out of regular resources. This diversity puts a responsibility for quality control on both the outside groups and the principals and teachers, however. The principals are probably in the best position to ensure that supplementary programs reinforce rather than replace the health messages embodied in the curriculum. Community groups and outside funders should try wherever possible to support rather than supplant what the schools are doing.

Evaluations of prevention programs based on the social influence model have shown positive results, but it is also clear that much more needs to be learned. Early childhood programs for children in high-risk families are a particular need. These programs, like many pre-
vention efforts, are not directed solely at substance abuse, though reduction of future substance abuse is usually one of their goals. Even in the absence of strong research evidence, some of the strategies being used in these programs appear promising, so both public- and private-sector funders should put a high priority on encouraging further local experimentation and adaptation of these early childhood programs. Collaborative efforts linking family-, school-, and community-based activities are likely to produce useful results.

Secondary prevention (especially in the high schools) has been somewhat slighted in the recent emphasis on getting primary prevention established in the curriculum. The state agencies have promoted SAPs as ways to provide early intervention for problems that often lead to substance abuse (and, in doing so, have caused some resentment on the part of officials in both the city and the suburban jurisdictions). Few SAPs are currently in place in junior or senior high schools in the Detroit metropolitan area, especially in the inner city. Given the considerable harm that can come from drug users progressing to harder and more frequent drug use, the evidence that primary prevention programs do not affect use among those who have already started regular drug or tobacco use, and the lack of affordable formal treatment for young substance abusers, high priority should be given to developing new ways to help young people quit using addictive substances in the early stages of use. Private funding may be needed as a catalyst for this development, since the major emphasis in the public sector is elsewhere.

Obtaining the school-level support and commitment needed to mount SAPs in all schools would probably be difficult. But implementation of SAPs in inner-city schools having a large concentration of high-risk students appears to be a good idea for experimentation in Detroit city schools.

Finally, given the problems of program implementation and the great amount of discretion and variability of interest among principals and school communities, it would be worthwhile for policy makers to have some institutionalized ways to get feedback on the actual exposure of children to prevention programs. OSAS has sponsored the development of an Alcohol and Other Drugs survey for use by school districts, but few Detroit area districts have participated so far.10 This survey contains items on what programs or classes children remember having, as well as on their substance abuse knowledge, attitudes, and behaviors. At present there is much uncertainty about how many chil-

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10See the Appendix for details on these surveys.
dren, particularly high-risk children, are actually participating in the programs adopted by the districts. School and CA officials could use the information from such surveys to make better-informed decisions about allocating training and other resources and trying new or supplemental approaches.
4. PREVENTION IN THE COMMUNITY

The term community prevention covers a wide variety of activities, some aimed at very specific targets (e.g., ridding a particular neighborhood of open drug selling), and some aimed at more general areas (e.g., discouraging alcohol abuse and drug use in a wider population).\footnote{We use the term community prevention as a catch-all for all efforts aimed at preventing substance abuse that are not conducted in the schools. Some people object to the ambiguity of this term, preferring to distinguish community-wide prevention (comprehensive rather than targeted approaches) or community-based prevention (initiated by the members of the community that is to be served by the approaches, rather than by or at the behest of outsiders)—see Benard (1989, p. 126), for example.} Community initiatives, often organized by members of the affected neighborhoods, are crucial, but there are important roles for government as well.

Unfortunately, knowledge of what works in community prevention is even more fragmentary than knowledge of what works in school-based prevention. Until very recently, federal funding for research and demonstration projects was minimal, and even now, little is being done to evaluate the effect of such projects on drug use and drug selling. As a result, much of our discussion must focus on promising rather than proven ideas. We first review the current state of community prevention activities in the Detroit metropolitan area; we then assess some of the most important needs identified in our review of these activities.

CURRENT ACTIVITIES

In this subsection, we describe the current state of prevention in the Detroit metropolitan area, first examining the growth of public funding for prevention, and then discussing the experience of some community organizations that have grown without significant government involvement. We then provide an illustration of media-related campaigns, followed by a discussion of the networks, private funders, and providers of technical assistance that can serve as bridges between the “top-down” and “bottom-up” approaches.

Public Funding

The federal alcohol, drug abuse, and mental health block grant to the states requires that 20 percent of substance abuse funds be spent on
prevention. In Michigan, as in other states, little more than this prescribed minimum has traditionally been spent on prevention. Until recently, the requirement was largely met by statewide programs; only in the last two years has the Office of Substance Abuse Services (OSAS) passed down to the coordinating agencies (CAs) a requirement that they spend on prevention at least 15 percent of the state and federal funding they receive under OSAS contracts.

The four CAs for the Detroit metropolitan area are the City of Detroit Health Department; the Southeast Michigan Substance Abuse Services (SEMSAS), which covers all of Wayne County outside the city and Monroe County as well; Macomb County Community Mental Health Services; and Oakland County Health Department. The amounts of federal and state money allocated per resident under the CA budgets for prevention have never been large in absolute terms. As Table 5 shows, the FY 1989 prevention spending for the four CAs serving the Detroit metropolitan area ranged from just over $2 per person in the city of Detroit to between $35 and $65 per person for the rest of the metropolitan area. Many of the services funded are aimed at specific groups rather than spread evenly over the resident population, and metropolitan area residents benefit as well from the statewide activities funded by OSAS. However, it is clear that community prevention has not been a major item in public expenditure.

The CAs have had few full-time prevention specialists (two of them had no full-time person before 1989). Some have had considerable staff turnover.

<table>
<thead>
<tr>
<th>Coordinating Agency</th>
<th>Spending ($)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>City of Detroit</td>
<td>2,113,000</td>
</tr>
<tr>
<td>SEMSAS (rest of Wayne County, Monroe County)</td>
<td>391,000</td>
</tr>
<tr>
<td>Macomb County</td>
<td>256,000</td>
</tr>
<tr>
<td>Oakland County</td>
<td>704,000</td>
</tr>
<tr>
<td>Total metropolitan area</td>
<td>3,464,000</td>
</tr>
</tbody>
</table>

SOURCE: OSAS printouts.
NOTE: These figures exclude OSAS funding of statewide prevention projects.
Most of the prevention contracts awarded by the city of Detroit and Oakland and Macomb counties have supported services organized by school districts or private agencies. These services can be categorized as follows:2

- Programs for preschool children and their parents.
- School health curricula, including substance abuse prevention (Michigan Model, Growing Healthy), and Student Assistance Programs (SAPs).
- Community-based programs for specific groups of concern (e.g., high-crime neighborhoods, pregnant women, high-risk youth, seniors).
- Mass media campaigns.

Of the Detroit metropolitan area CAs, SEMSAS has the most limited range of prevention services, using its funds exclusively for SAPs. The Bureau of Substance Abuse Services in the Detroit Health Department has started major efforts to reach young women with prevention messages and to link substance abuse prevention to family skills training, in addition to funding training and technical assistance for community groups and organizations working in prevention.

Since 1987, additional federal funds for both school- and community-based prevention have become available to the states under the Drug-Free Schools and Communities Act. Of these new funds, 20 percent are set aside for each state as a governor’s discretionary fund; in Michigan, OSAS administers a Governor’s Initiative Grants (GIG) program that disbursed $1.6 million in grants in FY 1990 and $780,000 in FY 1991. As Table 6 shows, 25 percent of the GIG funds in 1990 were awarded for projects in the Detroit metropolitan area, and a further 11 percent were awarded for statewide projects. GIG-funded projects in the Detroit metropolitan area have included media activities (Detroit Educational Television’s Project Graduation), education and support groups for children of alcoholics (e.g., BABES and the Detroit Urban League’s LifePower Project), programs for specific racial or ethnic groups (e.g., workshops and counseling provided by the Arab-American and Chaldean Communities Social Services Council), prevention training for adolescents, the prevention activities of a treatment program (Sacred Heart Rehabilitation

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2The first two types of prevention services listed here are discussed in Sec. 3. The last two are discussed later in this section, under Community Organization and Media Campaigns.
Table 6
Prevention Funding Under Governor's Initiative Grants

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<thead>
<tr>
<th></th>
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<tr>
<td>Detroit metropolitan area</td>
<td>568,000</td>
<td>595,000</td>
<td>390,000</td>
</tr>
<tr>
<td>[31]</td>
<td>[30]</td>
<td>[25]</td>
<td></td>
</tr>
<tr>
<td>Rest of Michigan</td>
<td>1,233,000</td>
<td>1,215,000</td>
<td>1,011,000</td>
</tr>
<tr>
<td>[67]</td>
<td>[62]</td>
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<tr>
<td>Statewide</td>
<td>40,000</td>
<td>145,000</td>
<td>180,000</td>
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<tr>
<td>Total</td>
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<td>1,655,000</td>
<td>1,581,000</td>
</tr>
<tr>
<td>[100]</td>
<td>[100]</td>
<td>[100]</td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: OSAS GIG Summaries, various years.

Center), and a community minigrant program (New Detroit, Inc.). Statewide projects have included training for SADD groups and information centers.

In addition to the grant programs administered by OSAS, there are federal prevention grants made on a competitive basis directly to local applicants (both public and private agencies are eligible) under programs of the Office of Substance Abuse Prevention (OSAP). Two of the three most important OSAP grant programs are for high-risk youth and pregnant women; the third is a new “community partnership” program. Proposals from Detroit metropolitan area agencies fared poorly during the first few years of OSAP grant programs, but this pattern began to change in 1989 and 1990 (see Table 7). Of the four Detroit metropolitan area agencies that submitted applications for the first round of the high-risk youth programs in 1987, not one was funded. In 1990, however, seven Detroit metropolitan area groups applied for high-risk youth demonstration grants, and four were funded (La Casa Family Services, the Detroit Urban League, the Detroit Health Department, and the Warren Conner Development Coalition) for amounts ranging from $232,000 to $304,000 per year. Under the program of demonstration grants for pregnant women, the Detroit Health Department received a two-year grant in 1989 and 1990 and the League of Catholic Women received a five-year grant in 1990, both for amounts averaging around $250,000 per year. OSAP direct funding has thus begun to add to prevention resources in the Detroit metropolitan area.
Table 7
Prevention Funding from Office of Substance Abuse Prevention

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Detroit Metropolitan Area</th>
<th>Michigan</th>
<th>Nationwide</th>
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<tbody>
<tr>
<td>1987</td>
<td>0</td>
<td>186,000</td>
<td>45,896,000</td>
</tr>
<tr>
<td>1988</td>
<td>0</td>
<td>188,000</td>
<td>26,888,000</td>
</tr>
<tr>
<td>1989</td>
<td>214,000</td>
<td>594,000</td>
<td>55,336,000</td>
</tr>
<tr>
<td>1990</td>
<td>1,634,000</td>
<td>2,176,000</td>
<td>155,608,000</td>
</tr>
</tbody>
</table>

SOURCE: Telephone conversations with OSAP personnel.

Community Organizations

The recent concern with increased cocaine use and the continuing concern with alcohol abuse have led to a good deal of prevention activity in metropolitan Detroit, much of it organized by community groups without significant government funding.

Urban Neighborhoods. Poor neighborhoods are often the sites of open drug markets and crack houses, with their attendant violence and social disruption. Several factors leave such neighborhoods vulnerable, notably economic decline and population exodus. Since 1960, the city of Detroit has lost population at a faster rate than any other American city. One consequence has been an increase in the number of abandoned houses in the city. Less tangible consequences stem from the fact that population decline and mobility may mean that many neighborhoods have been deprived of their “natural leaders,” leaving poor residents with little leadership and social support and restricting the number of role models for neighborhood children.

Churches and other religious institutions have initiated many of the community-based efforts. They can draw from a group of volunteers and leaders, and they often have experience in organizing neighborhood residents. Two of the established community organizations in Detroit—REACH, Inc., and the Ravendale Community Program—can serve to illustrate how such efforts get started and the challenges they face.

REACH, Inc. (Reach Everyone, Administer Care and Hope), grew out of the housing reclamation program of the Twelfth Street Baptist Church. In 1981, when a man was murdered on the street outside the
church, a local minister became determined to eliminate drug trafficking in the neighborhood. Since the most evident feature of the neighborhood facilitating drug sales was abandoned housing, the church decided that the most direct way to eliminate crack houses was to buy vacant buildings, renovate them, and sell them to local families. The goal of the program was to reduce open drug sales and violence; the strategy was to build residents' investment in the neighborhood through redevelopment and home ownership. The renovations were managed by the church, with local building contractors supervising and training residents (including ex-addicts and ex-dealers) in the building trades. Many of those trained in this program have since secured jobs outside the project.

REACH has expanded its services to provide a food distribution program for community elders and a summer recreation program for youth. With the support of REACH staff, the residents in the surrounding neighborhood organized a citizens' group to combat neighborhood drug sales in 1988. Called WePROS (We the People Reclaim Our Streets), this group has encouraged the organization of citizens' groups elsewhere in the city and has helped foster cooperation among groups.

The initial priorities of the Ravendale Community Program were to bring minority leadership back into the neighborhood through an “adopt-a-block approach” to community development. To assess the concerns of area residents, the group conducted a needs assessment and organized 31 block clubs in the neighborhood, the captains of which meet monthly.

After-school programs and summer camps were set up for latchkey children. Ravendale has worked with the Detroit Police Department, the prosecutor's office, the Detroit Health Department, public utility companies, and local businesses to discourage drug selling in the neighborhood. These institutions have assisted by tracking down crack-house landlords for notification of code violations, conducting arrest sweeps against open drug sales, and restricting area parking in order to reduce the traffic congestion caused by drug markets.

While REACH and Ravendale started differently, their structures and arrays of activities have tended to converge. Both have stimulated citizens' groups that march against open drug sales. Both sponsor (or are seeking funds for) youth recreation programs, counseling, and mentor programs for high-risk youth. Both have tried to serve local drug users—REACH through the organization of a Narcotics Anonymous program and job training, and Ravendale by attempting to establish a halfway house for recovering addicts.
Another example of urban communities organizing themselves, this time with the help of elected officials as well as church leaders, is provided by campaigns to reduce exposure to tobacco and alcohol advertising aimed specifically at minorities and young people. Wayne County Commissioner Alberta Tinsley-Williams has led such a campaign for several years in her district. As noted in Sec. 2, the health burden caused by tobacco and alcohol use is especially severe for the urban poor. Fighting back against outdoor commercial promotion of these pathogens is thus especially appropriate for this group. There is less clarity of purpose and public consensus surrounding tobacco and alcohol policy, however, since promotion of legal products can be construed as constitutionally protected speech, and the advertising revenue is important for many publications and marketing businesses. But by adding legal drugs to the target list, this movement has brought attention, including much media coverage, to the public health issues, rather than to just the narrow concern of keeping the lid on the violence of illegal drug markets.

The Suburbs. Many of the suburban groups have been organized around specific problems, such as the increased risk of traffic accidents caused by alcohol consumption. While their roles have expanded over the years, Mothers Against Drunk Driving (MADD) and its SADD offshoot have put their emphasis on two issues. The first is a concern for the threat to public safety that drunk drivers represent, reflected in campaigns to stiffen laws against driving while impaired and to encourage tougher enforcement of existing laws. The second is discouragement of adolescent drinking-and-driving through the use of behavioral contracts between parents and children, sponsorship of social events free of alcohol and drugs, and calls for tougher enforcement of minimum-age-of-purchase laws.

Another type of community organization in the suburbs is represented by the Families in Action movement, which aims to prevent alcohol and drug consumption among adolescents. These groups involve parents by providing education on adolescent substance abuse and the influence of parental attitudes and behaviors on the attitudes and behaviors of children. The West Bloomfield Hills Families in Action group, for example, works with several schools in an effort to enlist parent volunteers in an “adopt a school” program to support school-based prevention programs. Families in Action programs have targeted familial sources of adolescent risk by providing training in family communication and cooperative activities for parents and children. Groups are active in many Detroit metropolitan area communities, particularly in Oakland County.
Media Campaigns

Several of the CAs provide funding for media campaigns. Some of these campaigns are aimed at special groups (e.g., graduating seniors, pregnant women); others seek to reach a wider population of adolescents and adults.

Media campaigns in the Detroit metropolitan area (as elsewhere in recent years) have evolved beyond reliance on the isolated public service announcements that used to typify such efforts. Several have been coordinated with school- or community-based prevention programs. For example, a local public television station, WTVS/Channel 56, has broadcast programs linked to Project Graduation events for high school seniors in the entire region. The station receives funding from OSAS as well as from foundations. “Club Connect,” a show for teenagers, provides anti-drinking-and-driving and other prevention messages around the time of high school graduation and other special events, such as proms. Programs include a health-talk segment, a career/at-work segment in which teen reporters interview successful professional role models, a straight-talk segment to give students an opportunity to discuss issues of interest to them (e.g., mandatory drug testing, school dress codes), and information about community programs and services available to teens (e.g., crisis hotlines).

The Michigan Department of Public Health has hired an agency to develop a series of statewide television spots infused with antidrug (including antitobacco) messages. The state currently funds a series of twelve regional media campaigns for substance abuse prevention. There is also some media coverage of prevention events during the statewide Substance Abuse Awareness Month.

Grant Programs, Linking Institutions, and Technical Assistance

Several nonprofit organizations provide technical assistance and encourage the formation of networks among groups working in prevention. These serve a linking function that can be useful in such a diffuse field.

The Prevention Network was established in 1984 with funding from OSAS and the United Way to provide community groups with technical assistance in community organization, fund raising, access to prevention materials, and networking. It publishes a monthly newsletter that summarizes research results, lists funding sources, describes model projects, and documents legislative developments. It also
maintains referral hotlines and sponsors regional conferences for information sharing and training.

The Prevention Network minigrant program awards volunteer groups amounts of up to $500 to conduct very small scale primary prevention projects. During FY 1989, the Prevention Network awarded slightly more than $30,000 to support 63 community projects statewide, about a third of which were in the Detroit metropolitan area. Recipients have included theatrical productions with prevention messages; public education campaigns; the producers of prevention training materials; training and workshops for students, parents, and families; alternative activities that encourage drug-free life-styles; Project Graduation; and community meetings.

New Detroit, Inc., has sponsored a minigrant program for seven years. Since 1987, it has been funded by GIGs. In FY 1990, New Detroit made small grants totaling $50,000 to twelve programs ranging from community education and empowerment to youth mentoring. For FY 1991, New Detroit received a GIG of $42,000 to support this program. New Detroit is now expanding its role in technical assistance and requiring grant recipients to conduct process evaluations.

Under a new small- to medium-sized grant initiative, The Skillman Foundation awarded a total of $470,500 to 28 organizations in 1990 and the first five months of 1991. Skillman funded a wide variety of activities—e.g., a Partners in Prevention program at Common Ground, a Smart Moves program at the Boys and Girls Club of Pontiac, WePROS activities through core city neighborhoods, and the DARE program of the Detroit Police Department. Skillman's initiative in prevention encourages submissions that "build, improve or incorporate partnerships among a community's organizations and leaders" and "coordinate networks and share information among community organizations involved in substance abuse prevention." The initiative stimulated prevention proposals from traditional youth, social service, and recreation organizations.

Skillman has also made larger grants for substance abuse prevention as a part of its regular Children and Youth programming. Again, a wide range of activities was funded—e.g., organization of a statewide peer leadership program on drug and alcohol prevention at the middle school level (similar to the SADD programs), a program for children and siblings of adolescents and adults in residential treatment for substance abuse to prevent further substance abuse, and a comprehensive school district substance abuse prevention program in the Waterford School District.
The Community Foundation of Southeastern Michigan initiated a substance abuse prevention program by sponsoring a Think Tank for Action on Substance Abuse Prevention in Southeastern Michigan to develop a range of strategies for prevention in the region. Organized and administered by faculty of the University of Michigan’s School of Public Health, the Think Tank was an assembly of community leaders, researchers, and prevention experts. Its findings have been distributed in the form of a resource manual for prevention (Resource for Public Health Policy, 1990a) and the proceedings from a May 1990 regional conference (Resource for Public Health Policy, 1990b). The Community Foundation disbursed $400,000 in grants in 1990 and 1991 as part of an effort to encourage nonprofit organizations and local government agencies to engage in long-term, comprehensive approaches to substance abuse prevention. Awards ranged from $25,000 to $50,000 for use over one to three years.

Local community groups have also received small grants from such service agencies as the Junior League, the Michigan Council of the Arts, the Detroit Council of the Arts, and the Black United Fund. Those receiving the grants have included the city of Detroit’s Neighborhood Opportunity Fund, as well as the state and federal programs discussed above.

In 1990, the Prevention Coalition of Southeast Michigan (PREVCO) was organized as a regional resource for substance abuse prevention. Composed of individual activists and representatives of CAs, school districts, criminal justice agencies, human service agencies, business, the media, and community groups, PREVCO is intended to serve as a forum for discussion, strategic planning, and coordination of regional media campaigns, as well as a prevention information clearinghouse. Recently, four of the five CAs represented in PREVCO voted informally to appropriate nearly $50,000 for PREVCO’s efforts to coordinate regional media messages.

Project EPIC, established in 1985 by the Department of Community Medicine at Wayne State University with funding from the Detroit Health Department’s Bureau of Substance Abuse, also provides technical assistance to community groups in the city of Detroit. EPIC consultants provide assistance in community organization, fund raising, grant writing, and program evaluation. EPIC sponsored a series of workshops in 1990 on needs assessment, program development, and program evaluation.

Besides these institutions, there is some coordination among community groups within townships or cities and across neighboring jurisdictions. A community coalition in Romulus sponsored by that city’s
mayor has been active for two years, and its members have helped develop a similar group in neighboring Taylor.

ASSESSMENT

Is Prevention Possible?

It is impossible to draw definite conclusions about the effects of community efforts on drug use in the specific populations they target or on general attitudes toward drug use. Part of the reason for this inability is that few evaluations have been done of programs such as the ones started in the Detroit metropolitan area. In the past, not many resources were devoted to evaluating prevention programs; most research dealt with discrete media campaigns against smoking or driving while impaired. The lack of clear information on program effectiveness is also caused by the inherent difficulties of controlled research on diffuse, multifaceted, and decentralized activities. Organizations and neighborhoods have mobilized in many different ways against drug problems in their various forms. Often it is hard to specify exactly who the target audience is and how to define or measure success. As one OSAP monograph pointed out, “Efforts to mobilize whole communities to prevent AOD [alcohol and other drug] use cannot be studied in the same way as efforts to target particular grade levels in particular schools” (OSAP, 1989, p. 24).

Community prevention is not a discrete intervention, or even a package of separable interventions, whose short- and long-term effects can be studied in isolation. One official of the National Association of State Alcohol and Drug Directors has expressed the problem well in saying that “prevention is not a service you deliver; it’s a movement you support.”

There is a role for more evaluative research and for technical advisers (discussed below), but the primary task for policy makers is to check on the health of the “movement” and to support that movement with funds, information, and advice, rather than to control and direct a set of standardized programs.

The benefits of community-based prevention activities may be diffuse and measurable only in the long term, again making it hard to measure direct results, adjust programs, and allocate resources in the short term. These activities partly express and partly create the environment of public opinion in which focused programs (such as school prevention programs or, in many areas, law enforcement) operate.

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Christopher L. Faegre, personal communication.
Long-term trends in tobacco use point both to the possibilities of change in addictive behaviors and to the difficulty in ascribing change to any one cause. The federal government has limited its role in the issue of smoking mainly to sponsoring research and publicizing the results through Surgeon General reports, and most states and localities have laws prohibiting tobacco sales to minors, but enforcement of these laws has always been lax. Yet smoking rates fell dramatically in the 1970s and 1980s. The fall was most rapid for white male adults, but in every age, race, and sex category of the American population except women over age 65, the percentage of current smokers was considerably smaller in 1987 than in 1965. The decline was greatest (and current rates are lowest) for persons with higher education, but percentages of current smokers declined between 1974 and 1987 for every sex, race, and education category except white women with less than 12 years of schooling (DHHS, 1990, Tables 53 and 54). The prevalence of smoking is still discouragingly high, but the pervasive decline in the use of such a freely available product, to which most users become addicted, is a powerful testimony to the potential for changing behavior.

Smoking rates for young people as a whole fell rapidly in the 1970s and then leveled off during the 1980s. But within the context of clear public disapproval of smoking, primary prevention programs telling young people how to resist immediate pressures to use tobacco appear to have been reasonably successful (Ellickson, forthcoming). In contrast, the use of alcohol, about which there is no comparably simple public consensus, has not declined at all among young people. And school-based prevention programs have had little success in reducing or delaying alcohol use, in contrast to the success seen in reducing tobacco and marijuana use. Ellickson and Bell (1990) ascribe this failure to the ambivalence in the messages about alcohol use received from the larger society.

These examples point both to the possibility of success in changing drug use and to the importance of reinforcing the sense that society (not just some parts of it, or the authorities) disapproves of the use of certain substances.

**Deciding Which Activities to Support**

As discussed in Sec. 3, school-based prevention programs can be classified fairly readily by the dominant approach they use: information only, values clarification, or resistance skill training. School officials can evaluate curricula based on written materials, training manuals,
and the like, and can usually tell which broad approach is the basis for a proposed program.

These approaches also apply to certain types of community prevention activities. Advertising aimed at adolescents, for example, often uses the results of market research that is similar to research conducted on school programs. One still sees messages that use scare tactics that seem to glamorize drug use inadvertently, but messages increasingly match the school programs in how they handle near-term social and health consequences and in their provision of specific examples of how to resist pressures to use addictive substances.

In general, though, the professional-evaluation literature provides much less guidance for community prevention activities than for school-based prevention activities. Community prevention activities are diffuse and, below a very general level of classification (community organization, alternative activities for youth, mentoring, and the like) sound much the same. Nor are there distinct generations of programs: many current activities are similar to those of delinquency prevention and community organization in the 1960s or of the even earlier, settlement house movement.

Nonetheless, within a broad range of community prevention activities, the most important issue is probably not which activities to support, but which groups and organizations to support.

The REACH and Ravendale programs described earlier evolved and added elements as needed, rather than merely replicating a package that had been tried elsewhere. There should be a greater effort to evaluate community-based prevention, as we discuss below, but there is not yet anything close to a formula that can be recommended in all situations. CAs and other funders and providers of technical assistance would do better to support organizations that can convincingly show their ability to work in a particular community, rather than look for a program description conforming to current, rather vague guidelines for “best practice.”

Our counsel is not one of despair, as the allusions to community organization in the 1960s might suggest. One important difference is the political climate within which community-based prevention has to work. There is little fundamental disagreement about the goals of substance abuse prevention, at least as they pertain to illegal drugs. The War on Poverty programs in the 1960s and 1970s that produced direct grants from the federal government and national foundations to community groups ran afoul of the local government and political leaders, against whom much of the community organization was di-
rected. Partly because black officials now control urban government in much of the country, and the religious leaders and community organizers are often their allies, this source of antagonism and suspicion has likely diminished. No doubt because of the painful lessons of the War on Poverty, both OSAP and national foundations now emphasize the need for community partnership in their programs—i.e., evidence that the active cooperation of everyone important has been secured before a grant is made.

Risk Factors to Address

Research on the causes of drug abuse does not converge on clear-cut recommendations for program design. Ellickson (forthcoming) provides a concise review of what is known about antecedents, particularly those of gateway drug use. Much of this research has focused on personality characteristics: rebelliousness and lack of religious belief and practice have been found to be precursors for alcohol and drug use, as well as for other deviant behaviors. Evidence of the importance of other personality characteristics, such as low self-esteem and alienation, and early childhood factors such as parenting style or parental separation is more equivocal. Emotional distress and depression appear to be more important as predictors of problem use and hard-drug use than as predictors of initial use. However, Ellickson (1991, pp. 12–13) argues that “exposure to pro-drug social influences (others who use drugs or approve of doing so) is consistently among the most important factors predicting initial and continued substance use. . . . Parents and peers are the dominant role models for initial use, although siblings and media images enter in as well.”

Do community prevention programs such as those discussed above have an effect on these antecedents of drug use? One way they can have an effect is by making the common disapproval of drug use visible. Many different types of activities could serve this purpose, especially if participants and supporters are seen to be members of the relevant community. The broadcast and print media could be important not just as distant sources of exhortation, but as publicity vehicles for those taking action against drug and alcohol problems.

Given the importance of parental attitudes and examples, the many existing activities that try to involve and support parents are likely to be valuable. There is some research evidence that family skills training has led to improvements in children’s problem behaviors and reported intentions to reject alcohol and other drug use (OSAP, 1989, p. 27). Many of the youths at risk do not live in two-parent families,
so programs such as those of REACH and the Urban League that link youths with mentors who can provide adult direction would help create the right kind of immediate social environment. The Bureau of Substance Abuse Services in the Detroit Health Department has made family skills training a major part of its prevention funding in recent years, with programs reaching the high-risk population through jails, treatment programs, and maternal and child health clinics.

Activities that create for children an immediate environment in which there is clear disapproval of drug and alcohol use are also likely to be useful. Many such activities—the basketball leagues of REACH, the drug-free social events of student groups in the suburbs, etc.—may sound old-fashioned, but their importance to prevention is attested to by the modern and secular language of social research. The focus must be on the immediate social environment of the child. If he or she is in an environment that promotes drug and alcohol use, we must create an alternative environment that does not do so and that can attract children who are at risk.

Adequacy of Public Funding

At every level of government, prevention has suffered in resource allocation in terms of both programs and research. The reason may be that prevention aims at long-term goals for a diffuse group of beneficiaries rather than the immediate needs of an identifiable constituency.

Health, social service, and criminal justice agencies have all devoted resources to prevention efforts (broadly construed), but substance abuse prevention has never been their core task. When budgets are tight, as they will be increasingly in the next few years, agencies tend to concentrate on doing their core tasks. Prevention thus could be slighted, unless community groups and elected officials demand that it be given a higher priority. As part of the current effort by Michigan’s governor to “downsize” state government, OSAS may lose some of its autonomy, and the administration of prevention programs may be separated from that of treatment programs and transferred to other parts of Michigan’s Department of Public Health. There is no way to tell whether prevention will gain or lose in political and administrative salience as a result, but the prospects for funding major new initiatives are bleak.

For the time being, OSAS has helped ensure more funding for local prevention programs by requiring the CAs to spend a proportion of
OSAS's contract funds. (In the past, federal requirements for prevention spending were met solely through statewide programs.) For the CAs to exercise a real role in assisting prevention programs, creating networks, and monitoring activities, they need at least the level of resources that would allow one or two full-time professionals to work on prevention. Some of the CAs have only recently, and barely, met this criterion.

Michigan's share of federal block grant funds for substance abuse treatment and prevention has risen slightly in recent years because of a change in the federal allocation formulas: urban populations are now more heavily weighted than they were in the past. But the Detroit metropolitan area did not fare well in the competitive grant programs set up by the 1986 and 1988 Anti-Drug Abuse acts until 1990, when some applications to OSAP proved successful. A major problem seems to be the quality of the proposals. Several federal officials to whom we spoke complained about that aspect of the proposals received from various Detroit area agencies, and these complaints were echoed by the officials of public and private agencies in Detroit itself. Local resources are very limited, and federal categorical programs (drugs in public housing, treatment improvement, community partnerships, etc.) constitute an essential source of funding for large-scale implementation of many of the activities discussed earlier. Both public and private agencies should make a greater effort to coordinate proposal efforts and to enlist the aid of local universities in presenting responsive, high-quality proposals.

If prevention is to be given new emphasis within drug policy, a good deal of advocacy will be required. Given the current state of knowledge on prevention, the message of this advocacy cannot be much more than, We should sustain many of the new efforts and see over time which ones appear to work. This message may sound weak, but proponents of new law enforcement solutions to drug problems—on which expenditures at every level of government are higher than those for prevention—have no stronger a basis for their initiatives (see discussion in Sec. 6).

**Needs of Community Organizations**

Some of the community organizations now active in prevention have a solid base and could serve as models and even sources of technical assistance for efforts in new neighborhoods. Others appear more fragile. Most rely heavily on volunteers; many are fairly small in scale but incorporate a wide variety of activities. All have the advantage that they are locally conceived and managed rather than being crea-
tures of a distant bureaucracy. Such local ownership is crucial if volunteers and part-timers are to maintain their interest and involvement. But a crucial test will come for these efforts in the next few years, as the sense of urgency surrounding the cocaine epidemic continues to diminish. The task for prevention activists will be to sustain the worthwhile efforts in spite of waning enthusiasm and concern.

For many of these efforts, the funding requirements are not large, often not reaching the minimum efficient grant level of the large foundations and federal agencies. But community organizations and church groups undertaking prevention activities for the first time may need help in making contacts with other groups, generating or copying ideas, and mobilizing available resources. The sense of urgency that motivates many actions can dissipate when the search for funding is difficult and long. According to Project EPIC staff, receiving even a small grant can be encouraging and can enhance a group's sense of efficacy.

The goals of community-based organizations and the approaches preferred by professionals sometimes do not match. Community-based organizations typically focus on resolving immediate, short-term problems, whereas professionals typically call for system- and community-wide approaches that are beyond the purview of small organizations and place great demands on the ability to coordinate. Inner-city community groups are often mainly concerned with the violence and neighborhood disorder associated with the drug market. Similarly, MADD members are most directly concerned with preventing drinking-and-driving, an immediate threat to their neighborhoods and children. Community groups with more diffuse or long-term targets, such as Families in Action, have had more difficulty eliciting the active involvement of parents and have spread more slowly than groups aimed specifically at drinking-and-driving.

Restoring public order is clearly a high priority for residents of neighborhoods where open drug sales are common. But remarkably little outside funding, technical assistance, and help with evaluation has gone to organizations dealing with this problem.

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4For example, consider the definition of community-wide prevention given by an OSAP official: “The systematic application of prevention strategies throughout the community in a sustained, highly integrated approach that simultaneously targets and involves diverse social systems such as families, schools, workplaces, media, governmental institutions, and community organizations” (Benard, 1989, p. 126).
At the national level, OSAP sponsors learning conferences for grantees, publishes a monograph series that summarizes the conventional prevention wisdom, and provides an information clearinghouse service. In the Detroit metropolitan area, as well, funding agencies need to help stimulate and shape proposals and create networks of grantees, rather than just choose among proposals already "on the shelf." New Detroit, Inc., has increased its technical assistance efforts and has required grantees to attend information-sharing and networking meetings. The Community Foundation held briefing sessions for prospective grantees in June 1990 in which Think Tank recommendations were discussed. Such efforts are important if prevention expertise is to be made available to groups newly involved in prevention activities.

Needs of Social Service Agencies

Social service agencies, broadly defined to include private organizations working with youth, can play an important role in substance abuse prevention. First, they come into contact with many substance abusers' children, who are at high risk of early and serious substance abuse. A study by the National Black Child Development Institute, for example, found that over half the placements of black children in foster care in the city of Detroit were because of alcohol or other drug abuse by parents (NBCDI, 1989, Table 5). Similarly, an official of the Wayne County Catholic Social Services, dealing with a mixed-race and multiethnic population, told us in an interview that a large proportion of their child and adolescent clients have parents with severe alcohol or drug problems. Recreation and youth service programs come into contact with a broad range of young people rather than a well-defined target group, but they do reach many who may not have strong ties to institutions such as schools and churches. Moreover, the social service and youth agencies have many of the same advantages as churches in terms of being foci for prevention: neighborhood coverage, professional staff, and committed volunteers.

Agencies working with high-risk youth are especially suited for early intervention with young children and secondary prevention programs for troubled teenagers—types of programs not incorporated into, or only weakly connected to, the school curricula that dominate the prevention field. Programs treating adults for alcohol and other drug problems sometimes also have adjunct programs for their clients' children. Such programs require skilled counselors and a good deal of specialized training in identifying and assessing problems. To our knowledge, there have been no studies specifically comparing the
costs and effectiveness of programs that target specific groups to those of programs pursuing the more diffuse primary prevention activities. But the promise held by these programs and the needs of the groups they address are sufficient for justifying more experimentation and evaluation.

For traditional youth organizations reaching broader groups, such as the Boys' and Girls' clubs, the Scouts, and the YMCA and YWCA, the organization's national level often works out programs that can provide materials, training for local staff and volunteers, feedback, and linkages to other programs. That is, the national level of the organization serves many of the functions that CAs or local contractors such as Project EPIC have to serve for grass-roots community groups. The Skillman Foundation has made grants in recent years to Boys' and Girls' clubs and similar youth organizations in the Detroit metropolitan area for local program implementation.

**Network Creation**

The institutions creating networks and spreading information about local activities are likely to be important in sustaining community interest in prevention in the coming years. Many of the voluntary agencies that have recently become involved in prevention and the community organizations engaged in a wide range of activities do not have large enough staffs to include prevention professionals. To keep these groups in touch with the prevention "movement" requires some help from outside.

Encouraging networking among grass-roots groups has been a priority for Project EPIC, partly because of the limits on funding for prevention work. Many of the individuals and groups that approach EPIC do so not for assistance in designing a prevention activity, but for help in identifying funding sources and completing grant applications. Members of community organizations often express frustration at proposal and reporting requirements. It would be unrealistic to wish away the paperwork requirements; they may be more complicated or onerous than is strictly necessary, but they exist in large part to provide accountability in the spending of public money.

Many programs are operating on a very limited basis, funded out of the pockets of volunteer program staff or by small donations from local residents and businesses. Networking would be particularly valuable to groups with limited experience in organization and fund raising. One advantage of the formation of networks could be the
pooling of resources, including cooperation on grant proposals, by small groups proposing similar activities.

**Media Campaigns**

Until recently, research on the effectiveness of mass media campaigns generally concluded that media spots by themselves do not typically lead to behavioral change. Many times, the problem was simply "lack of reach." Public service announcements were not seen or heard by many members of the targeted audiences, because the time donated for such messages is often the least valuable. More recently, however, surveys undertaken for the Partnerships for a Drug-Free America have shown significant effects for their series of advertisements in the prime-time broadcasting and print media. Both adults and children were more likely to have antidrug views in cities where the campaign was high intensity rather than low intensity. More important, marijuana use decreased more in the high-intensity than the low-intensity cities. This lesson has been taken to heart for a series of television spots developed for Michigan's Department of Public Health. These spots also use many of the approaches that have proven effective in school-based prevention research, such as focusing on the near-term negative consequences of tobacco, alcohol, and drug use rather than the more remote threats.

Several studies show that media campaigns can reinforce person-to-person messages—for example, those delivered through school programs (Flay, 1986). The connections that Detroit Educational Television has made between television programming and events for adolescents are likely to make the messages more effective. Flay and others have also pointed out the usefulness of coordinating messages (including the timing of delivery) across different media. This area is one for which coordination across jurisdictions in the metropolitan area is especially appropriate, since the market areas reached by the electronic and print media typically cross political boundaries. It is the objective of both PREVCO and the Prevention Network to foster this type of campaign coordination, but similar efforts have only recently begun in the Detroit metropolitan area.

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6See Bettinghaus (1986) for a review of this subject.

6James Berk, personal communication.
Research and Evaluation

Calling for more funding for community-based prevention still requires a leap of faith. The field has not received the same research scrutiny as have the fields of treatment and school-based prevention (Botvin, 1990). Increased funding from both public- and private-sector agencies should be accompanied by an increased effort to evaluate, as well as foster, the activities that look sustainable and effective. OSAP has recently begun to support the dissemination of prevention research findings in accessible forms (e.g., regional conferences, prevention monographs), but these often contain more exhortation than hard evidence about workable programs.

The lack of evidence is partially a result of the low levels of government funding in the past. Since rigorous evaluations can be expensive, and they benefit more than just one funding organization or even one local government agency, the natural funders for such research are state and, particularly, federal agencies. This research can be done locally in the Detroit metropolitan area, of course, perhaps best through partnerships between CAs and universities or research institutes. Because OSAP and a few national foundations (notably the Robert Wood Johnson and Conrad Hilton foundations) have recently begun to increase funding for prevention program evaluation, there should be a better basis for decision making in coming years. The staffs of CAs and the private linking institutions are best suited to distilling the results of evaluations in other parts of the country for use in local policy.

The lack of knowledge on what works is also partly the result of the complexity of community prevention activities and the long time horizon for results. To limit funding only to programs or elements of programs that have been shown effective in outcome evaluations would be too cautious a strategy for funders at this stage. And to require vigorous outcome evaluations of all funded programs would be infeasible.

What should be done to help eliminate the current state of uncertainty is to develop intermediate forms of evaluation using data generated for larger research projects or even for administrative reports. For example, local organizations could be assisted in using crime reports or DAWN ER reports to monitor apparent success in their areas (perhaps compared to otherwise similar parts of the Detroit metropolitan area). The types of data potentially available for these efforts include all those analyzed earlier, in Sec. 2 (none of which were specially generated for this project). Such data should be interpreted with a good deal of caution, since none are generated specifi-
cally for measuring drug problems in small areas. Confidentiality problems limit release of DAWN counts from individual hospitals. OSAS and university-based researchers would likely be able to advise funders and implementing organizations on how to increase the usefulness of evaluations, including those that are less than full-scale outcome evaluations.

Summary

Prevention, especially outside the schools, has traditionally been a low priority for public spending at all levels of government, both for programs and for research. Until recently, CA expenditures and staffing were below the critical minimum required to maintain continuity and learn from experience. The danger now is that momentum from the efforts of the past few years, both private and public, will be lost as drug problems in general become a lower priority on the national agenda. The recent growth of interest by private funders in the drug prevention field should be treated as a way to stimulate experimentation, not as a substitute for already scarce public funding. It is unlikely that foundation and charitable funding for substance abuse prevention will reach anywhere near the levels of school district and CA funding. The truly private funding sources have to be regarded as a catalyst for experimentation with new approaches and a useful supplement to, rather than substitute for, public expenditures.

Diversity and local experimentation should be encouraged, simply because there is no single proven model for how to prevent substance abuse in the community. We argue that in the absence of a formula for community prevention, the important criteria for funders to assess are (1) a group's record of working successfully on social issues in the target neighborhoods and (2) its evidence of local support and involvement. Churches and service agencies with youth programs are likely candidates. A good deal of local knowledge is required to identify groups or agencies that have effective programs to which prevention activities can be added. The CA staff and other prevention professionals are probably in the best position to identify candidates, stimulate proposals, and monitor progress. Outside institutions will be needed to help sustain such groups, not only with money but with technical assistance, but an effort must be made not to stifle the sense of local response to shared problems.

One of the difficulties is that the local groups that have arisen, or that have taken on the tasks of community prevention, are usually not experienced in dealing with large-scale funders (government agencies, national foundations). The migrant programs are a particularly
useful way to provide funds and other assistance to such community groups.

The CA prevention coordinators and professional staff of the larger agencies can promote contact among groups, serve as the transmitters of institutional memory about what has worked locally in prevention, and provide advice to community groups. There should be more emphasis on evaluation and on learning from experience in community prevention. Otherwise, much of what is being learned from the current generation of programs could be lost when their progenitors move on to other issues.
5. TREATMENT

Treatment offers the promise not only of relieving the suffering of drug-dependent persons and their families, but also of reducing the demand for illegal drugs and thus helping to control the social problems caused by drug use and drug selling. But treatment for drug use is not a simple, standardized, one-time-only procedure. To deal with the drug use problems described in Sec. 2, the treatment system requires both selective expansion and reforms, including more targeting of specific groups, to improve the effectiveness of its services.

BACKGROUND

The process of recovery proves slow and uncertain for most people dependent on drugs. It entails changing ingrained behaviors and dealing with the medical, psychological, and economic problems that underlie and are worsened by drug use. Often the dependent person's mental life, friendships, and daily routine have all been built around drug use.

Treatment options range from occasional counseling sessions to round-the-clock, highly structured residential programs. The research on how different types of treatment affect client outcomes has advanced, but the assignment of clients to treatments is still more an art than a science. It is thus understandable that many people receive lengthier or more expensive treatment than is justified by the benefits they derive from it, while others receive no treatment or less intensive or complete treatment than is they need. Both situations, over- and undertreatment, are wasteful.

Two distinct mechanisms for financing drug treatment have grown up separately in the past two decades. One, the public drug treatment system, relies on direct funding rather than the public insurance programs (such as Medicare or Medicaid) typically used to finance other types of health care. The other mechanism is private health insurance.

Drug addiction is an old problem in the United States, but the current forms of drug treatment have existed for barely two decades. In the Detroit metropolitan area, the treatment system began in 1968 with a federally funded research program that provided methadone mainte-
nance to a few dozen heroin addicts. At that time, the heroin epidemic of the 1960s had hit the Detroit metropolitan area hard, and the waiting list for the pilot methadone program grew quickly. The city of Detroit’s health department took responsibility for expanding the program. As part of the Nixon administration’s War on Drugs, federal support was used to create a national network of drug treatment facilities, most of which, including those in the Detroit metropolitan area, relied on methadone maintenance.

Federal aid was originally provided directly to local programs, but since 1974 it has been channeled through “single state agencies” for drug and alcohol treatment and prevention. In Michigan, this agency is the Office of Substance Abuse Services (OSAS) in Michigan’s Department of Public Health. OSAS contracts with the eighteen regional coordinating agencies (CAs), four of which serve the Detroit metropolitan area. The CAs in turn contract with programs licensed by OSAS to provide treatment for alcohol and drug abuse.

The treatment system in the Detroit metropolitan area, as elsewhere, soon expanded to include long-term residential programs. The original models for these programs were “therapeutic communities” established in the late 1950s and the 1960s, which were opposed to the use of maintenance therapy, considering it merely a substitution of one addiction for another. They created a highly structured, self-contained environment for recovering addicts, who were required to work their way gradually to positions of responsibility. These and other residential programs traditionally have relied more on program graduates and other recovering addicts as staff members than have programs of other types.

Residential programs have diversified in recent years. Many now have typical lengths of stay much shorter than the 18-month minimum that characterized the original therapeutic communities. They

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1Sall and Moton (1974) provide a history of the early years of the drug treatment program in Detroit.

2As stated earlier, the four CAs in the metropolitan area are the City of Detroit Health Department; the Southeastern Michigan Substance Abuse Services (SEMSAS), which serves Wayne County outside the city of Detroit and Monroe County; the Macomb County Community Mental Health Services; and the Oakland County Health Department.

3Yablonsky (1989) discusses the evolution of therapeutic communities and current treatment issues.

4In a recent OSAS-sponsored study of a sample of Michigan programs, 38 percent of staff members of residential programs reported that they were themselves in recovery, compared to only 7 percent of staff members of outpatient programs (Stoffelmayer, DeVoe, and Mavis, 1989, p. 20).
are often more concerned with integrating their clients into the world outside than with the traditional emphasis on building an alternative social environment. But it is still true that the regimen in most such programs is demanding, and many clients drop out fairly early in the treatment process. The nationwide Treatment Outcomes Prospective Study found significant reductions in drug use and crime rates for clients of therapeutic communities who stayed at least three months, but more than half of the people admitted to the communities dropped out before that point (Hubbard et al., 1989).

The 1970s also saw an increase in the number of nonmethadone outpatient treatment programs. These were designed partly to reach a larger population at lower costs and partly to make it easier for clients to stay in or reenter the larger community while maintaining a drug-free life-style. Outpatient programs are very diverse, involving a wide variety of institutions and counselors with very different backgrounds, training, and therapeutic orientations.

Self-help programs relying on the “Twelve Steps” of Alcoholics Anonymous (AA) are not usually considered by participants or treatment providers as alternatives to formal treatment, but many programs and providers endorse the Twelve-Step approach, provide sites for meetings, and encourage clients to participate in groups after the end of their formal treatment. AA offshoots include groups specifically for certain categories of users—e.g., women, teens, and those using substances other than alcohol (Cocaine Anonymous, Narcotics Anonymous)—and for family members of substance abusers. These groups are well established in the Detroit metropolitan area; Narcotics Anonymous, for example, has a directory listing almost 300 meetings per week of groups in the three counties. The efficacy of these groups is difficult to establish through the usual methods of randomized assignment and comparison groups, largely because the AA philosophy precludes cooperation with such research protocols. There is anecdotal evidence that the Twelve-Step approach helps many participants maintain sobriety, and that many people credit AA with saving their lives, whereas other people have found AA to be of little use. The Twelve-Step groups are not in any way a substitute for an effective system of public provision of drug abuse treatment, but

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5We follow the usage of the Institute of Medicine in referring to these programs as nonmethadone instead of drug free, since many of them use pharmacological treatments as adjuncts to other types of therapy. Antidepressant drugs are sometimes prescribed for cocaine addicts to reduce craving, and disulfiram is often prescribed as an alcohol antagonist. The FDA has not approved any pharmacological treatments for cocaine dependence equivalent to methadone therapy for heroin addiction.
they form part of a supportive environment for many treatment clients in the process of recovery.

More than 270 programs in the Detroit metropolitan area are now licensed by OSAS to provide drug treatment (see Table 8). Of these, only one-third receive state funding, and even they must often rely heavily on other funding sources as well. Private programs abound in the suburbs, especially in Oakland County. In the city of Detroit, by contrast, most programs receive some state funding.

Table 9 shows the licensed drug and alcohol treatment programs by types of services provided. More than 200 of the licensed programs in the Detroit metropolitan area provide services only on an outpatient basis. Sixty-two programs, either chemical dependency units of hospitals or free-standing facilities, provide residential treatment. Of these 62, most are licensed to provide outpatient services as well. Nine programs, most of which are in the city of Detroit, are licensed as methadone maintenance clinics for opiate addicts.

The research literature on the effectiveness of different types of treatment is inconclusive. Because clients have diverse needs (e.g.,

<table>
<thead>
<tr>
<th>Coordinating Agency</th>
<th>Licensed Programs</th>
<th>Number Receiving State Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Detroit</td>
<td>66</td>
<td>38</td>
</tr>
<tr>
<td>SEMSAS (rest of Wayne County, Monroe County)</td>
<td>82</td>
<td>24</td>
</tr>
<tr>
<td>Macomb County</td>
<td>44</td>
<td>12</td>
</tr>
<tr>
<td>Oakland County</td>
<td>80</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>272</td>
<td>90</td>
</tr>
</tbody>
</table>

NOTE: Programs providing only prevention and education or screening and assessment services are not included.

6Most licensed drug programs also obtain the separate license required for treatment of alcohol abuse.
7See Anglin and Hser (1990) and Office of Technology Assessment (1990) for good reviews of the literature on treatment effectiveness.
help with co-existing medical and psychological problems, housing and supervision, job and social skills training) and because no single treatment protocol has yet emerged as dominant, it is important to have a range of treatment options. The challenge to treatment agencies is to develop ways to assess client needs, assign clients to the right level of treatment, and follow up to ensure that clients do not simply disappear from the system.

COORDINATING AGENCIES AND PUBLIC FUNDING

The CAs contract with licensed programs to provide treatment. Most of the programs are operated by private agencies, though the largest network in the Detroit metropolitan area is operated by the city of Detroit's Neighborhood Services Department. OSAS contracts directly with a few treatment programs.

The number of admissions funded by the CAs for the Detroit metropolitan area stayed around 27,000 per year in the late 1980s (see Table 10). The city of Detroit accounted for 40 percent of the total number of publicly funded treatment admissions in the area. Of the four metropolitan area CAs, only the one for Oakland County reported a significant increase in admissions between 1986 and 1989. While the number of admissions remained stable in these years, there were notable changes in the primary drug of abuse listed upon admission (see Table 11). Alcohol still accounted for the largest number

Table 9
Licensed Drug Treatment Programs in Detroit Metropolitan Area by Type of Service, 1990

<table>
<thead>
<tr>
<th>Coordinating Agency</th>
<th>Outpatient</th>
<th>Inpatient or Residential</th>
<th>Methadone Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Detroit</td>
<td>36</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>SEMSAS (rest of Wayne County, Monroe County)</td>
<td>66</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Macomb County</td>
<td>34</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Oakland County</td>
<td>65</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>201</td>
<td>62</td>
<td>9</td>
</tr>
</tbody>
</table>

NOTE: Most residential and methadone programs are licensed for outpatient services as well.
Table 10
Admissions to Publicly Funded Substance Abuse Treatment Programs in Detroit Metropolitan Area, 1986 and 1989

<table>
<thead>
<tr>
<th>Coordinating Agency</th>
<th>Admissions 1986</th>
<th>Admissions 1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Detroit</td>
<td>12,023</td>
<td>11,028</td>
</tr>
<tr>
<td>SEMSAS (rest of Wayne County, Monroe County)</td>
<td>6,767</td>
<td>6,893</td>
</tr>
<tr>
<td>Macomb County</td>
<td>3,668</td>
<td>3,654</td>
</tr>
<tr>
<td>Oakland County</td>
<td>4,892</td>
<td>5,931</td>
</tr>
<tr>
<td>Total</td>
<td>27,350</td>
<td>27,506</td>
</tr>
</tbody>
</table>

SOURCE: OSAS tabulations.

Table 11
Admissions to Publicly Funded Substance Abuse Treatment Programs in Detroit Metropolitan Area by Primary Substance of Abuse, 1986 and 1989

<table>
<thead>
<tr>
<th>Primary Substance of Abuse</th>
<th>Admissions 1986</th>
<th>Admissions 1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>16,652</td>
<td>12,787</td>
</tr>
<tr>
<td>Opiates</td>
<td>3,846</td>
<td>2,625</td>
</tr>
<tr>
<td>Cocaines (Crack)</td>
<td>3,393 (0)</td>
<td>8,864 (3,454)</td>
</tr>
<tr>
<td>Other drugs</td>
<td>3,459</td>
<td>3,230</td>
</tr>
<tr>
<td>Total</td>
<td>27,350</td>
<td>27,506</td>
</tr>
</tbody>
</table>

SOURCE: OSAS tabulations.

of admissions, but that number fell from 16,652 (61 percent of all admissions) to 12,787 (46 percent) per year. The number of opiate admissions fell in the city of Detroit and for the metropolitan Detroit area as a whole. By contrast, the yearly number of admissions listing cocaine as the primary substance of abuse more than doubled, from 3393 (12 percent of all admissions) in 1986 to 8864 (33 percent) in 1989. In the city of Detroit, 49 percent of all admissions to state-funded programs listed cocaine as the primary substance of abuse.
Since the total number of admissions was constant during these years, it is possible that the increasing numbers of people treated in public programs for cocaine dependency "crowded out" people who needed treatment for alcohol or heroin dependency. Unfortunately, this possibility cannot be directly examined with the OSAS data. The population in need of treatment does not sort neatly into groups dependent on single substances. Clinicians in Detroit, as elsewhere, report that most of their clients for whom an illegal drug is listed as primary also have significant problems with alcohol, and many of those who show up for treatment for alcohol dependency have significant problems with drugs. The choice of a primary substance for admission records is somewhat arbitrary.

Those being admitted for treatment who reported alcohol or opiates as their primary drug of abuse tended to be older than those who reported cocaine. In 1989, the average age was 33 for alcohol admissions, 36 for opiates, and 29 for cocaine (OSAS data). In 1986, those reporting cocaine as their primary substance were less likely to have had previous treatment episodes than those reporting alcohol or other drugs as primary (see Table 12). This difference presumably reflected the fact that the cocaine users were younger than the users of alcohol and other drugs and had only recently reached the later stages of drug dependence. By 1989, however, this difference had disappeared; half of those admitted with cocaine as the primary substance of abuse had been in treatment before. To a large extent, then, the public

<table>
<thead>
<tr>
<th>Primary Substance of Abuse</th>
<th>Percentage of Admittes with One or More Prior Treatment Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1986</td>
</tr>
<tr>
<td>Alcohol</td>
<td>53</td>
</tr>
<tr>
<td>Opiates</td>
<td>70</td>
</tr>
<tr>
<td>Cocaine</td>
<td>37</td>
</tr>
<tr>
<td>Other drugs</td>
<td>25</td>
</tr>
<tr>
<td>Any drug</td>
<td>50</td>
</tr>
</tbody>
</table>

SOURCE: OSAS tabulations.
treatment system is dealing not with new clients, but with relapsers who have had previous contact with the system.

In FY 1989, OSAS provided about $15 million to the four CAs in the Detroit metropolitan area to finance drug and alcohol treatment. Just under half of the OSAS treatment budget was funded by grants from the federal government, and half was funded by state general monies. City and county funds added about another $1 million to this total.

In 1986, the federal government provided funds equal to only 29 percent of total OSAS expenditures for drug and alcohol treatment and prevention programs in Michigan. By FY 1989, after increased federal funding was authorized by the 1986 and 1988 Anti-Drug Abuse acts, the federal share had risen to 46 percent.8

The OSAS formula for allocating funds to CAs is based in part on the number of persons in families below the federal poverty threshold. The city of Detroit receives more on a per capita basis than the other jurisdictions in the area (see Table 13).

### Table 13

<table>
<thead>
<tr>
<th>Coordinating Agency</th>
<th>Treatment</th>
<th>Prevention</th>
<th>Total</th>
<th>Per Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Detroit</td>
<td>6,859,000</td>
<td>2,112,000</td>
<td>8,972,000</td>
<td>10.40</td>
</tr>
<tr>
<td>SEMSAS (rest of Wayne County, Monroe County)</td>
<td>4,408,000</td>
<td>391,000</td>
<td>4,799,000</td>
<td>4.40</td>
</tr>
<tr>
<td>Oakland County</td>
<td>1,700,000</td>
<td>704,000</td>
<td>2,404,000</td>
<td>2.70</td>
</tr>
<tr>
<td>Macomb County</td>
<td>1,942,000</td>
<td>256,000</td>
<td>2,198,000</td>
<td>3.60</td>
</tr>
<tr>
<td>Total</td>
<td>14,909,000</td>
<td>3,463,000</td>
<td>18,374,000</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** OSAS.

**NOTE:** The average for the rest of the state was $6.30 per resident.

---

8The Alcohol, Drug, and Mental Health Services block grant program was created in 1981 by consolidating ten related federal programs providing funds to state and local governments. The program was reauthorized and expanded as part of the Anti-Drug Abuse Act of 1988 (Public Law 100-690), which added an emergency alcohol and drug treatment block grant and a special grant for treatment of intravenous drug abusers.
The 1988 Anti-Drug Abuse Act also included a program to provide competitive “Waiting List Reduction” grants to treatment programs in large cities. A total of $140 million was appropriated in FY 1989 and FY 1990 for this program; no additional money was appropriated in FY 1991. The city of Detroit received a share of this money in the form of grants to two substance abuse treatment programs. In Detroit, as in other cities, these grants had only a limited effect because they provided only one year of funding and the programs could not hire additional full-time staff on the basis of a short-term, potentially renewable grant. The two Detroit grants were not renewed in FY 1991.

PRIVATE SOURCES OF FINANCING

The public system dominates discussions of drug control policy. But it is also important to look at trends in private funding for treatment, both to assess their implications for the future work load of the public system and to assess the applicability of changes in privately funded treatment and cost control to the reform of the public system.

As Table 8 (shown earlier) indicates, only a third of the licensed drug treatment programs in the Detroit metropolitan area receive state funds. Though we do not have private-fund data specific to the Detroit metropolitan area, it has been estimated that 42 percent of the nationwide funding for substance abuse treatment in 1989 came from private sources: 29 percent from insurance reimbursement, 11 percent from fees paid by clients or their families, and 2 percent from grants and donations (Butynski, Canova, and Reda, 1990, p. 8).

Insurance Coverage

Most health insurance is provided as a benefit of employment, with employers or unions paying part or all of the premiums. Besides traditional indemnity insurance, health maintenance organizations provide care to many consumers in the Detroit metropolitan area.

Michigan has one of the lowest percentages of uninsured residents under age 65 of any state, mainly because of the large proportion of the work force that is in manufacturing, the economic sector with the best employment-based insurance provisions.\(^9\) Only 8 percent of

\(^9\)At age 65, nearly everyone qualifies for Medicare coverage for hospital and physician costs for acute care. In Michigan, 73 percent of persons under age 65 have insurance provided by an employer or union, compared to 66 percent of persons nationwide (GAO, 1991a, Tables III.1 and III.8). Only 6 percent of Michigan’s manufac-
Michigan residents under age 65 lacked health insurance in 1988, compared with 15 percent nationwide (GAO, 1991a, Tables II.2 and III.1). Ten percent of Michigan’s under-65 population had coverage through the state’s Medicaid program, which covers some costs of substance abuse treatment.\textsuperscript{10} Even so, nearly 650,000 Michigan residents under age 65 lacked health insurance. The poor and the unemployed were overrepresented among the uninsured, as might be expected. And in Michigan, as in other states, the percentage of persons uninsured was highest in the 19 through 34 age group, the group for which drug abuse treatment is in greatest demand (GAO, 1991a, Table vii.1). The proportion of those who need treatment for substance abuse and lack private insurance, and thus must rely on publicly funded treatment, will grow, especially if the current economic recession is prolonged.

As the figures from the public system show (see Table 12), an increasing percentage of those now seeking treatment for cocaine dependency have had episodes of treatment before. This finding suggests that in the next few years, more and more of those who are dependent on cocaine will be exhausting the lifetime limits that many health insurance policies place on substance abuse coverage. More stringent limits on benefits, tighter utilization review, and increasing unemployment, especially in large companies with traditionally generous insurance, will all result in greater pressure on the public treatment system, which serves as the third-party funder of last resort.\textsuperscript{11}

State law requires that all health insurance policies sold in Michigan include coverage of “intermediate and outpatient” therapy for those dependent on alcohol or drugs, including detoxification, pharmacological treatments, and counseling.\textsuperscript{12} Policies were required to offer reimbursement up to at least $2258 in 1990. This amount would cover

curing workers lack insurance, compared with 10 percent of service workers and 14 percent of workers in agriculture and extractive industries.

\textsuperscript{10}This coverage may be limited sharply by new rules adopted in 1991 that are designed to control costs.

\textsuperscript{11}Collective bargaining agreements usually contain provisions for extension of health insurance benefits for varying periods after an employee has lost his or her job. Employees covered by collective bargaining in the automotive industry have better protection following involuntary separations than most workers. Federal law requires companies to keep insurance available at group rates for employees who lose their jobs involuntarily. But many workers not covered by collective bargaining lose their insurance benefits soon after losing a job, or allow policies to lapse when they must cover the share of premiums formerly paid by their employers.

\textsuperscript{12}The relevant state laws are Public Act 429 of 1980 (commercial insurance carriers), Public Act 232 of 1982 (Blue Cross/Blue Shield), and Public Act 354 of 1982 (health maintenance organizations).
the charges for most limited courses of outpatient therapy, but not all charges for most courses of treatment involving an inpatient stay.\textsuperscript{13} The state-mandated minimum would not buy much intensive treatment without a substantial contribution from the insured, but most plans cover considerably more than the minimum.

The "Big Three" automobile manufacturers' employees and their dependents constitute a large share of the market for private substance abuse treatment in Michigan. The terms of the auto workers' triennial contracts thus have a large effect on the demand for different types of private treatment. General Motors (GM) alone estimates that its health insurance covered about 660,000 "lives" in the Detroit area, for about 1 percent of whom a substance abuse rehabilitation claim was made in 1989.\textsuperscript{14} Alcohol has always been the substance most commonly abused by the working population—64 percent of the substance abuse claims for GM employees and dependents are for alcohol as the primary substance of abuse. Cocaine, in second place, accounts for 17 percent.

**Changing Benefits and Utilization Review**

Employers have been struggling to hold down the rising costs of health benefits, including the increasing share attributable to substance abuse treatment. Insurers and large employers have felt that there are many inappropriate hospitalizations, and that much care is ineffective because so many claims are either for detoxification without any form of continued follow-up treatment or for incomplete courses of treatment.

In 1985, GM and the United Auto Workers negotiated changes in substance abuse benefits. These included separating substance abuse from other mental health benefits and contracting with a third party to review claims, both of which are examples of a nationwide trend among large employers (Rogowski, 1991). GM contracted with Connecticut General Corporation to administer its substance abuse claims and with Family Service America (FSA) for utilization review. Now, after the first reimbursable treatment episode, all subsequent

\textsuperscript{13}The minimum benefit would cover a longer period of less intense outpatient treatment, of course. Michigan Blue Cross/Blue Shield currently reimburses outpatient drug and alcohol treatment at a rate of $45 per hour, so about 50 hours of such treatment would be covered. The rate of $45 per hour has been criticized as unrealistically low for providers, however.

\textsuperscript{14}GM paid claims for under 7000 admissions to rehabilitation programs in 1989. GM also paid claims for just over 7000 admissions to detoxification in that year, many of which were followed by admissions to rehabilitation.
episodes require prior approval by FSA. Since 1987, even for the first detoxification episode, the client's treatment plan must be approved by Connecticut General before the client is discharged to a rehabilitation program. Employees are liable for a large payment if they do not complete a course of treatment and cannot provide a reason for dropping out that satisfies the Employee Assistance Program (EAP).\textsuperscript{15} Similar utilization review plans have been instituted by other large companies nationwide.

There have been reports that stricter scrutiny has reversed the growth of spending on substance abuse treatment. Chrysler reported a 38 percent decrease in its costs for substance abuse claims between 1988 and 1989, mainly as a result of a decline in the average length of stay rather than a lower number of admissions. According to treatment providers, the effects of benefit changes and utilization review have been to reduce the number of people referred to chemical dependency units and free-standing residential programs and to increase the number referred to 14-day "intensive outpatient" programs.

These cost containment efforts by insurers and employers are likely to continue. In interviews with EAP professionals, we were told that some of the cost savings in the first few years of utilization review were relatively easy—for example, those realized by disallowing referrals to expensive out-of-state chemical dependency programs when comparable, cheaper programs were available nearby. But practice and referral patterns have probably adapted by now to the more careful scrutiny of third-party payers. Efforts to hold costs down in the coming years may involve more frequent conflict between utilization reviewers and providers over individual cases.\textsuperscript{16}

According to some of the CA officials and providers we interviewed, the effects of cost containment can already be felt in programs providing treatment to poor and lower-middle-class clients. Reimbursement rates for insured clients are no longer high enough to cover as much of the shared costs as they did previously, which cuts into the ability of programs to charge lower fees for clients lacking health insurance.

The problems facing substance abuse treatment have their parallels in the large sphere of health care financing. Health care providers increasingly resent the intrusion into clinical decision making, even

\textsuperscript{15}Now found in most large companies, EAPs provide employees with confidential counseling, screening, and, if necessary, referral to outside sources of help for a variety of problems, including substance abuse.

\textsuperscript{16}Meacham (1990) discusses some of the issues disputed by treatment providers and utilization review staffs.
when claims are eventually approved. Unfortunately, as a recent report by the Institute of Medicine complained, “Systematic evidence about the impact of utilization management methods on the quality of care and on patient and provider costs . . . is virtually nonexistent” (IOM, 1989, p. 146).

ASSESSMENT
How Much Is Enough?

Is there enough treatment for substance abuse in the Detroit metropolitan area? This question is very awkward to address because of the lack of data on needs and the peculiarities of the demand for treatment. In our view, the major problem is not an overall lack of capacity, but the lack of access to suitable treatment for specific populations: the uninsured, women, intravenous drug users, and young people.

Using the data in Tables 11 and 12, we calculated that in 1989 there were about 6200 admissions to publicly funded treatment of persons who reported no prior treatment episodes (i.e., “new admissions”) and for whom cocaine, opiates, or other drugs (not alcohol) were listed as the primary substance of abuse. To these new drug admissions should be added a proportion of the 6394 new admissions for which alcohol was primary, since OSAS estimates that about 45 percent of those admitted with alcohol as the primary substance of abuse also have problems with drugs (Butynski, Canova, and Reda, 1990, Table 15). Thus, the total number of drug abusers admitted for the first time to public substance abuse treatment programs in the area in 1989 was around 9000. Though we have no local estimates of the number of nonpublicly funded admissions to licensed treatment programs, it is unlikely to be much more than the number for public treatment.17 The number of persons receiving drug abuse treatment for the first time in the Detroit metropolitan area was therefore likely to be at most 18,000 per year.18

17As pointed out earlier, 42 percent of the nationwide financing for substance abuse treatment is from private sources. But part of this private funding goes to treatment programs that also receive public funds, which are already counted in Tables 11 and 12. The GM data cited above show that most of the substance abuse treatment funded privately is for alcohol as the primary substance of abuse. Table 8 indicates that there are twice as many licensed programs receiving no public funds as there are programs receiving such funds, but the latter include the larger programs.

18A large proportion of those receiving treatment in the mental health system whose primary diagnoses are other than substance abuse also have substance abuse problems. A current study by the Wayne State University Department of Community
Many, probably most, of those showing up for treatment do so under some type of coercion, whether generated formally by the criminal justice system or informally by spouses, other relatives, friends, or employers. "Treatment on Demand" is thus a slogan rather than an answer to the question posed here. One of the problems in substance abuse treatment is precisely that those who meet diagnostic criteria for substance abuse disorders very often do not demand, or even cooperate with, treatment provision.

A Committee of the Institute of Medicine recently estimated that 2 percent of the nation's adult population meets the clinical criteria for drug dependence (IOM, 1990), which corresponds to 85,000 persons in the Detroit metropolitan area. Among these 85,000 are relapers—those who have been treated before for drug abuse (some of whom could benefit from further treatment)—and some unknown proportion who will "mature out" of addiction, quitting on their own without formal treatment. If these "complications" did not exist (that is, if no one had received treatment before and all 85,000 needed it), we could say that a system maintaining 18,000 new admissions per year would provide a chance at treatment to every drug-dependent person in just over five years. The indicators of cocaine and heroin use have shown some decline from peaks in the late 1980s (see Sec. 2), so it is likely that the proportion of those showing up for treatment who have had some previous contact with the system will continue to rise in the coming years. This likelihood does not negate the need for more treatment slots (discussed below), but it does suggest that the priorities for the public treatment system as a whole in the next few years should emphasize improving the quality of services rather than simply expanding them.

The best evidence that more people need treatment than are currently getting it may simply be that many programs in the Detroit metropolitan area report more applicants than they have spaces for. The problem is especially acute in the city of Detroit. Programs funded by the city's Bureau of Substance Abuse Services are all at full capacity, and many people seeking treatment are turned away (Gaines, 1991). Many of those who work in social service agencies and make referrals to treatment programs complain that they cannot get people into the programs they think will do some good. Neither of these points means, however, that there is a shortage of private treatment relative to the effective demand for it. We were told by CA officials that people who have insurance coverage can find a program

Medicine will produce estimates of the size of this "dual-diagnosis" population in Detroit.
that will take them without much delay. The shortages are specifically for subsidized treatment.

As the recent Institute of Medicine report pointed out, public funding for treatment declined at a faster rate throughout the country in the late 1970s and early 1980s than did treatment admissions, the result being that treatment in the public sector was "spread thinner" until funding began to increase again in real terms after 1986 (IOM, 1990). The consequences are not well documented, but the report argues that there were high dropout rates for clients; high staff-to-client ratios, which resulted in insufficient attention being paid to individuals and infrequent contact with outpatient clients; and low pay and high turnover among counselors. The report calls for a "deepening" of public treatment—that is, not simply expanding the number of slots and cycling more people through the system with uncertain results, but improving the effectiveness of what already exists. In most cases, doing so would require spending more money per treatment admission in the public system (IOM, 1990, Chap. 7).

These generic problems with public treatment programs all surfaced in our talks with providers and program staff in the Detroit metropolitan area. The deepening of resources per client admission may already have begun in the area. Expenditures increased by 14 percent in real terms between 1986 and 1989 without an increase in the number of admissions, so average spending per admission has increased proportionally. Existing data do not allow us to say whether this increase in resources spent per admission will result in increased numbers of clients completing courses of treatment satisfactorily and staying drug free for longer periods after treatment. If the effectiveness of the system is to be improved, there will have to be greater efforts to monitor outcomes.

Monitoring Outcomes

Drug treatment programs are under pressure to improve performance. In part, this pressure comes from the federal and state governments. The 1988 Anti-Drug Abuse Act requires states to prepare a treatment plan as a condition for receipt of block grants. The National Drug Control Strategy (ONDCP, 1989) calls for states to increase efforts to "hold programs accountable" for their performance, and new legislation will require that state treatment plans include

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specific proposals for holding programs accountable. OSAS, which in the past required programs to collect drug-use data from former clients six months after a treatment episode, recently revised its requirements for collection and analysis of outcome data.

Such follow-up studies of treatment clients are difficult to conduct. While some clients are motivated to stay in touch with programs as part of their own recovery, many others have an understandable desire to put behind them everything connected with an unpleasant part of their lives. Others may avoid contact because of embarrassment about relapse or fear about maintenance of confidentiality. Several of the CAs have contracted with Michigan State University or other research groups for follow-up studies. These efforts could provide useful information both for program management and for assessment and referral agencies. But if analyses (and policies based on them) fail to account for the differences among programs with regard to the severity of clients’ problems at intake, attempts to hold programs accountable for the success of their clients may lead to a concentration on only the most promising clients.

**Matching Clients to Treatments**

Another approach to improving the performance of the system that has received a great deal of attention involves changing intake procedures so that clients are better matched to treatment. The rationale for this approach is partly based on the fact that relapse and dropout rates are so high. It is thought that many people who might be good candidates for treatment drop out because they do not fit with the program or the individual counselor to whom they are first assigned. A good deal of effort is expended on people who show up once or only a few times; the system could be more effective if program referrals were “right the first time.” To this end, some programs with waiting lists use pretreatment groups to accustom new entrants to what will be demanded of them and to sort those who are serious about getting better from those who are not. At this point, little is known about what happens to the no-shows and dropouts: Do they try to get treatment again soon or simply continue or return to using drugs?

Public agencies have a difficult time carefully assessing the needs of their large numbers of clients and matching those needs to the services of the many different providers. Under current practice, programs often have their least experienced staff members dealing with intake and new admissions (DeLeon, 1989, p. 808). Many agencies have high rates of staff turnover, which hinder the development of organizational memory and individual skill in making assignments. If
the task of matching clients to treatments is expected to take place at the central diagnostic facility, many agencies will require additional staff.

A current Michigan State University study (Stoffelmayer, DeVoss, and Mavis, 1989) is exploring the potential for better matching using the Addictions Severity Index to examine differences among client and program types in treatment outcomes for a large sample of Michigan programs. This study may provide guidance for large-scale implementation of matching schemes through the CAs in the Detroit metropolitan area.

SEMSAS has implemented an innovative method of separating assessment and referral from treatment provision. Under its old system, SEMSAS contracted each year with a small number of treatment providers for a certain number of treatment slots. Under the new system, the agency does the initial assessment and then refers clients to any of a much larger number of programs in the area, reimbursing the programs as a private insurance company would. SEMSAS follows up with the clients directly, as an EAP in the private sector would, to see that improvement is being made. This approach has several possible advantages for both matching and quality control: the agency can react in a continuous fashion to feedback about program effectiveness as a whole or for particular types of clients simply by referring more or fewer clients in the future. The province of Ontario and the state of Minnesota have set up similar nontreatment centers for assessment and referral of alcohol and drug abuse clients (IOM, 1990).

This new procedure has not only changed the nature of the tasks for the SEMSAS staff, it has also put providers at greater risk, since they no longer know at the beginning of each year exactly how much business to expect from their major customer. Indeed, part of the reason for such a reform could be to have agencies sever their relations with existing contractors. The private treatment field is crowded, and public agencies could use their market power more effectively by opening up competition to a wider number of suppliers than was feasible in the past. Testing whether this model is useful and replicable in other CAs will require a careful evaluation of the experience; this sort of “supply-side” research on the treatment system has been sorely neglected.
Improving Coordination with the Criminal Justice System

In the SEMSAS jurisdiction and Oakland and Macomb counties, over half the clients admitted to state-funded programs are involved with the criminal justice system at the time of admission. In the city of Detroit, the corresponding proportion is about a quarter of admissions. The lower proportion in the city of Detroit's system is mainly the result of a policy decision to restrict the intake of referrals from the criminal justice system in order to avoid a situation (such as prevailed in Washington DC) in which the treatment system is swamped by referrals generated by increased numbers of drug-related arrests (Reuter et al., 1988, Chap. V). Since most arrestees are men, without this decision it would be impossible for the treatment system to respond to calls for it to target specific groups (e.g., women or teens) for more resources. Intake priorities would be a by-product of police enforcement activity. The city of Detroit has probably done well to keep the public substance abuse treatment system from becoming simply an adjunct to the criminal justice system, as has happened in other large cities.

On the other hand, there are advantages to improved coordination between the two systems, both for the suburban jurisdictions and for the city of Detroit. In the United States as a whole, a large proportion of those dependent on drugs are under the supervision of some part of the criminal justice system—about one-fifth of all persons in need of treatment, by one recent estimate (IOM, 1990, Table 3-4). Choosing the best candidates for treatment from among those in contact with the criminal justice system, assigning them to effective treatment programs, and ensuring that they stay for the course of the treatment could contribute to a reduction of drug use in a severely affected population and, according to some studies, to lower recidivism of offenders (IOM, 1990, pp. 176-184).

Perhaps surprisingly, most treatment outcome studies show that those who begin treatment as a result of a more or less coercive referral from the criminal justice system do as well as those whose admission is voluntary. The authors of the nationwide Treatment Outcomes Prospective Study suggest that the reason for this finding is that clients who are under some form of coercion are more likely to stay past the first few weeks, thus giving treatment a chance to work (Hubbard et al., 1989).

The Treatment Alternatives to Street Crime (TASC) program, operated by the Wayne County Adult Probation Services, conducts a large screening and urine testing program for nearly all persons arrested for felonies in Wayne County and processed at the 36th District
Court. Probationers are also subject to urine testing, and the Wayne County Adult Probation Services agency receives continual reports on test results for hundreds of persons in its charge. From both the probation agency and the Detroit Health Department, we learned that, using the current process, it is difficult to track treatment referrals and ensure that those referred by a judge or probation officer actually show up within a reasonable time at the Detroit Health Department's Central Diagnostic and Referral Service (CDRS), and it is even more difficult to ensure that those people then follow through by showing up at the program to which CDRS refers them.

Maintaining Contact with Intravenous Drug Users

The problems created by the cocaine epidemic added to, rather than replaced, the continuing problems caused by heroin use. Nearly all heroin use is intravenous, and intravenous drug users, their sex partners, and their children are all at high risk of AIDS infection. (As mentioned in Sec. 2, intravenous drug users are also at risk for many other serious physical problems, mainly due to needle contamination.)

Several methadone programs have begun to rely on client fees for their funding in recent years. The city of Detroit's government, through the Health and the Neighborhood Services departments, used to fund most methadone treatment in the Detroit metropolitan area, but there has been a policy decision to move away from methadone maintenance and steer heroin addicts toward non-methadone programs.

The opposition to methadone of many treatment providers, policy makers, and Detroit metropolitan area residents is based on several factors. A common criticism is that methadone simply substitutes one addiction for another. Many methadone clients continue to use other drugs, including heroin and cocaine. Also, despite all the controls, some methadone is diverted and sold for unauthorized use. But against these criticisms must be set the potential advantages of methadone treatment, at least for some addicts.

As discussed in the early part of this section, methadone maintenance was the original cornerstone of the public treatment system, and there is a fairly large and solid body of related evaluation studies. Methadone clients show improvement in terms of employment, lower crime and arrest rates, and less frequent drug use, compared either to

\[\text{Reference:} \text{Institute of Medicine (1990) and Office of Technology Assessment (1990) for reviews.}\]
their own pretreatment record or to comparison groups from programs that have discontinued methadone therapy. Programs that offer only short-term detoxification and rely on low-dose prescriptions have higher dropout rates than those offering long-term maintenance. Given the overriding need to bring intravenous drug users into contact with the medical system and to keep them from needle use, especially needle sharing, it is important to keep methadone therapy, including high-dose and long-term maintenance, as an option for addicts who cannot succeed in other types of treatment.

Providing More Treatment for Women

Concern about the crack baby phenomenon has brought into sharp relief the lack of treatment options for women. Serious as this phenomenon is, it should not be considered the sole rationale for increasing the range and effectiveness of treatment programs for women; alcohol- and drug-dependent women need treatment for restoration of their own health as well as that of their offspring. Most of the well-established substance abuse treatment programs are either for men only or have few or none of the ancillary services considered necessary to keep women in treatment long enough to see benefits. The lack of child care, to take a basic example, is often reported to be an obstacle to young women's participation in substance abuse treatment.

The women entering the treatment programs participating in the current Michigan State University study reported more severe medical, familial, and psychological problems than did the men entering the programs (Stoffelmayr, DeVoss, and Mavis, 1989, p. 31). Women who use drugs and alcohol heavily are often involved in abusive relationships with men and/or economically dependent on men who oppose the women's efforts at recovery. Women in treatment may therefore have housing needs, either long-term or for emergencies, that are more pressing than those of men with otherwise similar substance abuse problems.

The apparent underrepresentation of women in treatment may not be merely a matter of supply constraint. There are many anecdotal reports of women being less willing than men to seek treatment because the stigma associated with substance abuse is greater for women than for men. Also, as noted earlier, since the criminal justice system is a primary source of referrals to public drug treatment programs, the fact that women are less likely than men to get arrested may be why so few women are in such programs.
The Detroit metropolitan area has one program, at the Eleanore Hutzel Recovery Center, that has been frequently cited as a national model for integrated medical and substance abuse treatment of pregnant addicts.\textsuperscript{21} Though outcome data for this program have not been evaluated, it appears to be effective and well organized. We did, however, hear from several people in social service agencies who make referrals that the waiting lists are long. The demand for more such programs seems pressing.

Children of substance-abusing parents often suffer from parental neglect or mistreatment and exhibit developmental and behavioral problems. Recent attention has focused on the long-term effects of maternal cocaine use, but parental abuse of alcohol and other drugs can also inhibit a child's emotional and behavioral development (AAP Committee on Substance Abuse, 1990). Parental substance abuse generates many referrals to Families First, a home-based program to prevent placement of children outside their homes, as well as to many foster care placements. Provision of treatment compatible with child rearing could help many women trying to keep their families together.

The Hutzel Recovery Center has an adjunct day-care center where children of the clients receive not just babysitting, but special education. The provision of this kind of day care at treatment programs serving women could have the added useful effect of keeping women in treatment long enough to increase their chances of recovery. Intensive day care is an expensive proposition, though, and involves hiring staff members whose qualifications are very different from those of substance abuse counselors. Providing adjunct child-care services could be an excellent way for private funds to increase the effectiveness of the money being spent on substance abuse treatment.

Since 1988, the federal block grants have included a requirement that states set aside at least 10 percent of their total award to provide treatment and prevention services for women. OSAS and the four CAs in the Detroit metropolitan area are planning to implement that requirement by developing four new programs that will provide services to women, including pregnant women.

\textbf{Increasing the Range of Treatment Options}

One of the weakest links in the continuum of care is the lack of halfway houses, particularly those that can accommodate women and

\textsuperscript{21}A newspaper article by Ritchie (1990) describes the program.
young people. Several officials and treatment providers working in the suburbs identified this lack as an important gap in services. The problem has been one of siting as much as of funding: halfway houses for substance abusers are not typically welcomed by neighborhoods. The Oakland County Health Division refers suitable clients to three halfway houses, only one of which is located in Oakland County (the other two are in Detroit and Lansing).

The recent Institute of Medicine report (IOM, 1990) identified a need for more intensive treatment than is provided by the majority of outpatient programs. But providing round-the-clock residential care to large numbers of substance abusers would probably not be cost effective. It might not even be desirable for many clients, since residential care can disrupt existing positive ties to society as well as stigmatize clients. New forms of day/night treatment and halfway houses have been developed in the Detroit metropolitan area, partly in response to expanded coverage provisions in the last round of benefit negotiations for the auto workers. The federal government has attached set-aside provisions to block grant treatment funds to stimulate development of self-sustaining halfway houses. OSAS recently called for a 25 percent increase in treatment provided to adolescents, along with a 10 percent increase for women (OSAS, 1989). Here again, though, it is important to accompany the call for more treatment with the call for more effective use of treatment resources. There is some evidence that many committals of teenagers to long-term residential care for psychiatric and/or substance abuse problems are unnecessary (Schwartz, 1989; Meacham, 1990a). At the same time, social service agency staff members, both in the city and in the suburbs, reported that they often see juveniles with significant (and possibly treatable) substance abuse problems for whom there are insufficient treatment options. This is particularly a problem when, as is often the case, the young person no longer has ties to a parental home and must find temporary housing as well as substance abuse treatment.

The CAs could help promote the development of these intermediate forms of treatment in part by more aggressive screening of those people now referred to traditional residential programs, but many CAs indicate that they have already tightened criteria for residential referrals and have little scope for further tightening without compromising standards. Private-sector funders could also help by giving priority in their prevention grants to community groups that include support for more local treatment facilities among their objectives. REACH, Inc. (described in Sec. 4), for example, sought city support for a substance abuse treatment program in their project area, as well
as help in neighborhood reclamation. This example could be used by suburban groups as well.

Summary

Both the public and private systems for substance abuse treatment are hard pressed. The public system has had to adapt to the new flow of cocaine users, who are younger than and often have different treatment needs than the alcohol and heroin users who until recently constituted the majority of clients. In both the public and private sectors, current efforts to control costs through benefit limitations, more careful screening, and referrals to less expensive forms of treatment run the risk of indiscriminate undertreatment. The problems of the two sectors are linked: as the economic recession continues, high unemployment and increasing premiums are likely to leave more people uninsured or underinsured. The public system will be left with more of the burden of paying for treatment. As the full effect of recent increases in cocaine use is felt in the coming years, both public- and private-sector institutions must decide how much treatment will be provided and who will pay for it.

There is a need for more substance abuse treatment in the Detroit metropolitan area, but we argue that the first priority of the public systems in the next few years should be to improve the effectiveness of existing services and to expand services to special populations rather than simply to expand uniformly. In recent years, a growth in federal grants made possible an increase in funding for treatment in the Detroit metropolitan area; state government funding has remained level. Both the city and the state face fiscal crises among the worst in the nation, a fact that only adds to the importance of improving the effectiveness with which resources are used in the public system.

The public treatment system has been geared mainly to middle-aged males. To serve the many women and young people who would benefit from treatment, the system thus needs a certain amount of reorientation. Particularly, the system needs to address the shortage of treatment slots where pregnant women can receive prenatal care (and child care for their older children) at the same time they are being counseled for substance abuse and other problems.

The city of Detroit receives more state and federal funding per capita than any of the suburban jurisdictions: more than twice as much as the rest of Wayne County and Macomb County, and nearly four times as much as Oakland County. As was shown in Sec. 2, though, city
residents are about three times as likely as suburban residents to visit hospital ERs for causes related to substance abuse and are more likely to die of addiction-related causes. Higher per capita spending could thus be justified by these more severe health consequences alone. The greater reliance of city residents on the public treatment system (suggested by the much denser concentration of private programs in the suburbs) also suggests that public spending on treatment should be greater in the city.

The CAs should promote the development of intermediate forms of treatment (day/night treatment, halfway houses) as a cost-effective alternative to intensive residential treatment of those for whom outpatient counseling alone does not prove sufficient.

Given the overriding need to bring intravenous drug users into contact with the medical system and to keep them from needle use, especially needle sharing, it is important to maintain the network of treatment services for intravenous drug users. Methadone therapy, including high-dose and long-term maintenance, should be provided as an option for addicts who cannot succeed in other types of treatment.

There is a need for better coordination between the public treatment agencies and the criminal justice system and for better tracking of those referred to treatment programs. This need can only be met through increased investment, particularly in CA resources for initial assessment and case management. A high priority should be to evaluate the changes SEMSAS has made in its case management and contracting procedures and their replicability elsewhere.

In the Detroit metropolitan area, as in the rest of the nation, most substance abuse treatment is financed either by government, private insurance, or user fees. Foundations and other private grantors have been only minimally involved in treatment. Many of the reforms for which this report calls (e.g., targeting neglected populations for service, improving assessment and treatment matching) represent the kind of innovations that private organizations are particularly suited to fund and evaluate on a small-scale experimental basis. Private funders, with cooperation from university researchers, could be more active in leading the way in redesigning drug treatment in the Detroit metropolitan area.
6. DRUG LAW ENFORCEMENT

The appearance of crack houses, the growth of open cocaine markets, and the violence surrounding cocaine sales have greatly increased the workload for all parts of the criminal justice system in the Detroit metropolitan area. We do not have specific estimates for Michigan or the Detroit metropolitan area corresponding to those prepared for the federal government, but it is likely that in Michigan, as in the nation as a whole, law enforcement expenditures constitute the bulk of public spending on programs to control drug abuse (ONDCP, 1991). This concentration of funds on law enforcement is partially caused by priorities embodied in legislation: Michigan, for example, has mandatory minimum sentencing laws for drug offenses that are among the most severe in the nation. Within the broad limits set by the need to maintain the rule of law, though, the agencies of the criminal justice system, particularly the police, have some leeway in their choice of enforcement strategies. This section briefly outlines the major types of enforcement strategies, the purpose being to make two points:

1. The current drug problems of the Detroit metropolitan area are not caused by the criminal justice system's failure to "get tough" in enforcing the drug laws or to experiment with the alternative policies recommended by the federal government's Office of the National Drug Control Policy (1989). On the contrary, there was a steady increase in enforcement, backed by all levels of the system, throughout the period in which drug problems appeared to be worsening, and agencies in Michigan and the Detroit metropolitan area have been among the pioneers in experiments with alternative forms of policing and corrections. These efforts should continue, but there is little to suggest that tougher or more imaginative enforcement by itself will eliminate the area's drug problems.

2. The police have an important role to play in supporting neighborhood efforts to organize against drug trafficking and other drug-related problems, such as those discussed in Sec. 4. The policy alternatives are not simply enforcement versus treatment and prevention. In many ways, the actions of the enforcement agencies can be reoriented to help achieve the goals of demand reduction.

Arrests for drug law violations in the Detroit metropolitan area increased 60 percent in just two years, from around 9000 in 1986 to
nearly 16,000 in 1988. Most of the increase came in the city of Detroit, which now accounts for about two-thirds of the metropolitan area’s drug arrests. These were not just “revolving-door” arrests or easy arrests for possession and minor offenses. The prosecutors and courts followed through by bringing an increasing number of felony cases. The Wayne County Prosecutor reports that drug felony arraignments tripled from 1985 to 1988, while nondrug felony arraignments increased by only 8 percent (GAO, 1991b). Despite several diversion and early-release programs, the jails and prisons are now filled with drug offenders. A recent report of the General Accounting Office points out that over 75 percent of the inmates of the Wayne County jail are held for violations of drug laws, and overcrowding at every point in the criminal justice system has forced increased reliance on pretrial release of felons (GAO, 1991b). Statewide, over 25 percent of all prison inmates were convicted for drug law violations. The state has been building prisons at a rapid pace since 1985 (five facilities were opened in 1989, and six more are scheduled to open by the end of 1991), but four of the men’s prisons are operating under court orders for overcrowding, and projections of the prison population show that over-crowding will persist even after the new capacity is added.

POLICE STRATEGIES

Drug law enforcement by the police can be classified by its target (high-level enforcement, retail enforcement, buyer sanctions) and, within the retail enforcement category, by the methods used (e.g., sweeps or focused crackdowns) (Kleiman and Smith, 1990). In the Detroit Police Department, investigations directed against high-level dealers are the responsibility of the Narcotics Division, which has about 200 officers. Though the Detroit metropolitan area is fragmented by its many jurisdictions, a good deal of cooperation among the federal Drug Enforcement Administration, the state police, and the local agencies is achieved through eighteen cooperative drug teams that cross jurisdictional boundaries (GAO, 1991b; OCJ, 1989).

High-level enforcement serves the ends of justice more than those of public health. In theory, enforcement directed against importers or wholesalers of cocaine should reduce the supply of imported cocaine, raise cocaine’s street price, and increase the search time required to find cocaine on the streets (Reuter and Kleiman, 1986). In practice, however, the great increase in efforts to “seal the borders” and capture high-level dealers in recent years have not choked off the supply of cocaine and other drugs to American cities, mainly because dealers
caught as a result of investigations have proved easily replaceable. The price of cocaine has increased in the last few years, but as pointed out in Sec. 2, the increase has not even brought street prices back to what they were in 1985 and 1986, when cocaine use increased greatly. Federal, state, and local agencies should not abandon high-level enforcement, if only because it would be unjust to continue to pursue low-level dealers while their suppliers, who make higher profits, escape. But high-level enforcement alone is unlikely to provide a solution to the drug problems of Detroit metropolitan area residents.

More directly relevant to the problems caused by the open drug trades in the Detroit metropolitan area are the strategies classified as retail enforcement. The Narcotics Division and the precincts of the Detroit Police Department have had a series of continuing operations and special “initiatives” directed at street drug sales and crack houses. Operation Maximum Effort, begun in December 1987, involved surveillance, use of informants, and filmed undercover purchases. Maximum Effort teams conducted raids at a very rapid pace and have accounted for much of the increase in arrests. One criticism, though, has been that Maximum Effort is a roving operation, which means that residents of neighborhoods with drug markets see a good deal of activity near the time of raids but may not see much afterwards (Kleiman and Smith, 1990). Clearly, from the viewpoint of a single neighborhood, continuous pressure would be more helpful, but there is evidence that even intermittent crackdowns have an effect that lasts for weeks or even months afterwards (Sherman, 1990). Given the inability of the police to sustain crackdowns everywhere at once, a strategy of focused crackdowns—i.e., periodic returns to particular neighborhoods—could be cost effective (Sherman, 1990; Kleiman and Smith, 1990).

Other Detroit Police Department initiatives include Pressure Point, begun in May 1988, which entails conducting several raids simultaneously in a small area; Buy and Bust, which involves undercover purchases followed by an immediate raid on a building to recover evidence; and Padlock, which entails confiscating houses under the Nuisance Abatement Act.

Besides these initiatives, which are directed specifically at drug dealers, the city of Detroit has a tradition of community policing that offers promise for both promoting neighborhood order and arresting drug dealers. There are different versions of community policing, but what they have in common is a change from a police style of reacting to crime reports (usually in radio-dispatched patrol cars) to a visible and continuous presence in neighborhoods. Many of these ideas are
embodied by decentralized ministrations and organization coupled with liaison with neighborhood anticrime groups by the police department's Crime Prevention Division. The Detroit Police Department was one of the leaders in developing these methods, largely in response to the problems revealed in the 1960s involving antagonism between an almost all-white police force and black residents (Skolnick and Bayley, 1986). In drug law enforcement, community policing calls for cooperation among the precinct police (who develop tactical intelligence, make street arrests, and patrol targeted areas intensively after raids), the Narcotics Division (which conducts indoor raids) and the Crime Prevention Division (which works with residents of targeted neighborhoods after a sweep).

Community policing is meant to rely on the police to back up the efforts of a neighborhood's "natural caretakers," i.e., a small number of residents who "meet regularly, note neighborhood conditions, schedule a few annual events, maintain liaison with other neighborhood groups and 'official government,' and rally neighborhood forces in the face of some threat" (Kelling and Stewart, 1989, p. 5). Community policing cannot be applied everywhere, since not every locality qualifies as a neighborhood in the sense of having residents who are willing and able to serve as caretakers.

As is so often the case with drug policy, advocates of community policing and sustained crackdowns aimed at helping neighborhoods whose residents are organized to "police themselves" must base their arguments more on plausibility and the lack of effective alternatives than on the results of well-designed evaluations. Few evaluations have compared results in neighborhoods where police work with residents concerned about drug sales and keep up a continual presence with results in neighborhoods where enforcement consists only of traditional "response" policing and sporadic drug raids. One evaluation (Uchida, Forst, and Annan, 1990) compared neighborhoods in Oakland, California, and Montgomery, Alabama, that were similar except that different combinations of these strategies were tried. It found that residents of neighborhoods where there were door-to-door contacts with police and a visible police presence felt more optimistic about the chances of reclaiming the neighborhood from drug dealers.

This finding suggests that similar approaches to retail drug law enforcement may do more for specific neighborhoods than the more ambitious efforts to capture big dealers or break up organizations through investigations. The goal of restoring order to particular neighborhoods could easily be overlooked if police performance is judged solely on numbers of arrests, numbers of important dealers ar-
rested, or amounts of drugs seized. Local law enforcement agencies should continue to target neighborhoods where self-help efforts are under way and to help organize such efforts in other neighborhoods damaged by drug selling and related violence. Unfortunately, this work is time consuming and requires both coordination among several divisions within the Detroit Police Department and the attention of high-level management. These initiatives come at a time when hiring freezes and budget reductions will make it hard for the Detroit Police Department, as well as some of the police departments in surrounding jurisdictions, to meet competing objectives.

Innovative ways to punish drug purchasers, such as confiscating cars used in drive-up drug purchases, have been tried in the city of Detroit and several of the surrounding jurisdictions. These could play a role in both expressing and enforcing antidrug norms. Since open-air drug markets and crack houses appear to be concentrated in poor and minority neighborhoods, law enforcement directed only at sellers there would put the burden exclusively on residents of those neighborhoods and violate standards of fairness. Operation Rip Ride of the Detroit Police Department’s Narcotics Division includes confiscation of vehicles used to make drug purchases in Detroit neighborhoods. According to an informal estimate of Detroit Police Department officials, the majority of those arrested for purchases from their vehicles are not residents of the city. Wayne County’s Operation Push-Off, an effort begun in October 1990, similarly aims to deter drug buyers by car forfeiture (Freedman, 1991). These efforts have the advantage of being civil rather than criminal actions, so the burden of proof is less and police resources need not be tied up in court work to the same extent they would be for criminal procedures. Residents of inner-city neighborhoods will be the most direct beneficiaries of sustained efforts to control local drug markets, but they will also bear a disproportionate share of the nuisance. The use of buyer sanctions would “spread the pain” more equitably by including residents of other neighborhoods and other jurisdictions who contribute to drug problems as sellers or consumers. Though there has been little research on the effectiveness of different police strategies, buyer sanctions may also achieve some deterrence, a goal that enforcement against higher levels of the drug trades generally does not achieve.

CORRECTIONS

The National Drug Control Strategy published by the Office of National Drug Control Policy in February 1989 called on states and cities to increase their prison capacity, to experiment with interme-
mediate (nonprison) punishments for drug offenders, and to develop sanctions for drug buyers as well as drug sellers. The call for increased prison capacity was largely a matter of ratifying a trend that was already taking place (and urging construction to catch up with growth in the size of the prison population). Nationwide, in 1989, prisons were the fastest-growing item in state government budgets, and in Michigan, prison construction was the only capital budget item increased that year (Dionne, 1989).

Michigan and the Detroit metropolitan area criminal justice agencies have been among the leaders in developing alternatives to traditional long-term incarceration and in applying civil sanctions to drug dealers (Mackenzie, 1989). The experience in Michigan and in other states so far indicates that none of these devices is the "magic bullet" for solving an area's drug problems, though they may have a place in the overall law enforcement strategy for coping with the problems.

In 1989, Michigan instituted a 90-day Special Alternative to Incarceration (SAI) program for men aged 17 to 25 that was designed to reduce prison overcrowding, cut costs, and reduce recidivism. The program consists of strict discipline, hard physical work, and exercises to develop a work ethic and sense of self-esteem, the standard features of the "boot camps" that have been developed in other states and are proposed for further expansion in the Detroit metropolitan area. There are not yet any data for a specific evaluation of Michigan's SAI, but similar programs in other states have had mixed results. There is no evidence that these programs reduce recidivism (Parent, 1989; Mackenzie and Shaw, 1990). Depending on the types of participants selected, these programs may have reduced prison overcrowding and costs without violating the public sense that dealers should not be let off lightly.

Such alternatives are worth developing, even if they cannot be shown to reduce the future criminal activity of their graduates. Since 1978, Michigan has had among the most stringent minimum-sentencing laws in the nation; those convicted of possessing more than 650 grams of cocaine are required to be sentenced to life imprisonment without parole (the highest penalty under Michigan criminal law). It is beyond the scope of this report to deal with the merits of determinate sentencing and restrictions on judiciary discretion, but even those who consider drug law enforcement an important adjunct to other means of controlling drug problems could question the use of equivalent punishments for a midlevel cocaine dealer and a murderer (Marcus, 1990).
7. DRUG POLICY IN THE 1990s

So far we have dealt with drug use prevention and treatment separately. Though the policies adopted in those separate areas, and in drug law enforcement, impinge on each other, the public- and private-sector institutions working in those areas adhere to a traditional division of labor, with the result that their audiences for policy recommendations only partially overlap. This final section discusses the priorities of the public and private sectors, including themes that apply across both of them.

GREATER EMPHASIS ON PREVENTION

The share of local discretionary resources devoted to prevention should be larger than it now is. Compared to treatment and drug law enforcement, prevention has always come out last in resource allocation at every level of government, both for programs and research, because it serves long-term goals for a diffuse group of beneficiaries rather than the immediate needs of an identifiable constituency.

The coordinating agencies (CAs) are pressured to provide ever more treatment because so many programs have waiting lists and potential clients show up (often referred by criminal justice agencies) daily. Police work is dominated by the need to respond to incidents of law-breaking. The courts and corrections systems are hard pressed to keep up with processing, punishing, and housing drug dealers. These agencies have all devoted resources to prevention efforts (broadly construed), but for none is drug use prevention the core task. When budgets are tight, as they will be increasingly in the next few years, agencies tend to concentrate on doing their core tasks. Prevention could be slighted, unless community groups and elected officials demand that it be given a higher priority.

The provision of more funding for community prevention requires a leap of faith. There are many views, inside and outside government, about how prevention works or could work, but community prevention has not received the same research scrutiny given to treatment and to prevention in the schools. This situation is due in large part to low levels of government funding in the past. Increased funding should be accompanied by an increased effort to evaluate and subsequently foster the community prevention activities that look sustainable and effective.
The bulk of the funding for increased effort in prevention will have to continue to come from the public sector. Local foundations and voluntary service agencies have been increasingly involved in recent years in substance abuse prevention, and national foundations have made some grants through the Community Foundation of Southeastern Michigan, but contracts from the CAs, derived ultimately from federal, state, and local government funds, have financed most of the community prevention programs described in Sec. 4.

Much law enforcement serves prevention goals (deterring drug buyers, helping neighborhoods minimize the collateral damage from drug selling). Again, there has been little systematic evaluation of the various police strategies (and policies of the courts and corrections systems) to see how well they serve these goals. Their potential value is great enough to warrant more experimentation.

BUILDING COALITIONS

The Detroit metropolitan area's drug problems spill over city and county boundaries, but there are few institutions and individuals working to coordinate efforts across boundaries. There are some important means for sharing information and pooling resources in the prevention field: the Prevention Coalition, the statewide Prevention Network, and some of the private-sector organizations and foundations funding programs throughout the region. There have also been some initiatives at the neighborhood and church levels, such as attempts to link sister churches in the city of Detroit and its suburbs.

Some incentive to coordinate efforts across city and county boundaries (and between public and private sectors) is provided by the conditions for grants from the federal government (especially the Office of Substance Abuse Prevention—OSAP) and national foundations. But this incentive is unlikely to last long if Detroit metropolitan area institutions do not themselves see advantages coming from cooperation.

Efforts to promote cooperation among governments in southeast Michigan in dealing with policy problems that cross boundaries have often been frustrated by fundamental political and financial difficulties. On the political side, black elected officials are understandably suspicious of proposals that involve surrendering autonomy to regional bodies. Only recently have blacks been elected to city and county offices; to change the rules of the game at this point would take away hard-won victories. Suburban officials are leery of taking on (or having their constituents think they are taking on) complex and expensive “city” problems. For basic services financed mainly
through property taxes, notably education, there are no mechanisms for redistribution from rich to poor districts. There have been some successes in regional cooperation, but mainly in land-use planning and some other highly technical fields.\footnote{Darden et al. (1987) provides a history of metropolitan and regional cooperation, especially in Chap. 6.} What reason is there to think that cooperation at a metropolitan level is more feasible in drug policy than in other fields?

One reason is that mechanisms for allocating public resources where they are most needed are already in place. Since so much of the financing for public treatment and prevention programs comes from the federal and state governments, the Office of Substance Abuse Services (OSAS) allocation formulas strongly affect per capita spending. Thus, with regard to financing, the treatment and prevention situation is the reverse of the school situation: more public money is spent for city than for suburb residents. The city/suburban distinction is not the only one relevant to needs, of course, since many suburban jurisdictions, such as the older downriver communities, also have high unemployment rates and large numbers of uninsured residents, and thus a greater reliance on public funding for treatment and community prevention. Though we were unable to obtain figures for allocations within the CA jurisdictions, we did learn from interviews that programs reaching poorer areas are emphasized.

From the viewpoint of local officials, a potential problem with state and federal financing is that it is accompanied by state and federal policy priorities. Several times in our interviews, local officials expressed misgivings about certain state policies: adoption of the Michigan Model as the health curriculum for school prevention, promotion of Student Assistance Programs (SAPs) in the elementary rather than secondary schools, and a return to methadone programs that provide high-dose and long-term maintenance for heroin users. However, we did find a good deal of agreement among different-level officials on treatment policy priorities (such as improving matching and case management and reaching previously underserved populations), and the specifications from higher levels of government with regard to community prevention are necessarily general and thus allow a good deal of room for local officials to experiment. Much of what is done in community prevention involves mixed private and public partnerships, public funding through private conduits, and multiple funding sources; and federal officials and national foundations appear to accept the importance of local “ownership” of
community prevention programs. Some conflict between local and nonlocal priorities is inevitable, but we do not see this issue as a major hindrance in the Detroit metropolitan area.

If substance abuse policy is to be metropolitan in scope, it should not be defined narrowly as dealing with a single drug. The cocaine crisis was a good motivator for public concern, but the danger now is that improvements in cocaine indicators will be seen in the nonurban, majority population as evidence that (1) the problem has been solved and (2) even if not solved, it is not our problem. As the press coverage and political history of the AIDS epidemic have shown, the salience of health issues is affected by the perceived threat of a breakout in the general population. A disease affecting only one part of the population may elicit expressions of concern but no commitment of resources on a serious scale. Abuse of alcohol remains common throughout the American population and ranks just behind use of tobacco as a major cause of preventable death. Both public and private organizations dealing with substance abuse can help maintain its prominence on the public health agenda by emphasizing the need for broad efforts rather than defining the problem in terms of one drug.

The changes we have proposed, or any other reforms that may take place in drug and alcohol control programs in the next few years, must be considered in the context of an overall retrenchment of government services and increasing demands on private funding sources. The city of Detroit had to deal with the cocaine epidemic following years of economic stagnation, depopulation, a declining tax base, and cutbacks in public sector work forces, including the police force. The federal government has proved incapable of eliminating large budget deficits in years of peace and (for most of the country) prosperity in the 1980s. Spending on substance abuse programs has grown in recent federal budgets, but these programs are unlikely to continue to escape general cutbacks in discretionary spending on domestic programs. Michigan's state government faces in FY 1991 a projected deficit larger than that of all but one of the other states. Just as it does for the federal government, the economic recession tends to drive up state expenditures for entitlement programs (unemployment insurance, Medicaid, general assistance) and drive down revenues. The city of Detroit in the first months of FY 1991 was facing a need to reduce its work force still further.

The increase in federal block grants to the states for drug and alcohol treatment and prevention programs, and the new grant programs set up by the 1986 and 1988 Anti-Drug Abuse acts, made possible most of the increase in spending on public-sector programs in the Detroit
metropolitan area during the period 1986–1990. The Detroit metropolitan area fared less well in obtaining funds under the newer, competitive grant programs. Given the scope of problems in the metropolitan area and the fiscal crises at state and local levels of government, more effort needs to go into prevention and treatment partnerships and proposal preparation.

**SUSTAINED EFFORT, WITH REALISTIC TIME HORIZONS**

In assessing the mix of policies for dealing with drug abuse, it is important to keep in view the varying time scales on which they can be expected to work and the different populations affected. Unrealistic expectations about quick and complete solutions may lead the public and their representatives to abandon promising efforts in discouragement. Many problems affecting different parts of the Detroit metropolitan area populations are lumped together as “The Drug Problem” in a shorthand description. Judging the success of various programs requires monitoring a range of effects through the next decade and beyond.

Primary prevention programs aimed at children now aged 10 to 14 should, if reductions in drug and alcohol use are sustained, result in lower rates of drug use and alcohol abuse when these children reach peak alcohol- and drug-using ages eight to ten years from now. The full effects of today’s prevention programs will not be felt for a decade or more.

Community prevention efforts could have a mixture of both short- and long-term effects. Efforts to clear out crack houses and drive away open drug selling have often had notable success within a year or so if backed up by police work. The challenge is to sustain results, since short-term crackdowns often produce only short-term improvements. Community efforts are typically also aimed at reducing drug use by residents. As is true for school-based programs, the success of these efforts is hard to measure directly and, in any case, will show up gradually. Efforts to increase the number of treatment slots available should help improve the conditions of those now dependent on drugs and alcohol, as well as the conditions of their families. Treatment can be a slow and uncertain process, though. Some clients will not show much improvement or will relapse after short periods of improvement; others will require several episodes over several years to show much improvement. The effects of increasing the capacity of the treatment system on the size of the substance-dependent population and the size of the illegal drug market will thus also be spread out over many years. Improving the efficiency of the system by better
matching of clients to programs and aftercare should likewise have effects spread out over some years, both for those currently in need of treatment and for drug users who progress to drug dependence in the future.
Appendix

SOURCES OF DATA ON DRUG USE IN THE DETROIT METROPOLITAN AREA

In the Detroit metropolitan area, there are 49 emergency rooms (ERs) eligible to participate in the National Institute on Drug Abuse (NIDA) Drug Abuse Warning Network (DAWN) system. Of these, 41 participated regularly during 1989, and 34 participated regularly throughout 1987, 1988, and 1989. There were just under a million visits to these 41 ERs during 1989. Hospital staff members working on the DAWN reports reviewed the ER records and filled out an “episode report” for the 9886 cases in which use of one or more drugs was recorded in the files. As many as four drugs could be recorded for each episode. There were 16,060 separate drug “mentions” in the 9886 episodes reported during 1989 by participating ERs in the Detroit metropolitan area, for an average of 1.62 drugs per episode. A separate item on the form asks whether alcohol use was also involved.

The DAWN system does not report data from individual facilities, nor are participating facilities ever identified by name. We were able to determine whether facilities in the city of Detroit had a higher participation rate than those in the surrounding jurisdictions by comparing the distribution of zip codes for the facilities represented with those for all ERs in the three-county area. Of the 34 facilities included in our sample for 1987–1989, the proportions in the city of Detroit, the rest of Wayne County, and Macomb and Oakland counties were very close to the proportions for all ERs (see Table A.1). Based on this evidence, the set of DAWN-reporting ERs in the Detroit metropolitan area should be geographically representative of the universe of ERs in the area, not weighted toward either the city or the surrounding jurisdictions. It may be that the nonparticipating facilities differ in some systematic way from the participating ones, though, and drug users who are detected in ERs may differ from the total population of drug users. (There is evidence from Florida, for example, that physicians and nurses are more likely to ask about drug use when treating urban blacks than when treating whites or blacks living in the suburbs.) Our analyses are, then, subject to “detection bias” and may not reflect the total population of drug users in the Detroit metropolitan area.
### Table A.1

**Emergency Room Locations**

<table>
<thead>
<tr>
<th></th>
<th>City of Detroit</th>
<th>Rest of Wayne County</th>
<th>Macomb County</th>
<th>Oakland County</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of eligible ERs (% of metropolitan area)</td>
<td>14 (28)</td>
<td>17 (35)</td>
<td>9 (18)</td>
<td>9 (18)</td>
<td>49 (100)</td>
</tr>
<tr>
<td>Number that participated regularly in DAWN program, 1987–1989 (% of metropolitan area)</td>
<td>10 (29)</td>
<td>11 (32)</td>
<td>7 (20)</td>
<td>6 (18)</td>
<td>34 (100)</td>
</tr>
</tbody>
</table>

The DAWN system was not designed for making comparisons across metropolitan areas of rates of drug use in the general population. In some metropolitan areas, such as Newark and Washington, nearly all eligible ERs participate. In others, such as Los Angeles and New York, half or fewer do. Participating ERs do not constitute a representative sample for the metropolitan area. NIDA has redesigned the DAWN system so that a subset of the participating ERs constitutes a representative national sample of ERs. In the Detroit metropolitan area, for example, 22 of the 41 ERs that responded consistently in 1989 were included in the representative sample from which weighted estimates were produced for the published DAWN annual reports. The figures and tables in Sec. 2 use data from the entire set of reporting ERs in the Detroit metropolitan area (adjusted for consistency across the years compared) and the raw nationwide totals (under the original design), rather than the smaller representative sample. Our discussion of trends thus should not be affected by the changes in the DAWN design.

DAWN also collects data from the medical examiners (MEs) for the Detroit metropolitan area. Of the 6924 deaths in 1989 inspected by these MEs, drugs were detected in 299. A total of 794 separate drug mentions were recorded for the 299 corpses. Again, the DAWN ME data are more useful for analyzing changes in the types of drugs used than for making comparisons across metropolitan areas of the prevalence of drug use in the population at large.

Another source of information on drug use trends, albeit in a selective sample of the population, is the Drug Use Forecasting (DUF) system funded by the National Institute of Justice. This nationwide program collects data on drug use by arrestees, using fairly standard procedures that make it possible to compare data across cities. There are some problems in making such comparisons: sampling procedures
vary in some ways, and the catchment areas for central booking facilities (where DUF operates) vary across metropolitan areas. In the city of Detroit, the research is conducted by Wayne State University under a contract with the National Institute of Justice.¹

There are no surveys collecting self-report data on drug use that could be used to produce population estimates specific to the Detroit metropolitan area. As part of its household survey program, NIDA recently began experimenting with means of producing estimates valid at the level of a metropolitan area, but these have not involved the Detroit metropolitan area so far.

OSAS recently began a program of Alcohol and Other Drug Use surveys at several grade levels in junior and senior high schools throughout Michigan. The sampling procedures and many items of the instruments used in these surveys are comparable to those of the nationwide Monitoring the Future survey conducted by the University of Michigan (some of whose researchers were involved in developing the Alcohol and Other Drug Use instrument for the state). The Alcohol and Other Drug Use survey results could, in theory, allow drug problems among students in the Detroit metropolitan area to be monitored and compared with national trends, which could provide a crude indicator of the overall effectiveness of prevention efforts. School districts in the area have been slow to participate in the state program, though, and confidentiality concerns have been given as a reason for not publicizing results from individual districts. In our view, the usefulness of local data collected over an extended time through a standard instrument for all those concerned with drug policy would be worth the effort to devise ways to report results without violating confidentiality.

¹See Misckowski (1990) for a description of sampling and interview methods.
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