
PART

**D R U G U S E
A N D R E L A T E D
B E H A V I O R :
F I N D I N G S**

I. Overall Findings and ADAM Redesign

With this year's annual report, the transition from the Drug Use Forecasting (DUF) program to the Arrestee Drug Abuse Monitoring (ADAM) program is complete. The findings reported here are from the redesigned ADAM program. ADAM was changed to make it more scientifically rigorous and to generate more information. In 2000 the changes were fully implemented. The goal is the same as before: to track drug use and related behavior among arrestees in many of the Nation's largest cities. ADAM remains the only program that does so by using urinalysis as an objective and accurate measure.

The transition to ADAM involved major changes. To select participating adult males, probability-based sampling was adopted, and all ADAM sites now use standardized procedures to collect data. Several new topics were added to the questionnaire, and although that was done before on an ad hoc basis, these new areas of inquiry will continue. Finally, the number of sites is now 38, up from 23.

The changes make this annual report different from those of previous years. As in the past, the report updates findings on arrestees' use of drugs, but this year it also explains how the new ADAM method was used to analyze the 2000 data, and in a series of essays the report examines some of the new topics (Part I). Information about arrestee drug use is presented site by site, as in previous annual reports (Part II). Another set of essays documents the new ADAM method and explores possible further ways to use it (Part III).

If ADAM has changed dramatically, the "audiences" remain the same. For policy-makers, ADAM offers a broad overview of drug use by people at risk for crime. For the police and other criminal justice practitioners at the individual sites who deal with drug use on a day-to-day basis, ADAM offers data useful for planning control strategies; and they can compare their site with the others. For researchers, ADAM offers a wealth of topics for investigating the drug-crime link.

Extent of drug use as detected by urinalysis

As in previous years, the levels of drug use detected were high. The urinalysis test used in ADAM can identify any of 10 substances, but the analysis focuses on the "NIDA-5" drugs (cocaine, opiates, marijuana, methamphetamine, and PCP).¹ (See "ADAM Drug Testing—the Procedure, the Drugs" for details of these drugs.) In half the ADAM sites that reported data, 64 percent or more of the adult male arrestees² had recently used at least one of these drugs. Use ranged from 52 percent of arrestees (Anchorage) to 80 percent (New York) (See Appendix Table 1-1.)

For each drug there were major variations among the sites and regions. These are explored here. In each site there were also distinctive patterns, examined in the section profiling the sites. An analysis that combined data from many regions of the country into a nationwide picture of drug use by arrestees would mask these differences. The differences revealed by ADAM suggest a one-size-fits-all approach to controlling drug use may not be

the optimal one, and policies and strategies for enforcement and treatment are best tailored to specific user groups and locations.

Of the 10 drugs analyzed by ADAM through urinalysis, four—cocaine (both crack and powder), marijuana, methamphetamine, and opiates (heroin, for example)—were the ones used most often by adult male arrestees in most sites. Of these, marijuana was most commonly used, followed by cocaine, opiates, and methamphetamine, in that order. In half the sites at least 40 percent of the adult male arrestees tested positive for marijuana. Use was lowest in Laredo (29 percent testing positive), with Oklahoma City at the top of the range (57 percent testing positive).

Large percentages of adult male arrestees recently used cocaine (undistinguished here between crack and powder). In half the sites, at least 31 percent tested positive, with the range between 11 percent (Des Moines) and 49 percent (Atlanta and New York). Many sites where the proportions testing positive for cocaine were relatively low (under 20 percent) were on the West Coast and in the Pacific Northwest. These include Sacramento and Salt Lake City (both 18 percent), Honolulu (16 percent), Spokane and San Diego (both 15 percent), and San Jose (12 percent).

For methamphetamine, the West is where the proportions of adult male arrestees who used this drug were highest. In several Midwestern States as well, substantial proportions of arrestees tested positive for this substance. Confirmatory urinalyses³ indicated the highest methamphetamine use (20 percent or more of adult male arrestees) was in Honolulu (36 percent), Sacramento (29 percent), San Diego (26 percent), San Jose (22 percent), Portland (21 percent), and Spokane (20 percent). Double-digit rates also showed up in Phoenix and Des Moines (both 19 percent), Las Vegas (18 percent), Salt Lake City (17 percent), and Oklahoma City and Omaha (both 11 percent).

In some sites, urinalysis indicated no recent methamphetamine use. These sites, 8 in number, are largely in the eastern part of the

country (Albany/New York Capital Area, Chicago, Detroit, Fort Lauderdale, Laredo, Miami, New York, and Philadelphia). In nine other sites, only between one-tenth of 1 percent and 1 percent of adult male arrestees tested positive. These two groups of sites, 17 in all, where 1 percent or fewer arrestees tested positive for methamphetamine, lower the median for all the sites.⁴ Although that midpoint is only 2 percent (in half the sites, 2 percent or fewer tested positive), it does not obscure the fact that in 12 sites more than 10 percent of the arrestees were positive for methamphetamine.

Only in a few sites were opiates used extensively. In most sites, few adult male arrestees tested positive for these substances (in half the sites, the proportion was 7 percent or fewer). The range was 2 percent of arrestees (Charlotte-Metro, Fort Lauderdale, and Omaha) to 27 percent (Chicago). In addition to Chicago, sites with double-digit opiate-positive rates were New York (21 percent), New Orleans (16 percent), Portland (14 percent), Philadelphia and Albuquerque (both 12 percent), and Birmingham, San Antonio, Laredo, and Seattle (each 10 percent). This distribution suggests no geographic pattern.

PCP was used by only a small percentage of arrestees in most of the sites (in half the sites, the proportion who used it was 0.3 percent or less). This low rate is consistent with the findings of earlier DUF and ADAM reports. In only two sites in 2000 did 5 percent or more of the adult male arrestees test positive for PCP (Cleveland, 8 percent, and Oklahoma City, 5 percent), and in 12 sites no arrestees tested positive.

Most adult male arrestees tested positive for only one of the five drugs. In half the sites, 21 percent or more tested positive for polydrug use, with the sites ranging from 10 percent of arrestees (Anchorage and Albany) to 34 percent (Chicago). For polydrug use the evidence should be interpreted cautiously, because the test detects only recent use. Studies have consistently shown past year or past month polydrug use the norm,⁵ with users substituting one

drug for another when the drug of choice is scarce, or mixing drugs to counter or moderate the effects of one or the other. The ADAM interviews can add to the information from urinalysis and reveal whether arrestees are using different types of drugs in the period of a month⁶ or a year (and how frequently they are used).

The new ADAM method

The redesigned ADAM program provides better estimates of drug use and related behavior than it did previously.⁷ Data collection is now based on probability sampling. The sample of arrestees at any site is selected in such a way that the findings become an accurate estimate of the proportion of all arrestees in the county who would test positive for drugs had all of them been interviewed and tested. This also means data for use in research projects at each site are stronger. And because the sites will be able to place the numbers within confidence intervals, trend analysis (year-to-year comparisons) will be more reliable and more easily interpreted than in the past.

The year 2000 was the first time these probability-based samples were obtained for adult male arrestees. Some sites were unable to implement the new procedures as quickly and effectively as others. But at most ADAM sites, beginning in 2000, the data collected constituted statistically reliable estimates of the proportion of all male arrestees in the area who had used drugs within a specified time period. Plans are to develop probability-based sampling plans for female arrestees as well.

Ensuring a representative sample

The new sampling procedure ensures a representativeness not possible under the DUF program and during the first years of the ADAM program.⁸ In each city, data were generally collected at only one lockup facility—the largest—and interviews were conducted with volunteers who had been arrested no more than 48 hours previously. DUF and ADAM staff tried to gain access to

the facilities at times during the day when there was a large number of arrests, though these times varied considerably from site to site. As a result, the representativeness of the time period of data collection and of the resultant sample was unknown, and standard errors for the samples could not be calculated. With the introduction of probability sampling in 2000, which refined the procedures for when and where data collection would take place, ADAM gained greater scientific rigor in estimating drug use.

Sample sizes and weighting

The findings reported here come from 35 of the 38 ADAM sites—those able to collect data during at least one calendar quarter in 2000. In general, the ADAM sites are very successful in convincing arrestees to participate. That was true in 2000, when at least 81 percent of adult male arrestees in half the sites agreed to be interviewed (Appendix Table 1-2). The refusal rate ranged from a low of 6 percent (Fort Lauderdale) to a high of 40 percent (Charlotte-Metro area).

The vast majority of arrestees interviewed also agreed to provide a urine specimen for analysis. In half the sites, 89 percent or more agreed, with a low of 75 percent (Albany) to a high of 98 percent (Oklahoma City). (See Appendix Table 1-2.) In half the sites, 600 or more interviews were “complete” (that is, an interview was conducted and a urine sample obtained), with the range from 109 (Charlotte-Metro area) to 1,534 (Phoenix).

A number of factors contributed to the variation in sample size (See “Why Sample Sizes Vary from Site to Site—and the Implications”), and when numbers were very small, they were not used in some analyses presented here. The number of adult male arrestees selected for inclusion in the sample averaged close to 300 per calendar quarter for each site. On the whole, these samples (the unweighted data) were more than adequate to allow data analysis and a reasonable interpretation of the results.

Why Sample Sizes Vary from Site to Site—and the Implications

In general, this report presents findings from all the ADAM sites. Of the 38 sites, findings are reported from all those (35 in number) where data were collected in at least one calendar quarter of 2000. Although the new procedure ensures representativeness of the sample, its adoption introduced complexities that affect comparability of findings from site to site. The findings should be read with an understanding that some data are missing and that in some cases changes were made to increase the representativeness of what data were available.

Sampling difficulties

Although 24 of the 35 sites were able to collect data in all four quarters, others were not. Six sites collected data in three quarters, 3 sites collected data in two quarters, and 2 sites collected data in only one quarter. (See Appendix Table 1-2.) In some sites, not enough data from arrestee case flow were obtained to permit weighting and thus these sites did not report data in the quarters when this information was missing. Some sites collected information from different populations from quarter to quarter. Findings reported here have not been adjusted for the missing quarters of data.

A site-by-site breakdown reveals the difficulties:

- **Minneapolis and Philadelphia:** Because they began data collection in the second quarter of the year, they reported data for only three quarters.
- **Los Angeles:** After several years of collecting data at the Los Angeles Police Department's main facility, this site lost access in 2000. The site staff spent the year re-establishing authorization. Therefore, this report does not contain information about Los Angeles.
- **Albuquerque:** Staffing problems in the jail prevented this site from collecting data in the fourth quarter.
- **Dallas:** Data are presented for only three quarters, because the site team went on hiatus status to resolve sampling difficulties.
- **Houston and Fort Lauderdale:** In these sites, staffing changes on the site team reduced to two the number of quarters when data were collected.
- **Miami:** Here, staffing changes reduced to three the number of quarters in which data were collected.
- **Albany and Charlotte-Metro area:** These two sites became part of the ADAM program as "affiliates"

and did not collect data in all four quarters. Albany began collection in the second quarter and Charlotte-Metro in the fourth quarter.

A few other sites encountered major obstacles to obtaining the census data needed to weight their samples, which in turn limited the number of quarters weighted data were available:

- **Chicago and Detroit:** Data collection took place at these sites for more than one quarter, but both sites could provide adequate census data for only one quarter.
- **Atlanta:** At this site it was impossible to obtain census data for all facilities in the sample. The findings are from Fulton County only, although data were collected from both Fulton and DeKalb counties.

Making the data more representative

As a result of these difficulties, changes were made to increase the representativeness of the data. As the examples of Houston, Dallas, and New York illustrate, in some cases the changes were dramatic.

- **Houston:** In the first quarter, data were collected at the jails operated by the Houston Police Department and in the second quarter at a jail operated by the Harris County Sheriff's Department. This meant the first-quarter data reflect people arrested within the Houston city limits, while the second-quarter data reflect people arrested throughout Harris County.
- **Dallas:** Collection had taken place in the main county jail, expanding to other booking facilities only in the fourth quarter (after a hiatus in the third quarter). As a result, fourth-quarter data are more representative of all arrestees in Dallas County than are first- and second-quarter data.
- **New York:** Data collection, which had taken place in all five boroughs in the first quarter, was reduced to one borough—Manhattan—for subsequent quarters because of difficulties in sampling and obtaining census data from the other four.

In some sites where there were several jails (Atlanta, Birmingham, Cleveland, Dallas, Des Moines, Detroit, Phoenix, San Antonio, and Seattle), the sampling plans used a stratified cluster model (explained in the *Methodology Guide for ADAM*. See note 8.) This required obtaining case flow data for all arrestees in the county. However, the data from these sites were weighted to the facilities in the site sampling plans—not to the county as a whole. Weights will be refined annually to reflect the countywide arrestee population; that is, the statistical inflation factor will be applied once all data are obtained.

With the adoption of probability-based sampling, the numbers can be converted by weighting to represent all arrestees in a given county/site—many more than in the original sample. The 2000 sample, when weighted, represents a large number of arrestees, from 921 in Laredo, Texas, to 18,037 in New York City. In more than half the sites the weighted sample size is more than 4,000. (See Table 1-1.)

Refining the catchment area—where data are collected

ADAM sites are typically named for the largest city in an area (the “primary city”). However, in most sites the catchment area has been redefined by ADAM to encompass a substantially larger geographic area than the urban center. The standard catchment area—the geographic region from which samples are drawn—is now the county in all the sites. The organization of booking facilities (jails), where arrestees are interviewed for the ADAM program, varies

considerably by county. Some have a single, large facility where arrestees are brought by both city and county law enforcement agencies. Others have numerous smaller jails throughout the county. Generally, however, the jurisdictional reach of law enforcement agencies does not extend beyond county lines.

Defining the sites by the county where a major metropolitan center is located (but does not necessarily encompass) means the primary unit of analysis for ADAM coincides with the standard government jurisdiction in which law enforcement’s jurisdiction is generally defined. There are now 38 sites in 26 States and the District of Columbia.

How the samples are now selected

The sampling “frame” for ADAM data collection is now the total number of adult males arrested in a county in a two-week period, regardless of charge. The probability-based sampling has two stages: drawing

Table 1-1		NUMBER OF WEIGHTED CASES, BY SITE—ADULT MALE ARRESTEES, 2000	
Primary City	Number of Arrestees	Primary City	Number of Arrestees
Albany/Capital Area, NY	1,722	Miami, FL	7,336
Albuquerque, NM	2,912	Minneapolis, MN	4,018
Anchorage, AK	1,094	New Orleans, LA	8,095
Atlanta, GA	7,879	New York, NY	18,037
Birmingham, AL	2,528	Oklahoma City, OK	3,362
Charlotte-Metro, NC	1,221	Omaha, NE	4,290
Chicago, IL	1,645	Philadelphia, PA	2,111
Cleveland, OH	5,877	Phoenix, AZ	15,395
Dallas, TX	9,227	Portland, OR	3,883
Denver, CO	5,191	Sacramento, CA	7,540
Des Moines, IA	1,966	Salt Lake City, UT	3,180
Detroit, MI	1,093	San Antonio, TX	9,395
Fort Lauderdale, FL	4,524	San Diego, CA	9,165
Honolulu, HI	2,245	San Jose, CA	9,621
Houston, TX	4,935	Seattle, WA	5,926
Indianapolis, IN	8,614	Spokane, WA	2,660
Laredo, TX	921	Tucson, AZ	3,474
Las Vegas, NV	7,733		
TOTAL		188,815	

samples of booking facilities and, within the facilities, drawing samples of arrestees. To allocate ADAM resources efficiently, a sampling simulation exercise is initially used to choose the optimal sampling design, select the booking facilities to be sampled, and distribute interviewer resources in each site. The overall goal of the design is to minimize the standard error of estimates for each site while recognizing the real-world constraints within which the program operates. The precision of estimates varies somewhat from site to site; it may be lower in some site where more than one facility is included. The specific goal is to generate estimates of drug use and related behavior that have no more than a .05 standard error overall for all sites.

Selecting the booking facilities. In the first stage, a sample of booking facilities is drawn at each site from all facilities where people are arrested. The method of selection varies by site, depending on the number of facilities in the county and the number of arrestees booked into each. For sites that have only one booking facility, all cases are drawn from it. Sites with a small number of facilities (2 to 5) are stratified by size, and cases are sampled proportionate to the size of the facility. For sites having many facilities, the facilities are clustered, principally by size, and those in each cluster are sampled proportionate to size. In a few counties, a more complex sampling model that recognizes movement of arrestees within the county is required.⁹

Selecting the arrestees. Once the facilities are selected, the second step is to draw a sample of arrestees from each. The sampling method in every facility is the same. An attempt is made to select cases systematically. Some arrestees are selected during the time of day when the volume of arrestees (“arrestee flow”) is highest. In order to include a sample of arrestees booked when interviewers are not on site (“arrestee stock”), others are randomly selected during the rest of each 24-hour period. Arrestees who cannot be interviewed because they were released early are represented through statistical imputation.

Sites are given a target number of interviews to complete each calendar quarter. It is based on an assumption of the number of interviews completed by one interviewer who works a regular shift each day of the week for a 1- or 2-week period. The probability of selection and the assignment of case weights are calculated by examining data on all arrestees booked at each facility in the two-week arrest/interview period.

The new interview instrument

The interview is a key component of the ADAM program—the source of information that cannot be obtained from official records or urinalyses. The interview process itself remains the same as in the past. Interviews are conducted among arrestees who volunteer to participate, and the process conforms to stringent Federal confidentiality regulations. Privacy is ensured because these regulations prohibit linking the interview to the arrestee’s name and using the information for or against the arrestee during booking or adjudication. No record is kept of arrestees’ names or other personal identifiers. Only a common ID number is assigned to the interview form and the urine specimen container so that these data can be linked.

The interview-process and administration

As in the past, interviews are conducted four times a year among male and female adult arrestees and juvenile detainees who have been in a booking facility less than 48 hours. They take place typically during a 4- to 8-hour period every day for one to two weeks. At each site, data collection proceeds on a staggered schedule, with collection periods for any single population (males, females, or juveniles) generally lasting one to two consecutive weeks. In most sites, more than 80 percent of the people asked to be interviewed agree.

At each site, data collection is managed by a local team that includes a site director and site coordinator.¹⁰ A pool of interviewers administers the interviews and collects the urine specimens.

All interviewers must successfully complete a 3-day training course. At all sites, local data collection staff are trained in interview techniques and in administering the ADAM interview instrument. The same, standardized training materials are used at all sites. Training is conducted just before data collection so that new skills can be applied immediately to field conditions and so that interviewers can be observed by the trainers. All interviewers also must take enhancement training every quarter.

The new design

From 1987, the year the DUF program was established, through 1999, a relatively limited amount of information could be obtained during the interviews. It included the types of drugs arrestees used, arrestees' perceived dependence on drugs, and arrestees' perceived need for alcohol or drug treatment or both. Because the offense was known, the relationship between type of offense and drug use could be analyzed. Demographic and related information were also obtained during the interview. As part of the ADAM redesign, the interview instrument (questionnaire) has been enhanced significantly and a great deal more information is collected.

The newly designed instrument, which takes about 10 minutes longer than previously (approximately 25 minutes) to administer, preserves the key measures of

drug use and thus ensures comparability of data from year to year. The new features extend the usefulness of the information obtained:

- Greater focus on the NIDA-5 drugs and patterns of use in the year before the arrestees were interviewed.
- A screen for identifying arrestees' risk for drug dependence and clinically defined drug "abuse."
- Questions about arrestees' participation in inpatient and outpatient drug and alcohol treatment and mental health treatment.
- Questions about arrest history.
- Questions about drug acquisition and recent use patterns.

The latter feature offers insights into the dynamics of not only drug markets but also drug use and drug sharing. The new instrument is structured to permit crosswalks to other national datasets on drug use, such as the National Household Survey on Drug Abuse (NHSDA), the Treatment Episode Data Set (TEDS), the System to Retrieve Information from Drug Evidence (STRIDE), and the Uniform Crime Reports (UCR). All data are available for use by anyone who has a bona fide research project. (See "Availability of 'Raw' ADAM Data.")

Availability of "Raw" ADAM Data

The ADAM data are both a research product and a resource to be used in future research. The National Institute of Justice recognizes the need to preserve and make available these and other machine-coded data collected with public funds.

All archived ADAM data files are stored with the Inter-University Consortium for Political and Social Research (ICPSR), at the University of Michigan. Researchers who would like to obtain the raw data files may contact the ICPSR (by phone at 800-999-0960 or 734-998-9825 or on the Web at <http://www.icpsr.umich.edu/NACJD/>).

NIJ's policy on use of ADAM data is on ADAM Web page (<http://www.adam-nij.net>), which can be accessed via the Web site of the National Institute of Justice (<http://www.ojp.usdoj.gov/nij>). In general, ADAM data for a particular year are available for public use after they have been presented in the ADAM annual report for that year.

NOTES

1. The ten drugs for which arrestees are tested in the ADAM program are cocaine, opiates, marijuana, methamphetamine, phencyclidine (PCP), methadone, benzodiazepines, methaqualone, propoxyphene, and barbiturates. The first five are the “NIDA-5,” established as a standard panel of commonly used illegal drugs by the National Institute on Drug Abuse.
2. An adult is defined here as anyone brought to an adult lockup facility.
3. Urinalysis can detect drugs in the amphetamine group, but only a confirmatory test indicates whether the drug is methamphetamine. The confirmation is also necessary because several cold and diet medications contain amphetamines, which would produce false positives.
4. Unless indicated otherwise, all averages are expressed as medians.
5. U.S. Department of Health and Human Services, Office of Applied Studies, SAMSHA, *National Household Survey on Drug Abuse—Main Findings*, Washington, DC: 1998.
6. Throughout this report, “past month” and “past 30 days” are used interchangeably to refer to the 30 days before the arrestees were interviewed.
7. See Chapter 7 for an in-depth discussion of the ADAM redesign.
8. A detailed discussion of the method used to collect ADAM data is in *Methodology Guide for ADAM*, by D. Hunt and W. Rhodes. Prepared by Abt Associates Inc. in May 2001, it can be downloaded from the ADAM Web page (<http://www.adam-nij.net>) on the NIJ Web site (<http://www.ojp.usdoj.gov/nij>).
9. For more details, see *Methodology Guide for ADAM*.
10. Accountability from all data collection sites is ensured by the contractor that manages ADAM for NIJ. The contractor provides centralized oversight for such matters as fiscal management, rigorously standardized data collection procedures, and minimum requirements for interviewers.

ADAM DRUG TESTING—THE PROCEDURE, THE DRUGS

Drug testing by urinalysis is a unique and important component of the ADAM program. ADAM uses an immunoassay (EMIT (Enzyme Multiplied Immunoassay Testing), to screen for the presence of drugs in urine. EMIT tests have been shown to be one of the most consistently accurate drug testing methods, with greater than 95 percent accuracy and specificity for most drugs.

The procedure

At the conclusion of the ADAM interview, arrestees are asked to provide a urine sample. Over the years of the program, approximately 80 percent agree to be interviewed, and of those more than 80 percent also agree to give a sample. Arrestees who have complete interviews (that is, they have been interviewed and have also given a urine sample) are given an incentive (for example, candy bars, gift certificates, or a soft drink). The urine specimens are removed daily from the ADAM site facilities.

A positive result from the EMIT assay (or “screen”) indicates that the drug for which the test is performed is present in the urine

sample at a level above or equal to a specified cutoff point. A negative result means either there is no drug in the urine sample or the level is below the cutoff point. Because ADAM tracks the epidemiology of drug use over time, it is not necessary or cost-effective to take other steps to confirm the presence of drugs. A confirmatory test is performed only when it is necessary to detect a particular subclass of a drug. For instance, all amphetamine positives are confirmed by gas chromatography/mass spectrometry (GC/MS) to determine whether methamphetamine was used. Specimens from all the sites are screened at a central laboratory.

The drugs detected by ADAM

ADAM detects as many as 10 drugs, but the focus of the program is the “NIDA-5,” so called because the National Institute on Drug Abuse has identified them as a standard panel of commonly used illegal drugs. They are cocaine, marijuana, methamphetamine, opiates, and phencyclidine (PCP). The other five are methadone, benzodiazepines, methaqualone, propoxyphene, and barbiturates.

Immunoassays and what they detect

An immunoassay is a test that uses antibodies to detect the presence of drugs and other substances in urine. Each immunoassay is designed to detect one particular drug or drug class. In some cases, the EMIT assay used by ADAM detects the drug itself, while in other cases it detects the metabolites of the drug. Metabolites are compounds produced by the breakdown of a drug in the body. The drug–metabolite distinction is important. There is no specific EMIT heroin assay, for example. Instead, EMIT detects metabolites common to all opiates, including heroin and codeine. When a screen detects a class of drugs, such as opiates, a confirmation test can be performed to identify the specific drug.

Drug Testing—Cutoff Levels and Detection Periods for Urinalysis—“NIDA-5” Drugs

DRUG	CUTOFF LEVEL ^a	DETECTION PERIOD ^b
Cocaine	300 ng/ml	2–3 days
Marijuana	50 ng/ml	7 days (infrequent use) 30 days maximum (chronic use)
Methamphetamine	300 ng/ml	2–4 days
Opiates	300 ng/ml	2–3 days
PCP	25 ng/ml	3–8 days

a. The cutoff level is the amount of the drug in nanograms per milliliter below which the amount is considered undetectable and the result is negative.

b. The detection period is the number of days after ingestion during which the drug can be detected in the body.

Drug Testing—Cutoff Levels and Detection Periods for Urinalysis—Other ADAM Drugs

DRUG	CUTOFF LEVEL ^a	DETECTION PERIOD ^b
Amphetamines	1,000 ng/ml	2–4 days
Barbiturates	300 ng/ml	3 days
Benzodiazepines	300 ng/ml	Up to 2 weeks
Methadone	300 ng/ml	2–4 days
Methaqualone	300 ng/ml	Up to 10 days
Propoxyphene	300 ng/ml	3–7 days

a. The cutoff level is the amount of the drug in nanograms per milliliter below which the amount is determined to be undetectable.

b. The detection period is the number of days during which the drug can be detected in the urine.

Amphetamines

A positive EMIT screen result indicates the presence of one or more drugs in the amphetamine group. Drugs that produce an amphetamine-positive screen include:

- *d* - Amphetamine
- *d* - Methamphetamine
- Methylendioxyamphetamine (MDA)
- Methylendioxymethamphetamine (MDMA).

When a test conducted to detect methamphetamine is positive, that means amphetamines are in the urine. In this country, most amphetamine use represents legal or illegal ingestion of manufactured products containing the substance. Several over-the-

counter cold and diet medications, as well as drugs used to treat ADD, can trigger a positive EMIT result. By contrast, most methamphetamine use represents consumption of an illegal substance. To determine whether the substance detected is in fact methamphetamine, screens that indicate the presence of amphetamines are subjected to a confirmatory, GC/MS test.

The percentage of a dose of amphetamine excreted from the body unchanged into a metabolite varies with the pH of the urine, with the range 2 percent (alkaline pH) to 68 percent (acidic pH). Typically, 20 to 30 percent of the substance is excreted as unchanged amphetamine and 25 percent as benzoic acid and a simple compound (hippuric acid). Methamphetamine is excreted

primarily unchanged, with a small fraction as amphetamine (44 percent and 6 percent, respectively).

Barbiturates

A barbiturate screen detects drugs in the barbiturate group. A positive screen indicates the presence of any metabolites of the group. The EMIT screen process is most efficient at detecting secobarbital in the urine. However, depending on the concentration of drug, the screen will also detect other commonly encountered barbiturates, including butalbital, pentobarbital, alphenal, amobarbital, aprobarbital, barbital, cyclopentobarbital, 5-ethyl-5-(4-hydroxyphenyl) barbituric acid, butabarbital, phenobarbital, talbutal, and thiopental.

Benzodiazepines

Most benzodiazepines are metabolized extensively in the liver and excreted through the urine as metabolites. The EMIT assay is best at detecting oxazepam, a common metabolite of benzodiazepines. However, the assay can be positive for many other benzodiazepines and/or metabolites, such as the compounds alprazolam, bromazepam, chlordiazepoxide, clobazam, clonazepam, clorazepate, clotiazepam, demoxepam, N-desalkylflurazepam, N-desmethyldiazepam, diazepam, flunitrazepam (Rohypnol), flurazepam, halazepam (Halcion), a-hydroxyalprazolam, 1-N-hydroxyethylflurazepam, a-hydroxytriazolam, ketazolam, lorazepam, medazepam, midazolam, nitrazepam, norchlordiazepoxide, prazepam, temazepam, tetrazepam, and triazolam.

Cocaine

Cocaine is metabolized extensively by liver and plasma esterases,* and only 1 percent of the dose is excreted in the urine unchanged. The primary metabolite of cocaine, benzoylecgonine, is easily identified in a urine specimen. Therefore, the EMIT assay was specifically designed to detect benzoylecgonine.

Marijuana

Delta-9-tetrahydrocannabinol (THC) is the primary psychoactive ingredient in marijuana. THC is one of approximately 30 compounds known as cannabinoids. Almost no THC is excreted in the urine unchanged into a metabolite. The primary metabolite of THC is 11-nor-D⁹-THC-9-carboxylic acid. Other major metabolites detected by EMIT assay, and which indicate marijuana use, include:

- *11-nor-D⁹-THC-9-carboxylic acid*
- *8-b-11-hydroxy-D⁹-THC*
- *8-b-hydroxy- D⁹-THC*
- *11-hydroxy- D⁹-THC*
- *11-hydroxy-D⁹-THC.*

Methadone

The EMIT assay is specific to methadone. Unchanged methadone is detectable in the urine.

Methaqualone

Methaqualone is metabolized extensively. Less than 1 percent of the dose is excreted unchanged in the urine, while 25 percent is excreted as hydroxylated metabolites. The assay detects the following compounds:

- *Methaqualone*
- *Macloqualone*
- *3'-hydroxy-methaqualone*
- *4'-hydroxy-methaqualone*
- *2'-hydroxymethyl-methaqualone.*

Opiates

Opiates are a broad class of drugs that include heroin, morphine, codeine, and semisynthetic derivatives of morphine. Heroin is rapidly broken down in the body, first to 6-monoacetylmorphine, which is metabolized to morphine. Both heroin and 6-monoacetylmorphine disappear rapidly from the blood. Codeine is also metabolized to morphine.

* An esterase is an enzyme that speeds the splitting up of an ester—a molecule consisting of an acid and an alcohol.

Because heroin and codeine break down to morphine, and the unique metabolite of heroin (6-monoacetylmorphine) disappears rapidly from the body, the EMIT opiate assay is designed to detect morphine and its metabolites. A positive screen on the EMIT assay indicates only that the substance might be heroin; use of other opiate drugs cannot be ruled out with the screen alone. Someone who has used morphine or codeine legally (morphine after surgery, for example, and codeine in a prescription drug, for example) might reasonably be expected to screen positive for opiates.

The EMIT assay can detect the following common compounds in the that belong to the class of opiates:

- *Morphine*
- *Morphine-3-glucuronide*
- *Codeine*
- *Dihydrocodeine*
- *Hydrocodone*
- *Hydromorphone*
- *Levallorphan.*

Morphine is metabolized extensively, with only 2 to 12 percent excreted unchanged in the urine. Large amounts (60 to 80 percent) of the conjugated metabolites (glucuronides) are excreted. In terms of quantity excreted, the most important metabolite of opiates is morphine-3-glucuronide-67 to 70 percent of the dose is excreted in the urine. The pattern of urinary excretion of morphine from heroin is similar to that of pharmaceutical morphine: 7 percent is excreted unchanged and 50 to 60 percent as conjugated morphine (glucuronides). Codeine is metabolized extensively, primarily to conjugated 6-codeine-glucuronide, while 10 to 15 percent of the dose forms morphine and norcodeine.

Phencyclidine (PCP)

The EMIT assay for PCP is designed to detect the following metabolites:

- *Phencyclidine*
- *N, N-diethyl-1-phenylcyclohexylamine (PCDE)*
- *1-(4-hydroxypiperidino) phenyl-cyclohexane*
- *1-(1-phenylcyclohexyl) morpholine (PCM)*
- *1-(1-phenylcyclohexyl) pyrrolidine (PCPy)*
- *4-phenyl-4-piperidinocyclohexanol*
- *1-(1-(2-thienyl)-cyclohexyl) morpholine (TCM)*
- *1-(1-(2-thienyl)-cyclohexyl) piperidine (TCP)*
- *1-(1-(2-thienyl)-cyclohexyl) pyrrolidine (TCPy).*

The body produces all these metabolites by consuming PCP. Only about 10 percent of a PCP dose is excreted unchanged in the urine. About 40 percent of the substances in a urine specimen containing PCP have not been identified by science.

Propoxyphene

Propoxyphene is classified as a narcotic analgesic, used for pain relief, that includes the trade name Darvon. The EMIT process detects the following compounds that indicate propoxyphene use:

- *Propoxyphene*
- *Norpropoxyphene.*

CHAPTER 1

A P P E N D I X
T A B L E S

**APPENDIX
Table 1-1**

**DRUG TEST RESULTS, BY DRUG BY SITE—ADULT
MALE ARRESTEES, 2000**

Primary City	Percent of Arrestees Who Tested Positive For:						
	Any NIDA-5 Drug*	Cocaine	Marijuana	Opiates	Methamphetamine	PCP	Multiple NIDA-5 Drugs
Albany/Capital Area, NY	64.9%	24.6%	44.7%	6.5%	0.0%	0.3%	10.4%
Albuquerque, NM	64.9	34.8	47.3	11.7	4.7	0.0	28.2
Anchorage, AK	52.2	22.1	37.7	3.5	0.2	0.0	10.3
Atlanta, GA	70.4	48.5	38.2	2.8	0.5	0.0	19.2
Birmingham, AL	64.8	33.0	45.3	10.2	0.2	0.0	21.8
Charlotte-Metro, NC	68.2	43.5	44.2	1.9	1.4	0.0	22.9
Chicago, IL	75.9	37.1	45.7	27.0	0.0	3.7	34.4
Cleveland, OH	72.0	38.4	49.2	3.7	0.1	8.1	25.6
Dallas, TX	54.5	27.7	35.8	3.0	2.1	3.9	14.8
Denver, CO	63.7	35.4	40.9	3.4	2.6	0.4	18.1
Des Moines, IA	55.3	11.0	41.4	2.7	18.6	1.7	19.1
Detroit, MI	69.5	24.4	49.8	7.8	0.0	0.0	11.7
Fort Lauderdale, FL	61.8	30.9	43.3	2.1	0.0	0.0	14.5
Honolulu, HI	62.9	15.8	30.4	6.8	35.9	0.2	22.6
Houston, TX	57.2	31.5	35.8	7.4	0.5	4.8	18.0
Indianapolis, IN	64.1	31.1	48.9	3.4	0.7	0.6	20.0
Laredo, TX	59.0	45.0	28.5	9.9	0.0	0.0	20.8
Las Vegas, NV	58.5	22.5	33.3	4.8	17.8	3.0	19.6
Miami, FL	62.8	43.5	38.5	4.0	0.0	0.0	22.5
Minneapolis, MN	66.7	25.7	54.2	3.0	1.6	1.8	18.5
New Orleans, LA	69.4	34.8	46.6	15.5	0.2	0.3	22.8
New York, NY	79.9	48.8	40.6	20.5	0.0	0.7	27.7
Omaha, NE	63.4	18.0	48.1	2.0	11.0	0.0	14.9
Oklahoma City, OK	71.4	22.4	57.0	3.2	11.3	5.2	24.8
Philadelphia, PA	71.9	30.9	49.4	11.8	0.0	2.5	17.8
Phoenix, AZ	65.5	31.9	33.7	6.6	19.1	1.7	24.1
Portland, OR	64.3	21.9	35.6	14.1	21.4	0.3	24.6
Sacramento, CA	73.5	18.4	50.0	3.3	29.3	0.3	25.3
Salt Lake City, UT	54.1	18.0	33.5	6.6	17.1	0.0	17.9
San Antonio, TX	52.9	20.4	40.7	10.2	0.2	0.0	17.6
San Diego, CA	63.8	14.8	38.6	6.0	26.3	0.1	20.2
San Jose, CA	52.9	12.1	35.9	5.9	21.5	3.6	21.0
Seattle, WA	64.2	31.3	37.8	9.9	9.2	1.4	21.5
Spokane, WA	57.9	15.1	40.2	7.9	20.4	0.8	21.4
Tucson, AZ	69.4	40.8	45.1	8.8	6.9	0.1	28.7
Median	64.2%	30.9%	40.9%	6.5%	1.6%	0.3%	20.8%

* The five drugs listed here are referred to as the NIDA-5, established by the National Institute on Drug Abuse as a standard panel of commonly used illegal drugs.

APPENDIX
Table 1-2

**ADAM SAMPLE SIZES, INTERVIEWS, AND URINALYSES,
BY SITE—ADULT MALE ARRESTEES, 2000**

Primary City	Number of Adult Male Arrestees in Sample					Number of Completed Interviews	Percent Who Refused to Be Interviewed ^a	Percent of Interviews in Which Arrestee Agreed to Urinalysis
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total			
Albany/Capital Area, NY ^b	ND	57	315	263	635	333	20.3%	74.7%
Albuquerque, NM	238	203	117	ND	558	326	20.1	87.5
Anchorage, AK	272	254	291	290	1,107	607	25.1	82.9
Atlanta, GA	263	269	283	300	1,115	756	12.4	96.9
Birmingham, AL	130	123	158	118	529	454	7.7	85.9
Charlotte-Metro, NC ^c	ND	ND	ND	322	322	109	40.1	88.0
Chicago, IL	ND	ND	1,078	ND	1,078	441	19.2	85.7
Cleveland, OH	359	443	548	675	2,025	1,111	8.8	82.0
Dallas, TX	447	662	ND	465	1,574	847	30.9	85.0
Denver, CO	289	287	255	299	1,130	731	10.3	93.4
Des Moines, IA	203	244	258	211	916	344	21.3	91.0
Detroit, MI	ND	ND	431	413	844	582	18.4	81.5
Fort Lauderdale, FL	216	198	ND	ND	414	353	5.9	96.6
Honolulu, HI	251	270	300	290	1,111	583	21.4	80.0
Houston, TX	828	502	ND	ND	1,330	765	12.8	88.4
Indianapolis, IN	375	322	496	651	1,844	793	34.0	94.1
Laredo, TX	83	109	105	77	374	306	10.3	93.1
Las Vegas, NV	348	461	443	513	1,765	980	14.7	89.3
Los Angeles, CA	ND	ND	ND	ND	ND	ND	ND	ND
Miami, FL	329	386	327	ND	1,042	671	12.6	94.2
Minneapolis, MN	ND	395	371	347	1,113	571	24.2	92.4
New Orleans, LA	219	245	211	209	884	668	6.8	96.1
New York, NY ^c	587	257	383	308	1,535	1,091	27.4	96.6
Oklahoma City, OK	279	281	232	207	999	734	15.0	97.9
Omaha, NE	119	108	169	171	567	443	11.4	85.1
Philadelphia, PA	ND	196	181	143	520	387	20.9	85.1
Phoenix, AZ	464	602	688	673	2,427	1,534	18.6	94.3
Portland, OR	222	349	528	420	1,519	779	30.5	88.9
Sacramento, CA	195	499	590	397	1,681	603	24.2	85.1
Salt Lake City, UT	282	294	325	298	1,199	698	16.5	89.9
San Antonio, TX	134	196	203	315	848	661	7.6	91.5
San Diego, CA	426	347	398	397	1,568	620	20.3	95.5
San Jose, CA	266	256	484	481	1,487	679	16.2	89.2
Seattle, WA	361	503	486	508	1,858	1,013	28.2	88.4
Spokane, WA	348	323	313	283	1,267	523	26.8	90.6
St. Louis, MO ^d	ND	ND	ND	ND	ND	ND	ND	ND
Tucson, AZ	313	301	272	310	1,196	626	14.9	89.0
Washington, DC	ND	ND	ND	ND	ND	ND	ND	ND
Median	279	284	315	309	1,113	626	18.6%	89.2%

a. Not a true response rate, because the base is adult male arrestees who were asked to be interviewed.

b. ADAM affiliate site.

c. During the first quarter of 2000, data were collected in all five boroughs of New York City, but for the remainder of the year only in Manhattan.

d. St. Louis has been in ADAM for several years, and is now in hiatus status. It will return to active status after resolution of financial and other issues.

Note: ND = no data available.

II. Drug Dependence and Treatment

by Christine R. Crossland and Henry H. Brownstein*

DUF and ADAM have revealed that people who come to the attention of the criminal justice system by being arrested are more often than not users of drugs and/or alcohol.¹ What is not known is the extent to which they have become dependent on these substances.² Nor is it known to what extent they need treatment or even have access to treatment.³ Nonetheless, dependence and access to treatment, particularly for this at-risk population, are serious social and public health problems⁴ about which data are often limited. Many communities have historically lacked the data needed to identify arrestees' treatment needs, because such users are typically undercounted in drug-use surveys (for example, the National Household Survey on Drug Abuse).

Two additions to the ADAM survey instrument were designed to promote understanding of arrestee dependence and treatment needs as a means to address the resultant public health problems. First, the instrument now includes a screening tool to assess risk for drug and alcohol dependence—a measure of need for treatment. Second, questions about arrestees' treatment history have been added in an attempt to determine whether arrestees have ever received drug or alcohol treatment and whether they received such treatment recently—specifically, in the year before they were arrested.⁵ With the redesigned ADAM program, many communities now have access to data on treatment and can use it to develop evidence-based policies that can help local and national policymakers acquire or target treatment resources.

Measuring drug dependence/treatment need

In response to the debate among researchers and policymakers about the distinction between physical and psychological dependence, sociologist Erich Goode has suggested that such distinction is “largely irrelevant.”⁶ He contends that chronic users of drugs that cause psychological dependence behave in much the same way as individuals who are addicted to drugs that cause physiological dependence. For example, while cocaine dependence is not the same as heroin addiction,⁷ the profound psychological need felt by cocaine users produces similar behavioral outcomes.

Because the behavioral effects of physiological and psychological addiction are similar, the emphasis in the ADAM screener for dependence is on behavior rather than on classic physiological markers, such as tolerance or withdrawal. (For details about the development of the screener and the screener itself, see “Screening Arrestees for Drug and Alcohol Dependence/Need for Treatment.”)

Arrestees at risk for dependence on drugs

Overall, among all adult male arrestees in the ADAM sample, between 27 percent (Houston and San Antonio) and 47 percent (Chicago) were found to be at risk for dependence on drugs. (See Appendix Table 2–1.) While in no site were more than half the arrestees found to be drug dependent, neither was there any site where less than one-fourth were drug dependent.

* Christine R. Crossland is a Program and Policy Analyst with the Drugs and Crime Research Division of the National Institute of Justice (NIJ); Henry H. Brownstein, Ph.D., is Director of the Drugs and Crime Research Division, NIJ, and Executive Director of the ADAM Program.

Risk for dependence by type of drug

Among users of marijuana, crack, powder cocaine, heroin, and methamphetamine, more than half were found to have been at risk for dependence in the past year. (See Appendix Table 2–2.) The proportions at risk varied by drug. In general, heroin users were more likely than users of other drugs to be at risk for dependence. The figure

was 88 percent or more in half the sites, with a range of 50 percent (Charlotte-Metro) to 100 percent (Birmingham, Des Moines, and Indianapolis).

At 56 percent in half the sites, the proportion of marijuana users at risk for dependence was much lower than for all other drugs. The range was 45 percent of drug-using arrestees (Denver) to 69 percent (Des

Screening Arrestees for Drug and Alcohol Dependence/Need for Treatment

As part of the redesign, ADAM added to the questionnaire a “screener” that generates information about risk for dependence on drugs and alcohol and consequent need for treatment. The screener was developed from a subset of questions derived from the Substance Use Disorder Diagnostic Schedule (SUDDS-IV), a clinical assessment based in turn on criteria for dependence in the American Psychiatric Association’s DSM–IV.^a This series of questions in the ADAM interview makes it possible to estimate the number of arrestees who are likely to be at risk for alcohol and/or drug dependence.

The information from the new series of questions can also aid in responding to the problem. Examining the use of specific drugs can help promote the development of strategies and planning policies to address new or emerging problems. For instance, if the number of heroin users increases, if that increase was recent, and if the proportions found at risk for dependence have increased, this information can be used by providers to assess the need for resources (for example, whether more methadone treatment is needed).

To measure substance abuse and risk for dependence, arrestees who said they used alcohol or drugs in the 12 months before their arrest are asked six questions. Pilot tests conducted in three

cities^b revealed these particular questions best predicted risk for dependence and abuse.

- Have they spent more time drinking or using drugs than they intended?
- Had they neglected their usual responsibilities because of drug or alcohol use?
- Had they wanted to cut down on drinking or drug use?
- Had anyone, during the past 12 months, objected to their use of drugs or alcohol?
- How frequently had they found themselves thinking about using drugs or alcohol?
- Had they had used drugs or alcohol to alleviate feelings such as sadness, anger, or boredom?

Arrestees who answered yes to only one or none of the six questions were considered at no risk for either drug abuse or dependence. A combination of two affirmative responses indicated risk for *abuse*, unless the two responses were to the questions about using drugs and alleviating negative emotions. Risk for abuse was also indicated when an arrestee answered yes to three or more questions, as long as thinking about using drugs or alcohol or alleviating negative emotions was among the three. A combination of three or more affirmative responses indicated risk for *dependence*, provided that either thinking about using drugs or alcohol or alleviating negative emotions was one of the three. In addition, if both thinking about using either substance and alleviating negative emotions were the only two affirmative responses, the person was considered at risk for dependence.

a. DSM–IV refers to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, compiled and published in 1994 by the American Psychiatric Association. It is used by psychiatrists for diagnoses and is widely used by others. See Hoffmann, N.G. and P.A. Harrison, *SUDDS-IV: Substance Use Disorder Diagnostic Schedule-IV*, St. Paul: New Standards, Inc., 1995; Hoffmann, N.G., et al., “UNCOPE: A Brief Substance Dependence Screen for Use with Arrestees,” in *Drug and Alcohol Dependence*, forthcoming; and Hunt, D. and W. Rhodes, *Methodology Guide for ADAM*, Washington, DC: U.S. Department of Justice, National Institute of Justice, May 2001. The *Guide* can be downloaded from the ADAM Web page (<http://www.adam-nij.net>) on the NIJ Web site (<http://www.ojp.usdoj.gov/nij>).

b. Hoffmann, et al., “UNCOPE.”

Moines). For users of the other drugs, the proportions at risk for dependence lay between the rates for heroin and marijuana. Thus, for crack cocaine, 80 percent of drug-using arrestees in half the sites were at risk; the figure for powder cocaine was 74 percent, for methamphetamine, 76 percent, and for other drugs, 74 percent. (Exhibit 2-1 shows these relative averages.⁸⁾)

Demographics and sociodemographics of those at risk

Among drug-using arrestees at risk for dependence, there was some variation by site in age, race, ethnicity, employment status, level of education, marital status, and whether or not the arrestee had health insurance. (See Appendix Table 2-3.) For example, the proportion of arrestees who scored at risk for drug dependence and were under 21 ranged from less than 10 percent (Denver and Las Vegas) to more than 35 percent (San Antonio). Of arrestees at risk for dependence, in Atlanta, Birmingham, Chicago, Detroit, and New Orleans, more than 75 percent were black; in Albuquerque, Honolulu, Laredo, Phoenix, Salt Lake City, San Antonio, and Spokane, fewer than 13 percent were black.

This breakdown may, of course, reflect the racial and ethnic composition of all adult male arrestees and all people living in the particular county.⁹ Thus, in the same way, in a number of southwestern sites, the proportion of arrestees who were both drug-dependent and Hispanic was relatively high (for example, 64 percent in Albuquerque; 93 percent in Laredo; 71 percent in San Antonio; and 42 percent in

Tucson). This reflects the high percentage of adult male arrestees in these sites who said they were of Hispanic heritage (Albuquerque, 60 percent; Laredo, 96 percent; San Antonio, 68 percent; and Tucson, 42 percent).

Prevalence of treatment among drug users

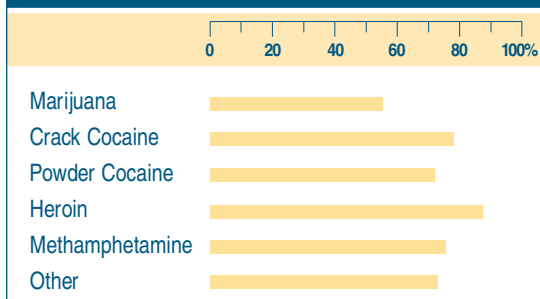
The adult male arrestees who said they used drugs were asked whether they had participated in inpatient and outpatient treatment for drugs or alcohol, both in the past year and in their lifetime. Fewer than one in ten said they had received inpatient drug or alcohol treatment (for example, in detox, rehab, a therapeutic community, or a hospital) in the past year (9 percent or less, in half the sites). The range was 4 percent (Birmingham) to 17 percent (Albany/New York Capital area). (See Appendix Table 2-1.)

The proportion who had ever been in inpatient treatment was higher: In half the sites, at least 29 percent of drug-using arrestees said they had ever been treated on an inpatient basis. (See Exhibit 2-2 for a visual illustration of the comparative percentages.) This may reflect the large numbers who have participated in (inpatient) detox programs. Mental health treatment was much less common, with 10 percent or less in half the sites saying they ever received such treatment. The proportions ranged from 2 percent (Charlotte-Metro) to 20 percent (Spokane).

Treatment by type of drug

The proportion of drug users who ever received treatment varied by type of drug used. For inpatient treatment, marijuana was the drug for which the proportion of arrestees was lowest (28 percent or less in half the sites). (See Exhibit 2-3.) Among drug users who ever used marijuana,¹⁰ the proportion who ever participated in inpatient treatment ranged from 16 percent (New Orleans) to 46 percent (Albany). (See Appendix Table 2-4.) The proportions who ever received outpatient treatment for this drug were somewhat lower, with the range 11 percent (New Orleans) to 42 percent (Albany).

Exhibit 2-1: Percentages of drug-using adult male arrestees at risk for dependence in past year, by drug, 2000



Note: Percentages are averages (medians) among all sites.

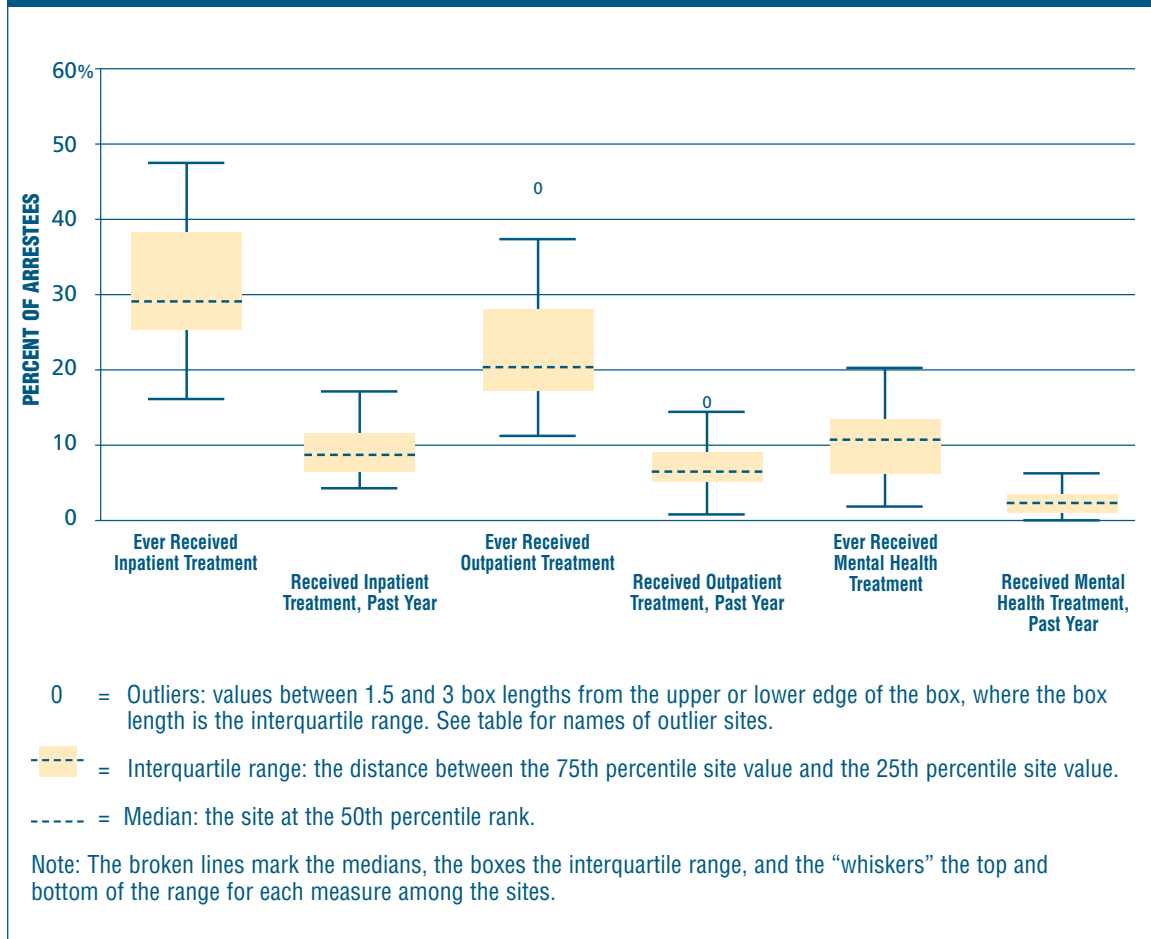
Arrestees who had used crack at some point in their lives were typically more likely than marijuana users to have ever received either type of treatment. In half the sites, 48 percent had received inpatient treatment and 31 percent outpatient treatment. For inpatient treatment, the range was 28 percent (New Orleans) to 73 percent (Albany); for outpatient treatment, it was 17 percent (New Orleans) to 66 percent (Albany).

The proportions of arrestees who ever used the other drugs—heroin, powder cocaine, or methamphetamine—and said they had ever been in treatment were relatively high, with figures varying somewhat by site. In all sites except four (Atlanta, Chicago, Dallas, and New Orleans), half or more of all arrestees who ever used heroin also said they had received inpatient drug treatment at some point in their lives.

Overall, at 61 percent, the proportion of heroin-using arrestees who had ever received inpatient treatment was higher than for those who used any of the other drugs. (See Exhibit 2–4.) The same was true of heroin users who received outpatient treatment, although the differences among the drugs were less dramatic.

In nine sites (Albany, Anchorage, Des Moines, Detroit, Minneapolis, New York, Portland, San Diego, and Seattle), half or more of the arrestees who ever used powder cocaine said they had received inpatient treatment at some time in their lives. Because the proportions who received treatment were in some instances relatively high, they suggest overall that many adult male arrestees who used drugs have at one time or another availed themselves of treatment but remain drug users.

Exhibit 2-2: Participation by drug-using adult male arrestees in drug or alcohol treatment or mental health treatment—ranges among the sites, 2000

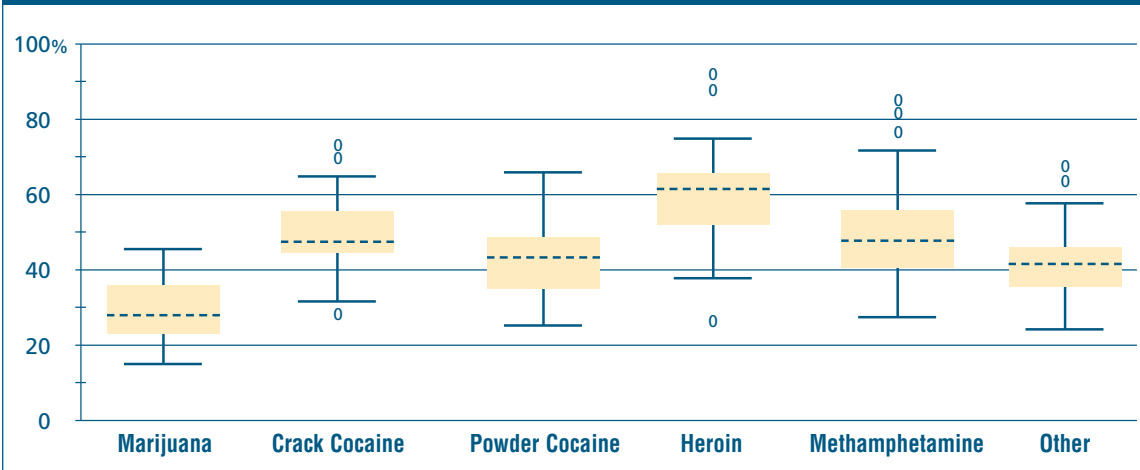


Demographics and socio-demographics

Among adult male arrestees who had participated in drug or alcohol treatment in the year before their arrest, there were few demographic differences by site. The average (median) age of those who had participated in inpatient treatment in the 12 months

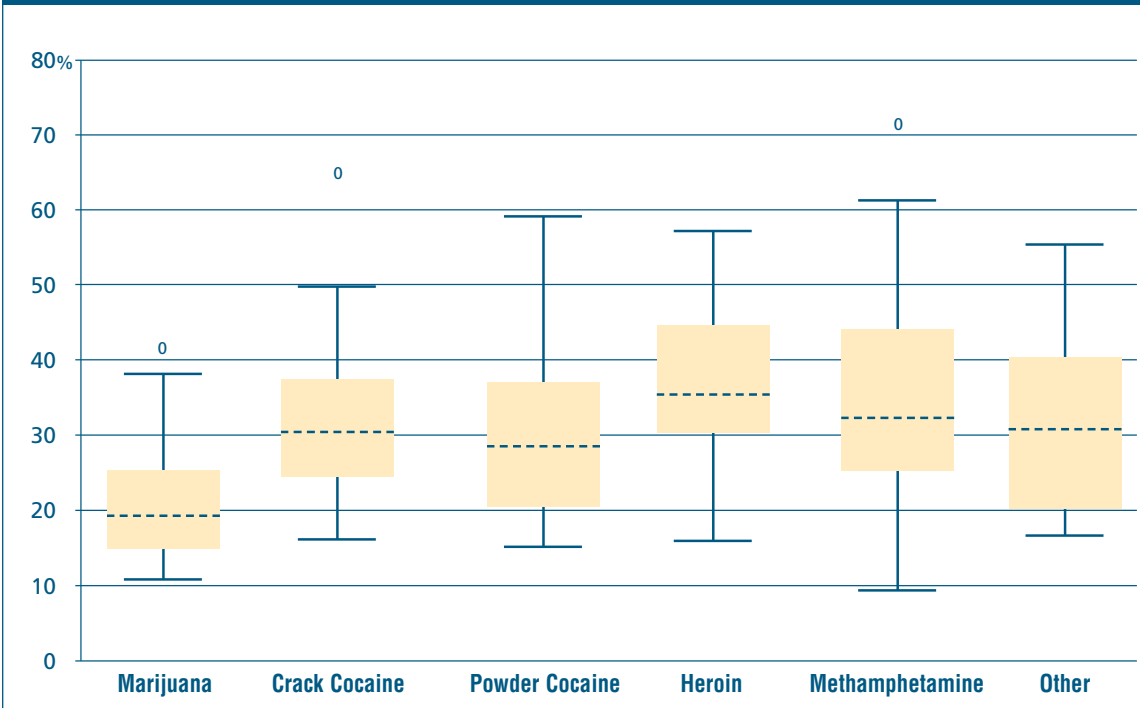
before their arrest was 34 years; among those participating in outpatient treatment it was 32. Among those who had participated in inpatient treatment, the proportion who did not have health insurance was high: In half the sites, at least 66 percent said they currently lacked health insurance. The range was 29 percent (Birmingham) to 85 percent

Exhibit 2-3: Percentages of drug-using adult male arrestees who ever received inpatient drug or alcohol treatment, by drug—ranges among the sites, 2000



Legend: See Exhibit 2-2.

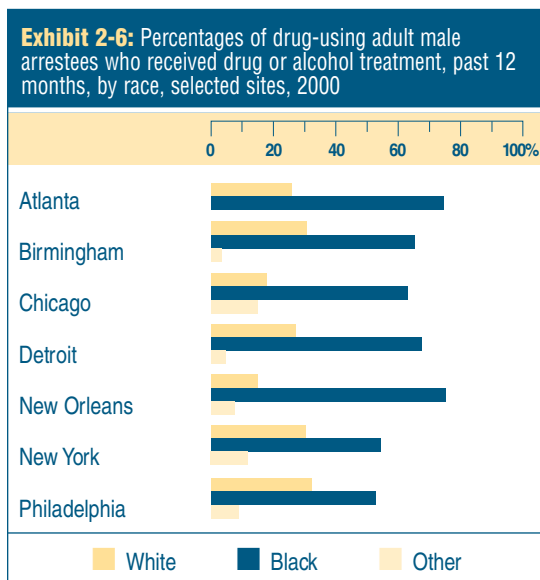
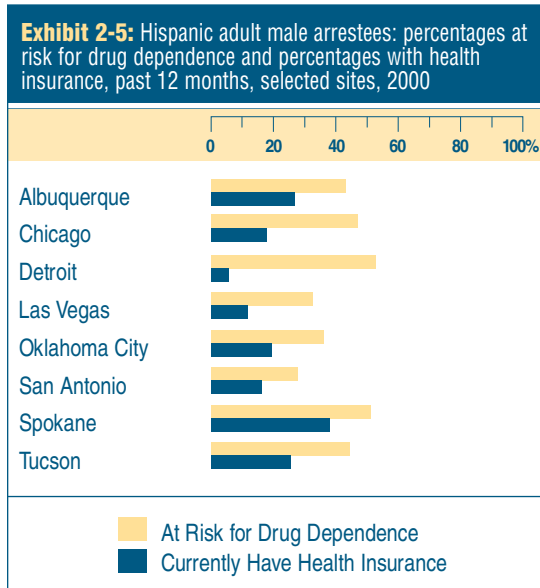
Exhibit 2-4: Percentages of drug-using adult male arrestees who ever received outpatient drug or alcohol treatment, by drug—ranges among the sites, 2000



Legend: See Exhibit 2-2.

(Indianapolis). The proportions who participated in outpatient treatment but lacked health insurance were also high: 64 percent or more in half the sites, with the range 31 percent (Omaha) to 91 percent (Charlotte-Metro). (See Appendix Table 2-5.)

The situation of Hispanic arrestees is particularly notable. High percentages were at risk for drug dependence, and among them the proportions who had the health insurance coverage needed to address the problem were relatively low. (See Exhibit 2-5.) As with other demographic characteristics, race appears to make a difference in likeli-

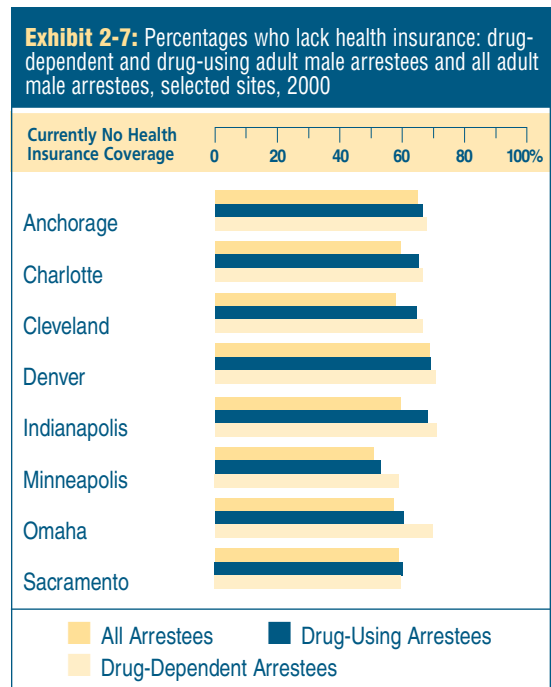


hood of being treated. Black arrestees were far more likely than whites and others to have said they had received treatment for drug or alcohol use in the year before they were arrested. (See Exhibit 2-6.)

Drug-dependent arrestees—treatment needs

The redesigned ADAM revealed notable proportions of adult male arrestees at risk for drug dependence and thus in particular need of treatment. Many had received treatment at some point in their lives, but the vast majority had not been treated recently (in the past year). (See Appendix Table 2-6.) In the year before their arrest, as few as 6 percent of drug-dependent arrestees (in Atlanta and Chicago) and rarely more than 20 percent (in Albany, Charlotte-Metro, Laredo, Minneapolis, and Portland) were treated on an inpatient basis, and in more than half the sites less than 10 percent received outpatient treatment.

There may be a number of reasons that, despite an evident need, arrestees do not receive treatment. One barrier may be lack of health insurance. In half of the sites, at least two-thirds of these at-risk arrestees lacked any type of health insurance. (See



Note: Treatment could be inpatient or outpatient.

Appendix Table 2–3.) The proportion lacking health insurance reached 50 percent in every site. For the most part, the proportion of drug-dependent arrestees who lacked insurance exceeded the proportions of drug-using arrestees who lacked insurance. (See Exhibit 2–7.)

Toward more in-depth investigation

ADAM has shown that not only is there considerable drug use among adult male arrestees, but there is also considerable risk for drug dependence—an index of need for treatment. As the ADAM program continues to expand and evolve, additional questions about drug dependence and treatment needs can be investigated. In addition to

the new questions about need for treatment and types of services received (whether inpatient or outpatient), it may be possible to explore treatment settings, modalities, and types of interventions.

In the near future, by adding to the interview instrument a more substantive module addressing treatment, the ADAM program will be able to offer practitioners, researchers, and policymakers more detailed information about arrestees' need for services. And it will be possible not only to identify treatment needs in particular areas at a particular time and to compare sites but, as data are collected from year to year, it will also be possible to track changes in specific sites.

NOTES

1. See, for example, Arrestee Drug Abuse Monitoring Program, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Research Report, Washington, DC: U.S. Department of Justice, National Institute of Justice, June 2000, NCJ 181426.
2. See Chen, H.T., et al., "Problems and Solutions for Estimating the Prevalence of Drug Abuse Among Arrestees," *Journal of Drug Issues* 27 (1997): 689–701; and Goode, E., *Drugs in American Society*, New York: McGraw Hill, 1993.
3. See Harrison, L., "The Revolving Prison Door for Drug-Involved Offenders: Challenges and Opportunities," *Crime and Delinquency* 47 (July 2001): 462–484; and Hser, Y.I., D. Longshore, and M.D. Anglin, "Prevalence of Drug Use Among Criminal Offender Populations: Implications for Control, Treatment, and Policy," in *Drugs and Crime—Evaluating Public Policy Initiatives*, ed. D.L. Layton and C.D. Uchida, Thousand Oaks, CA: Sage, 1994:18–41.
4. Horgan, C., K.C. Skwara, and G.S., *Substance Abuse—The Nation's Number One Health Problem*, Princeton, NJ: The Robert Wood Johnson Foundation, 2001; and Office of National Drug Control Policy, *The National Drug Control Strategy: 2001 Annual Report*, Washington, DC: Executive Office of the President, 2001.
5. In this report, 12 months and one year are used interchangeably.
6. Goode, *Drugs in American Society*: 33.
7. U.S. Sentencing Commission, *Cocaine and Federal Sentencing Policy*, Washington, DC: U.S. Sentencing Commission, 1995: 22–28.
8. Unless indicated otherwise, averages are expressed as medians.
9. For most demographic characteristics, the proportions of adult male arrestees who scored as at risk for dependence mirrored the overall rates for the entire ADAM sample. When differences occurred, they were among sites rather than between arrestees who were drug-dependent and those who were not.
10. The arrestees were asked about each drug separately; thus a single arrestee could be included in each group of users of a specific drug. For example, an arrestee who used marijuana might also be among the cocaine and/or methamphetamine users. This overlap should be kept in mind in interpreting the findings.

CHAPTER



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A P P E N D I X
T A B L E S

**APPENDIX
Table 2-1**

**DRUG DEPENDENCE AND TREATMENT STATUS, BY
SITE—ADULT MALE ARRESTEES, 2000**

Primary City	Percent at Risk for Drug Dependence ^a	Percent Who Said They Received Inpatient Drug or Alcohol Treatment		Percent Who Said They Received Outpatient Drug or Alcohol Treatment		Percent Who Said They Received Mental Health Treatment	
		Ever ^b	In Past 12 Months ^c	Ever ^b	In Past 12 Months ^c	Ever ^b	In Past 12 Months ^c
Albany/Capital Area, NY	33.3%	46.6%	17.4%	44.5%	14.0%	17.0%	2.4%
Albuquerque, NM	39.7	39.8	8.8	23.3	10.0	12.0	0.4
Anchorage, AK	29.3	41.8	10.8	35.5	9.2	16.9	3.8
Atlanta, GA	33.2	21.3	4.5	14.4	3.1	4.6	1.4
Birmingham, AL	29.1	29.0	4.1	17.0	5.5	5.8	1.1
Charlotte-Metro, NC	33.9	25.0	12.0	18.8	9.1	2.3	0.0
Chicago, IL	47.1	23.0	5.9	20.2	6.7	9.3	1.7
Cleveland, OH	36.7	30.6	10.2	22.8	5.1	10.2	2.2
Dallas, TX	29.6	23.3	7.7	15.6	6.0	6.2	1.4
Denver, CO	28.6	36.8	12.7	21.2	7.8	11.3	2.9
Des Moines, IA	41.1	47.4	9.2	36.3	13.6	16.4	4.3
Detroit, MI	37.2	25.3	6.0	17.5	4.1	10.2	3.1
Fort Lauderdale, FL	28.2	27.9	5.4	15.0	1.9	7.2	0.4
Honolulu, HI	41.5	37.1	13.0	26.5	9.3	16.1	4.2
Houston, TX	26.5	23.5	7.0	12.3	3.8	9.2	2.1
Indianapolis, IN	29.8	28.9	5.0	28.0	9.0	9.0	2.2
Laredo, TX	29.9	25.4	15.3	20.1	9.2	3.7	2.5
Las Vegas, NV	36.4	27.0	6.2	17.5	5.8	8.8	2.0
Miami, FL	28.8	27.3	11.7	20.9	6.4	8.1	1.6
Minneapolis, MN	37.3	39.9	13.3	29.2	8.6	10.4	2.7
New Orleans, LA	37.8	15.6	4.5	11.0	5.4	6.8	2.5
New York, NY	42.5	33.3	10.5	30.1	15.0	5.3	1.8
Oklahoma City, OK	42.0	37.1	9.4	15.3	2.9	14.1	1.2
Omaha, NE	32.0	23.2	5.5	18.7	3.5	14.3	1.4
Philadelphia, PA	43.1	27.6	10.4	19.3	7.9	11.5	5.0
Phoenix, AZ	41.3	34.4	10.5	20.6	5.7	12.1	2.5
Portland, OR	34.7	40.6	14.4	38.8	14.4	11.1	4.0
Sacramento, CA	43.7	25.3	6.9	15.1	6.6	13.1	4.4
Salt Lake City, UT	37.3	40.3	9.3	28.3	11.3	13.0	1.8
San Antonio, TX	26.5	27.2	9.8	20.0	3.1	5.3	0.6
San Diego, CA	39.8	38.4	12.8	22.9	7.0	10.8	3.7
San Jose, CA	37.7	26.4	8.4	18.2	6.5	6.2	1.8
Seattle, WA	41.7	40.8	9.7	38.6	12.7	12.7	3.2
Spokane, WA	41.9	38.0	10.7	35.8	8.6	20.3	6.4
Tucson, AZ	44.2	33.4	8.8	24.3	6.4	17.1	3.7
Median	37.2%	29.0%	9.4%	20.6%	6.7%	10.4%	2.3%

- a. Dependence is considered a measure of need for treatment.
- b. Question was asked of all adult male arrestees.
- c. Question was asked of those who said they had used drugs in the 12 months before their arrest.

**APPENDIX
Table 2-2**

**ADULT MALE ARRESTEES AT RISK FOR DRUG
DEPENDENCE, BY SELECTED DRUGS, BY SITE, 2000**

Primary City	Marijuana	Crack Cocaine	Powder Cocaine	Heroin	Methamphetamine	Other Drug
Albany/Capital Area, NY	50.9%	80.7%	76.6%	91.3%	76.1%	40.7%
Albuquerque, NM	56.4	75.6	68.2	86.7	75.6	64.0
Anchorage, AK	47.5	65.6	73.5	72.6	70.9	67.2
Atlanta, GA	53.2	68.1	70.4	80.5	54.9	74.7
Birmingham, AL	49.1	79.0	73.7	100.0	100.0	71.6
Charlotte-Metro, NC	50.0	68.7	54.1	50.0	0.0	19.1
Chicago, IL	62.8	80.8	86.6	83.2	0.0	100.0
Cleveland, OH	52.5	78.4	74.1	81.8	83.1	63.0
Dallas, TX	49.8	73.9	65.8	98.0	74.1	84.0
Denver, CO	44.7	71.9	59.4	77.2	63.6	51.6
Des Moines, IA	68.5	85.1	91.5	100.0	82.1	76.5
Detroit, MI	52.3	84.3	86.3	88.2	100.0	66.2
Fort Lauderdale, FL	49.4	71.0	65.8	52.2	0.0	65.1
Honolulu, HI	67.3	86.1	86.4	90.7	76.9	88.2
Houston, TX	48.5	85.2	61.4	76.6	70.8	59.1
Indianapolis, IN	49.5	71.3	72.8	100.0	89.0	73.9
Laredo, TX	66.5	83.1	61.0	86.7	100.0	81.9
Las Vegas, NV	59.3	72.6	73.6	87.6	66.5	76.6
Miami, FL	56.7	79.9	69.3	90.0	100.0	69.0
Minneapolis, MN	55.3	77.6	68.1	85.3	69.5	68.2
New Orleans, LA	56.1	72.4	72.2	77.2	100.0	70.2
New York, NY	51.2	74.9	69.9	80.7	100.0	34.4
Oklahoma City, OK	62.8	86.4	73.5	88.5	76.9	71.7
Omaha, NE	47.7	83.9	45.4	73.9	80.7	77.7
Philadelphia, PA	62.0	86.1	89.5	95.0	100.0	82.2
Phoenix, AZ	65.1	79.9	76.2	89.5	76.4	75.0
Portland, OR	49.4	71.3	77.0	82.8	70.5	78.6
Sacramento, CA	61.4	69.6	74.2	91.3	77.5	77.3
Salt Lake City, UT	64.8	83.8	75.5	93.0	79.8	85.0
San Antonio, TX	51.1	89.6	56.4	92.8	55.3	44.4
San Diego, CA	57.8	79.6	77.0	97.5	69.1	77.8
San Jose, CA	63.0	75.4	70.9	95.0	66.0	82.1
Seattle, WA	57.9	79.7	78.0	89.7	83.8	82.5
Spokane, WA	62.4	87.5	80.7	94.1	84.0	73.3
Tucson, AZ	58.9	80.6	69.4	78.7	72.6	78.1
Median	56.1%	79.6%	73.5%	88.2%	76.4%	73.9%

Note: Reflects proportions of adult male arrestees who said they used drugs in the year before they were arrested.

**APPENDIX
Table 2-3**

DEMOGRAPHICS AND SOCIODEMOGRAPHICS OF ADULT MALE ARRESTEES AT RISK FOR DRUG DEPENDENCE, BY SITE, 2000

Primary City	Percent Who Said Their Age Is:					Percent Who Said Racially/Ethnically They Are:		Percent Who Said They Were Not Working	Percent Who Said They Had No High School Diploma	Percent Who Said They Had No Health Insurance	Percent Who Said They Were Single
	Under 21	21-25	26-30	31-35	36+	Black	Hispanic				
Albany/Capital Area, NY	19.0%	18.9%	15.2%	14.3%	32.6%	45.8%	10.9%	40.5%	33.1%	67.4%	69.9%
Albuquerque, NM	20.4	19.5	15.8	11.2	33.1	10.5	64.2	35.9	25.7	67.9	65.2
Anchorage, AK	19.7	12.9	15.5	13.7	38.2	13.6	6.7	52.8	21.4	67.6	60.0
Atlanta, GA	10.6	16.3	13.0	17.6	42.4	91.6	1.9	40.2	33.4	66.1	74.0
Birmingham, AL	15.6	24.6	15.5	13.9	30.5	75.2	2.2	48.0	45.0	61.7	59.0
Charlotte-Metro, NC	22.2	28.1	11.1	25.3	13.3	74.7	0.0	38.7	29.1	66.0	78.3
Chicago, IL	23.1	17.8	13.2	13.6	32.3	78.8	13.9	41.6	43.3	72.8	73.2
Cleveland, OH	18.5	20.6	14.7	14.0	32.2	74.8	4.0	41.1	41.3	66.2	72.1
Dallas, TX	22.5	21.7	11.5	13.6	30.6	50.7	13.4	42.1	29.9	66.8	62.5
Denver, CO	9.8	16.0	16.7	14.9	42.5	37.5	31.8	43.0	29.5	72.1	56.0
Des Moines, IA	14.9	18.1	20.7	12.8	33.6	27.2	5.1	46.6	25.6	68.2	59.0
Detroit, MI	19.1	25.1	11.4	16.1	28.4	81.5	4.4	38.1	34.6	58.1	71.4
Fort Lauderdale, FL	17.5	26.7	11.3	15.2	29.3	44.8	13.8	28.3	37.0	62.7	62.8
Honolulu, HI	11.5	17.3	16.6	14.8	39.9	2.0	19.9	65.3	17.6	54.2	58.7
Houston, TX	20.4	29.0	11.4	8.6	30.6	53.0	21.4	27.5	28.7	68.9	54.9
Indianapolis, IN	19.0	16.6	17.1	15.6	31.7	56.9	3.7	34.6	42.2	72.7	67.0
Laredo, TX	28.6	23.7	16.3	9.8	21.6	3.0	92.8	34.4	51.0	73.0	33.7
Las Vegas, NV	9.7	19.8	18.2	16.8	35.6	26.0	18.3	39.0	29.0	77.7	56.9
Miami, FL	10.6	24.2	9.9	19.3	36.0	52.4	32.5	40.2	39.1	66.3	66.1
Minneapolis, MN	20.9	25.0	16.7	17.9	19.4	53.9	4.5	50.9	26.6	58.0	82.5
New Orleans, LA	25.0	30.2	16.6	7.7	20.4	87.3	0.8	37.1	55.9	62.0	81.0
New York, NY	12.1	9.2	14.1	19.6	44.9	59.0	32.6	58.6	38.5	56.2	73.7
Oklahoma City, OK	20.5	20.7	15.1	12.8	30.9	38.0	5.4	30.9	28.1	72.7	53.7
Omaha, NE	14.0	21.8	16.5	21.6	26.2	42.2	7.7	33.7	29.6	69.9	60.0
Philadelphia, PA	21.1	20.9	15.6	14.1	28.2	70.0	10.3	56.3	32.7	63.7	75.2
Phoenix, AZ	16.4	18.7	16.1	16.4	32.4	12.2	29.1	39.5	32.6	69.5	57.7
Portland, OR	11.6	16.3	20.7	13.8	37.6	19.0	8.3	60.2	26.2	49.8	64.6
Sacramento, CA	11.7	16.6	18.7	21.2	31.8	31.0	21.4	48.8	26.9	61.0	50.9
Salt Lake City, UT	15.8	21.6	19.0	14.5	29.3	5.5	19.8	38.1	38.3	74.9	53.1
San Antonio, TX	34.5	26.1	11.4	6.5	21.4	12.0	70.9	42.2	38.4	78.9	54.6
San Diego, CA	12.3	14.8	14.3	14.9	43.7	23.7	29.5	48.2	25.8	74.8	60.5
San Jose, CA	27.3	19.1	15.2	11.5	26.8	20.5	45.9	21.1	20.5	64.0	72.7
Seattle, WA	16.1	21.5	16.1	14.2	32.1	25.9	13.8	44.5	23.6	65.8	68.8
Spokane, WA	14.0	19.3	17.5	20.5	28.6	10.5	8.3	53.8	29.3	70.7	51.9
Tucson, AZ	18.4	18.8	21.0	12.0	29.7	12.5	42.0	42.7	35.1	70.1	63.5

Note: Reflects proportions of adult male arrestees who said they used drugs in the year before they were arrested.

**APPENDIX
Table 2-4**

ADULT MALE ARRESTEES WHO EVER RECEIVED DRUG OR ALCOHOL TREATMENT, BY SELECTED DRUGS, BY SITE, 2000

Primary City	Percent of Arrestees Who Said They Used One of the Following Drugs at Some Time in Their Life:						
	Marijuana	Crack Cocaine	Powder Cocaine	Heroin	Methamphetamine	Other Drug	
Albany/Capital Area, NY	Inpatient	46.0%	73.0%	66.5%	92.3%	77.2%	68.3%
	Outpatient	41.5%	65.6%	59.7%	56.9%	46.8%	54.7%
Albuquerque, NM	Inpatient	37.5	51.3	48.0	54.0	46.2	41.4
	Outpatient	25.6	31.0	29.4	26.2	25.8	19.3
Anchorage, AK	Inpatient	40.8	55.4	51.7	69.0	57.7	47.8
	Outpatient	37.0	44.5	43.5	55.0	46.1	42.0
Atlanta, GA	Inpatient	21.6	36.3	33.0	38.0	34.8	29.0
	Outpatient	14.7	25.7	21.9	29.2	36.5	20.1
Birmingham, AL	Inpatient	25.7	43.0	43.8	55.8	34.7	66.6
	Outpatient	15.1	18.3	22.2	36.4	32.5	42.0
Charlotte-Metro, NC	Inpatient	23.8	44.7	37.2	89.4	30.0	35.1
	Outpatient	17.9	34.4	26.3	44.7	35.7	32.3
Chicago, IL	Inpatient	20.1	45.0	38.4	38.3	79.6	34.2
	Outpatient	16.6	30.9	26.9	30.1	17.7	17.6
Cleveland, OH	Inpatient	29.1	50.2	45.5	50.5	52.2	37.1
	Outpatient	22.3	34.7	32.2	33.3	39.9	23.2
Dallas, TX	Inpatient	21.6	36.2	29.6	42.0	36.8	33.3
	Outpatient	15.0	25.5	23.4	21.7	28.2	17.8
Denver, CO	Inpatient	36.9	51.2	45.8	61.8	53.9	44.8
	Outpatient	22.0	29.6	30.4	34.5	39.4	30.9
Des Moines, IA	Inpatient	43.8	64.0	58.3	66.5	53.2	48.3
	Outpatient	35.8	45.8	44.5	48.4	44.6	49.1
Detroit, MI	Inpatient	22.1	57.0	56.9	54.2	72.3	58.8
	Outpatient	16.0	36.6	37.4	35.1	62.0	44.7
Fort Lauderdale, FL	Inpatient	28.2	51.8	44.3	51.7	50.7	39.2
	Outpatient	15.4	28.0	21.9	37.3	26.9	22.4
Honolulu, HI	Inpatient	32.0	49.1	45.1	61.3	35.3	53.4
	Outpatient	24.3	34.0	34.3	42.9	28.3	34.8
Houston, TX	Inpatient	22.0	47.3	39.7	77.7	50.0	33.2
	Outpatient	11.6	24.8	19.3	28.2	33.4	19.2
Indianapolis, IN	Inpatient	26.0	44.5	39.0	56.1	50.8	38.2
	Outpatient	26.5	33.3	37.0	47.1	40.6	37.8
Laredo, TX	Inpatient	25.3	44.8	25.5	55.8	48.0	42.6
	Outpatient	19.6	30.0	20.0	39.6	57.8	28.8
Las Vegas, NV	Inpatient	26.8	47.5	35.4	49.8	33.6	31.0
	Outpatient	16.3	23.9	22.1	30.8	19.2	21.5

APPENDIX
Table 2-4 (cont.)

ADULT MALE ARRESTEES WHO EVER RECEIVED DRUG OR ALCOHOL TREATMENT, BY SELECTED DRUGS, BY SITE, 2000

Primary City	Percent of Arrestees Who Said They Used One of the Following Drugs at Some Time in Their Life:					
	Marijuana	Crack Cocaine	Powder Cocaine	Heroin	Methamphetamine	Other Drug
Miami, FL						
Inpatient	23.9%	46.4%	35.3%	65.5%	82.3%	36.4%
Outpatient	19.7%	27.7%	28.0%	36.0%	40.0%	26.1%
Minneapolis, MN						
Inpatient	38.3	70.3	62.6	70.6	65.1	45.2
Outpatient	27.9	43.0	39.4	36.0	47.1	35.0
New Orleans, LA						
Inpatient	16.0	28.0	29.2	27.4	56.6	23.9
Outpatient	10.6	17.2	16.0	16.7	9.2	28.3
New York, NY						
Inpatient	33.9	52.6	50.7	51.4	56.4	44.6
Outpatient	29.2	40.7	44.7	54.5	72.5	56.1
Oklahoma City, OK						
Inpatient	34.8	58.7	48.3	72.0	49.9	44.8
Outpatient	14.4	24.1	21.1	35.3	21.1	17.9
Omaha, NE						
Inpatient	24.2	42.0	37.1	57.8	45.1	45.9
Outpatient	18.8	29.5	24.4	35.6	31.5	35.7
Philadelphia, PA						
Inpatient	25.0	55.8	48.7	63.3	71.5	38.7
Outpatient	17.6	37.8	32.8	36.6	46.7	21.7
Phoenix, AZ						
Inpatient	31.8	44.0	38.0	53.2	40.6	40.5
Outpatient	20.5	27.4	24.8	29.6	24.7	31.3
Portland, OR						
Inpatient	39.5	53.3	52.4	65.4	44.8	44.4
Outpatient	36.2	43.1	44.5	49.9	41.5	46.6
Sacramento, CA						
Inpatient	24.8	31.4	33.0	52.0	28.0	28.2
Outpatient	14.9	18.0	18.3	26.4	16.2	17.2
Salt Lake City, UT						
Inpatient	37.3	51.0	42.5	64.3	45.1	44.9
Outpatient	25.0	34.3	28.7	39.1	31.3	32.3
San Antonio, TX						
Inpatient	23.7	39.2	34.7	57.3	47.0	38.0
Outpatient	17.5	22.4	18.3	31.3	32.0	19.2
San Diego, CA						
Inpatient	37.5	60.3	49.5	71.0	47.0	47.1
Outpatient	21.3	33.1	29.1	38.8	27.5	32.1
San Jose, CA						
Inpatient	27.1	42.6	35.2	67.8	32.9	28.9
Outpatient	17.9	26.0	21.8	33.8	21.5	17.3
Seattle, WA						
Inpatient	39.4	59.1	54.1	64.7	49.9	48.3
Outpatient	38.7	50.9	51.1	57.2	46.0	47.0
Spokane, WA						
Inpatient	35.5	46.5	43.7	61.6	41.9	42.2
Outpatient	34.1	41.6	37.9	49.1	35.3	40.2
Tucson, AZ						
Inpatient	31.3	45.6	37.6	61.4	43.2	37.1
Outpatient	22.9	29.2	27.9	30.6	30.5	31.2
Median						
Inpatient	28.2%	47.5%	43.7%	61.3%	48.0%	41.4%
Outpatient	19.7%	30.9%	28.0%	36.0%	33.4%	31.2%

Note: Questions were asked of adult male arrestees who said they had used drugs at some time in their life.

**APPENDIX
Table 2-5**

**DEMOGRAPHICS AND SOCIODEMOGRAPHICS OF ADULT MALE ARRESTEES
WHO RECEIVED DRUG OR ALCOHOL TREATMENT IN PAST YEAR, BY SITE, 2000**

Primary City	Percent Who Said Their Age Is:					Percent Who Said Racially/Ethnically They Are:		Percent Who Said They Were Not Working	Percent Who Said They Had No High School Diploma	Percent Who Said They Had No Health Insurance	Percent Who Said They Were Single
	Under 21	21-25	26-30	31-35	36+	Black	Hispanic				
Albany/Capital Area, NY											
Inpatient	6.1%	31.6%	22.8%	8.2%	31.3%	37.9%	14.1%	48.2%	33.8%	51.3%	71.2%
Outpatient	22.4%	8.3%	16.8%	16.1%	36.3%	46.5%	9.7%	32.6%	23.0%	65.5%	56.8%
Albuquerque, NM											
Inpatient	4.8	16.1	21.9	34.5	22.7	0.0	71.9	36.5	37.1	63.8	59.3
Outpatient	7.6	18.7	16.5	23.0	34.1	0.0	66.1	29.2	17.7	63.1	63.2
Anchorage, AK											
Inpatient	6.6	6.0	12.7	8.3	66.4	8.9	5.0	70.1	7.3	49.2	50.7
Outpatient	11.2	25.6	21.3	6.0	35.9	7.3	5.9	41.5	8.7	57.6	60.6
Atlanta, GA											
Inpatient	0.0	12.7	0.0	9.8	77.5	71.2	0.0	44.1	22.7	81.8	75.1
Outpatient	5.4	3.1	27.2	12.7	51.6	87.1	0.0	45.4	50.8	63.5	85.0
Birmingham, AL											
Inpatient	0.0	11.8	10.8	44.4	33.0	61.9	0.0	41.0	22.2	28.5	28.4
Outpatient	14.9	33.9	33.5	13.7	4.0	72.4	13.7	44.7	13.4	82.4	60.9
Charlotte-Metro, NC											
Inpatient	0.0	50.2	0.0	26.2	23.5	77.6	0.0	66.0	23.5	64.8	76.5
Outpatient	9.5	29.1	0.0	61.4	0.0	19.0	0.0	19.0	49.7	90.5	69.3
Chicago, IL											
Inpatient	0.0	20.7	15.9	16.8	46.5	60.8	31.8	48.9	36.3	64.5	54.2
Outpatient	18.3	20.4	9.9	18.3	33.0	66.8	24.7	44.1	33.1	78.7	47.2
Cleveland, OH											
Inpatient	6.5	9.1	11.4	11.8	61.2	57.6	4.3	49.9	32.2	65.6	62.9
Outpatient	17.0	27.8	8.8	3.8	42.5	77.8	3.9	44.5	24.3	41.4	65.3
Dallas, TX											
Inpatient	2.4	31.0	24.1	18.7	23.7	51.3	10.3	51.7	35.2	77.2	69.0
Outpatient	7.8	16.8	24.7	17.5	33.3	55.1	20.3	53.6	4.7	71.5	48.8
Denver, CO											
Inpatient	5.1	2.5	8.5	20.3	63.6	27.1	15.9	54.3	20.0	71.1	68.1
Outpatient	14.3	5.0	15.4	13.9	51.4	26.4	37.3	36.8	25.2	64.0	45.0
Des Moines, IA											
Inpatient	13.7	9.9	21.9	16.4	38.2	22.8	0.0	55.7	20.8	76.1	52.5
Outpatient	25.8	22.9	17.7	9.1	24.6	17.5	0.0	35.6	16.0	68.2	68.9
Detroit, MI											
Inpatient	6.2	22.2	25.1	11.1	35.5	70.0	0.0	45.2	21.4	71.2	53.0
Outpatient	7.3	16.5	4.2	39.8	32.2	59.5	0.0	53.2	38.1	69.5	74.5
Fort Lauderdale, FL											
Inpatient	30.8	7.1	0.0	19.7	42.4	58.6	12.0	41.0	30.8	44.0	80.7
Outpatient	0.0	26.2	26.2	17.5	30.0	0.0	11.0	54.0	17.5	71.5	52.4
Honolulu, HI											
Inpatient	2.1	11.5	19.0	19.1	48.2	1.9	23.6	70.4	20.4	34.0	50.8
Outpatient	2.0	2.5	16.0	12.6	66.8	6.0	10.6	63.1	2.9	48.0	42.7
Houston, TX											
Inpatient	17.7	4.6	7.9	12.5	57.3	43.1	0.0	33.0	14.8	66.3	46.6
Outpatient	43.6	4.7	13.3	0.0	38.4	41.1	22.4	28.9	15.2	73.9	63.3
Indianapolis, IN											
Inpatient	7.5	5.1	6.3	29.3	51.8	64.4	3.2	40.7	21.4	84.5	44.6
Outpatient	12.1	18.2	22.7	13.9	33.1	48.0	5.5	25.2	25.4	81.9	61.4
Laredo, TX											
Inpatient	16.0	17.1	32.0	17.9	17.1	0.0	91.6	60.6	58.8	73.2	25.8
Outpatient	18.5	10.6	13.4	19.4	38.1	0.0	95.9	15.8	35.5	70.7	20.9
Las Vegas, NV											
Inpatient	9.8	10.8	7.8	18.8	52.8	28.0	21.9	44.4	29.8	79.0	70.2
Outpatient	12.8	10.2	30.6	3.5	43.0	22.2	9.2	21.0	33.3	73.3	40.6

APPENDIX
Table 2-5 (cont.)

DEMOGRAPHICS AND SOCIODEMOGRAPHICS OF ADULT MALE ARRESTEES WHO RECEIVED DRUG OR ALCOHOL TREATMENT IN PAST YEAR, BY SITE, 2000

Primary City	Percent Who Said Their Age Is:					Percent Who Said Racially/Ethnically They Are:		Percent Who Said They Were Not Working	Percent Who Said They Had No High School Diploma	Percent Who Said They Had No Health Insurance	Percent Who Said They Were Single
	Under 21	21-25	26-30	31-35	36+	Black	Hispanic				
Miami, FL											
Inpatient	10.5%	32.8%	11.3%	14.6%	30.8%	53.1%	26.0 %	58.0%	41.2%	55.9%	65.1%
Outpatient	14.0%	19.9%	26.8%	16.3%	23.1%	28.2%	40.2%	32.2%	50.1%	43.1%	72.1%
Minneapolis, MN											
Inpatient	11.0	16.0	16.8	23.7	32.4	44.5	7.1	47.3	34.4	37.7	70.6
Outpatient	23.8	28.6	11.5	19.6	16.6	66.1	3.0	49.1	32.4	44.1	71.6
New Orleans, LA											
Inpatient	27.4	27.1	0.0	4.9	40.6	71.9	0.0	53.1	53.0	48.8	69.9
Outpatient	34.3	28.1	0.0	14.6	22.9	78.3	0.0	63.7	54.8	66.5	82.5
New York, NY											
Inpatient	3.1	6.6	20.8	17.1	52.4	60.2	29.0	71.7	33.5	47.3	67.3
Outpatient	4.9	5.8	15.6	14.8	59.0	51.0	31.7	61.8	29.4	37.6	52.0
Oklahoma City, OK											
Inpatient	6.2	13.8	23.5	16.0	40.5	31.1	4.4	31.2	21.0	76.6	47.5
Outpatient	5.5	30.2	18.8	13.2	32.3	27.4	0.0	23.5	8.9	80.5	42.9
Omaha, NE											
Inpatient	9.8	0.0	16.2	25.3	48.7	32.8	0.0	40.0	20.0	68.4	54.9
Outpatient	9.8	32.0	17.6	4.7	35.9	27.0	0.0	35.5	2.3	30.9	61.5
Philadelphia, PA											
Inpatient	12.0	18.8	24.3	17.1	27.8	51.3	13.2	63.1	23.8	62.7	68.2
Outpatient	4.4	20.5	24.3	15.6	35.2	64.4	35.6	47.7	38.6	63.0	55.3
Phoenix, AZ											
Inpatient	15.8	11.1	12.2	19.2	41.7	11.5	19.8	60.5	34.3	69.4	53.6
Outpatient	19.7	18.0	16.3	20.9	25.0	7.0	25.5	47.0	21.1	68.6	52.7
Portland, OR											
Inpatient	10.9	15.1	19.2	5.5	49.4	18.8	7.3	68.3	22.3	37.6	61.2
Outpatient	12.1	10.2	15.6	19.3	42.8	26.2	3.5	45.6	15.7	35.3	73.7
Sacramento, CA											
Inpatient	12.7	5.2	23.5	11.6	47.0	38.1	6.4	57.0	34.4	54.9	46.0
Outpatient	20.7	20.7	17.1	5.1	36.4	28.2	16.4	49.8	10.1	44.7	50.8
Salt Lake City, UT											
Inpatient	13.7	17.5	20.3	12.6	35.9	1.2	8.8	44.4	32.3	69.5	59.8
Outpatient	16.2	25.6	18.0	9.5	30.7	1.5	17.7	38.0	55.3	62.3	57.7
San Antonio, TX											
Inpatient	4.9	14.8	27.3	5.8	47.3	26.4	66.9	43.8	9.6	84.3	32.5
Outpatient	30.1	19.9	4.4	12.0	33.6	0.0	63.1	40.4	42.7	84.0	77.5
San Diego, CA											
Inpatient	12.6	9.8	18.3	8.8	50.5	44.0	27.2	55.5	20.0	70.3	64.3
Outpatient	18.8	17.5	1.3	6.2	56.3	23.6	16.8	37.6	35.6	57.8	48.5
San Jose, CA											
Inpatient	41.8	15.2	8.3	8.5	26.2	46.7	61.6	19.4	9.2	81.7	78.0
Outpatient	14.6	24.2	12.6	14.8	33.8	1.4	48.4	11.7	12.0	53.9	50.5
Seattle, WA											
Inpatient	14.1	16.3	19.3	17.2	33.0	17.1	13.2	54.9	27.0	71.2	78.3
Outpatient	10.1	20.2	21.9	15.3	32.5	27.6	20.7	37.8	27.7	60.4	69.2
Spokane, WA											
Inpatient	13.3	18.8	5.9	27.3	34.7	11.0	10.5	68.3	23.4	43.6	54.0
Outpatient	9.6	14.3	18.8	20.5	36.9	23.2	1.6	43.4	7.0	57.5	52.1
Tucson, AZ											
Inpatient	4.9	7.0	17.9	18.5	51.6	8.4	26.2	44.0	12.4	65.9	47.8
Outpatient	29.6	7.7	19.4	16.4	27.0	0.0	38.6	44.0	25.8	59.1	56.3

Note: Reflects proportions of adult male arrestees who received treatment in the year before they were arrested.

**APPENDIX
Table 2-6**

**ADULT MALE ARRESTEES AT RISK FOR DRUG DEPENDENCE
WHO RECEIVED TREATMENT, BY SITE, 2000**

Primary City	Percent Who Said They Received Inpatient Treatment*		Percent Who Said They Received Outpatient Treatment*		Percent Who Said They Received Mental Health Treatment	
	Ever	In Past 12 Months	Ever	In Past 12 Months	Ever	In Past 12 Months
Albany/Capital Area, NY	55.0%	25.3%	51.1%	19.1%	19.1%	2.3%
Albuquerque, NM	49.5	11.3	30.2	14.2	15.9	0.7
Anchorage, AK	50.7	13.5	38.5	9.9	20.6	5.6
Atlanta, GA	28.5	6.4	16.5	5.2	6.7	2.3
Birmingham, AL	41.1	7.3	18.3	5.2	9.6	1.4
Charlotte-Metro, NC	39.6	25.0	16.9	5.6	2.9	0.0
Chicago, IL	28.4	6.1	24.7	8.6	9.1	2.0
Cleveland, OH	37.1	12.6	24.8	5.4	12.6	2.4
Dallas, TX	34.5	11.1	27.4	12.1	10.0	2.4
Denver, CO	45.3	16.0	26.5	8.3	12.9	4.8
Des Moines, IA	52.3	13.7	42.7	18.8	20.0	6.4
Detroit, MI	35.3	10.1	25.1	5.4	13.8	3.0
Fort Lauderdale, FL	38.4	6.6	22.8	3.4	8.4	0.7
Honolulu, HI	43.1	15.8	32.8	12.4	20.3	5.6
Houston, TX	32.4	11.2	19.1	7.3	12.1	2.4
Indianapolis, IN	36.5	8.2	35.9	13.3	12.0	4.1
Laredo, TX	40.9	25.3	27.5	14.8	5.6	4.0
Las Vegas, NV	31.3	7.7	22.9	8.5	8.9	2.0
Miami, FL	34.4	14.3	27.1	10.2	7.4	2.1
Minneapolis, MN	51.0	20.5	30.6	9.4	12.4	2.8
New Orleans, LA	22.1	7.4	15.0	8.1	9.6	3.3
New York, NY	42.2	13.7	39.5	21.8	6.3	1.9
Oklahoma City, OK	42.3	10.8	19.4	3.4	16.8	2.0
Omaha, NE	34.5	8.5	26.3	4.3	17.2	2.9
Philadelphia, PA	37.0	14.7	27.2	12.5	13.4	7.4
Phoenix, AZ	42.0	13.4	25.5	7.9	14.3	3.5
Portland, OR	57.0	23.5	46.3	17.5	13.0	5.1
Sacramento, CA	28.5	8.7	17.1	8.0	16.6	6.0
Salt Lake City, UT	44.8	13.1	33.6	14.7	14.8	2.0
San Antonio, TX	38.2	11.9	23.5	4.4	10.0	1.3
San Diego, CA	47.9	16.3	28.7	8.9	10.7	3.0
San Jose, CA	35.0	12.1	21.1	8.3	6.4	2.9
Seattle, WA	50.0	12.4	44.4	15.8	14.2	4.4
Spokane, WA	43.3	12.5	37.2	6.7	22.1	6.9
Tucson, AZ	38.2	10.6	26.7	7.2	16.7	2.3
Median	39.6%	12.4%	26.7%	8.5%	12.6%	2.8%

* Treatment was for either alcohol or drug use.