A Narcotics Case Register — Some Perspective on Multiple Reports* **

A. RICHMAN, J. J. FISHMAN, L. BERGNER, and S. W. PATRICK

Department of Psychiatry, Beth Israel Medical Center, New York, Mount Sinai School of Medicine of the City University of New York and Office of Research and Professional Training, and Narcotics Register, New York City Department of Health, New York, N. Y., U.S.A.

Summary. A narcotics register is described and the problems of accuracy and completeness of case ascertainment are detailed. A study of a sample of cases is presented to illustrate certain uses of a register in the investigation of the epidemiology of addiction and implications for program planning are discussed. A significant finding is that one-half of the sample first reported to the Narcotics Register had contacts with law enforcement agencies only during the follow-up period which varied from 12—14 months following the initial report.

Résumé. Un registre des cas d’abus de drogue est décrit dans ce travail et le problème de la contribution de dossiers exacts et complets est examiné en détail. Une étude d’un échantillon de cas est présentée pour illustrer l’usage qu'on peut faire d’un tel registre dans les recherches épidémiologiques sur la toxicomanie et les implications pour l’établissement d’un programme sont discutées. Un résultat significatif est que la moitié de l’échantillon qui a été inscrit le premier dans le registre avait eu affaire aux services judiciaires seulement pendant les 12—24 mois suivant le rapport initial. S’il ne nous a pas été possible d’avoir une vue complète de l’héroïnomane, nous avons cependant pu réunir une partie du matériel nécessaire.


Introduction

While a heroin addict seems to have no difficulty in getting a fix, there is considerable difficulty in researchers getting a fix on the heroin addict. One possible way, however, is by means of a case register.

The collation of contacts reported for an individual from a variety of community sources constitutes a case register. Case registers are intended to accumulate information in order to describe the characteristics of individuals and the sequence of contacts reported for them over a period of time.

This paper represents the first attempt to develop methods of analysis for the New York City Narcotics Register, taking into account a number of reports from various sources assembled for individuals. When one deals with multiple reports for an individual, additional problems are presented in defining diagnosis and assessing the nature of the contact itself.

Reports submitted to the Narcotics Register differ in the nature and consequences of contact they represent. A heroin user may present himself to a private physician or medical facility requesting detoxification for his addiction, or medical care for some complication of drug use. In such situations there is opportunity for medical assessment of drug use. On the other hand, a person at a social agency or upon arrest may be defined as an addict on the basis of a totally different set of criteria.

The reporting form used by the Narcotics Register is shown below.

Some of the forms are submitted to the Register without all of the information included. For those reports which do not specify the “drugs used,” how should the individuals be regarded? Should all reports from an addiction agency be presumed to be for narcotics addicts? Is the addiction current? Should different “weights” be assigned to reports from various sources, or might a “diagnostic” index be devised with various weights for different items? Should a person who had not been identified as a narcotic addict on an initial report be retroactively diagnosed as such upon receipt of a later report which indicates narcotics addiction? What time periods should be specified for retroactive diagnosis? The way in which these questions are answered will affect Register statements about the extent and characteristics of heroin users.

The numerical relation between the files of the Narcotics Register and the problem in the community is unknown. What is added to the files represents only a portion of incidence; what is present in the files can not be construed to represent prevalence—the number of addicts existing in the community at any one time. The Register has not yet established an effective means of subtracting those in jail, hospital, or treatment programs. The persons who may have stopped using narcotics are not detected. Only the deaths are regularly and systematically removed from the files.


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There are other problems of assessing prevalence and incidence. Incidence might be defined as "reported for the first time", it being recognized that incidence refers to onset and that reporting is a sequence of onset + contact with a reporting agency + identification as an addict + submission of a report + appropriate filing. Even more difficult is the question of prevalence. The dependence of the Bureau of Narcotics and Dangerous Drugs upon enforcement data is recognized. However, for this agency, prevalence data are based upon cases having a positive report submitted within a previous five-year period. No such time-limited definition of prevalence or activity has yet been derived for the Narcotics Register.

Furthermore, there is the problem of inferring the course of a condition from contacts reported for an individual over a period of time. What are the patterns reported, and what do they represent in terms of severity and/or progression? And what does lack of reports during an interval mean?

It is when one considers a series of reports for an individual over a period of time that the above questions become highlighted. It is the purpose of the present paper to illustrate some of the problems presented in attempting to consider multiple reports for an individual.

**Background**

In considering the epidemiology of heroin addiction, one has to assess the nature and sources of information about addicts. Probably the oldest and most specific source for information about narcotics addicts in the United States comes from the Federal Bureau of Narcotics. However, they derive their information primarily from one type of report: that is, from law enforcement agencies. Information from law enforcement agencies does not reflect those addicts who have not actually come in conflict with the law, but may be known to physicians or hospitals who treat them for medical conditions, or to agencies which treat them specifically for their addiction, or to public assistance agencies which see them when they ask for help.

What is needed to provide more comprehensive coverage is a mechanism for maintaining an unduplicated file of names by collating reports received from a wide variety of sources. Case registers have been used in public health, for tuberculosis and venereal disease and more recently for cancer, mental illness, and rubella.

The President's Advisory Commission on Narcotic and Drug Abuse (1963) recommended establishment of narcotics case registers. In the United Kingdom, the Working Party on Epidemiology of Drug Dependence (established in 1968) of the Medical Research Council, recommended collation of all the available information from a number of governmental bureaus because "research workers must have access to accurate information about national trends" [1]. It also recommended that: "special attention should be paid to techniques for collecting information for epidemiological studies and for testing its reliability and validity" [1]. Both of the previous statements refer to a case register of drug users. In Canada, reports have been collated from a wide variety of medical and pharmacy sources as well as from law enforcement agencies [5].

**The New York City Narcotics Register**

In New York City, collection of reports of drug addicts was begun in 1953 under section 11.05 [6].