

26-LS1126\S
Mischel
2/22/10

CS FOR HOUSE BILL NO. 259()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered: "

Referred:

Sponsor(s): REPRESENTATIVES KELLER AND GATTO, Kelly

A BILL

FOR AN ACT ENTITLED

"An Act relating to citizenship requirements and an alcohol impairment and drug testing program for applicants for and recipients of specified cash assistance."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.05 is amended by adding new sections to read:

Article 4. Alcohol and Drug Testing.

Sec. 47.05.400. Alcohol impairment and drug testing; legislative findings and purpose. The legislature finds that a statewide threat to public safety exists with regard to the use of cash assistance for the purchase of alcohol and illegal drugs. The purpose of the testing program established under AS 47.05.400 - 47.05.500 is to reduce that risk and to protect the residents of the state.

Sec. 47.05.410. Alcohol impairment and drug testing for eligibility; regulations; immunity. (a) The department shall implement a program consistent with AS 47.05.400 - 47.05.500 that provides for random and suspicion-based testing of recipients of cash assistance for use of alcohol that impairs a recipient's ability to

work or to seek work and of applicants for and recipients of cash assistance for the use of illegal drugs. In this paragraph, a "recipient of cash assistance" does not include a care provider or a third party recipient, as defined by the department in regulation.

(b) The department shall adopt regulations to implement this section. The regulations must include testing policies consistent with AS 47.05.430 and specify the type of testing to be conducted and the illegal drugs to be included in the testing program. The drug tested must have a cutoff level that yields a positive test result

(1) for initial testing of urine, as follows:

SUBSTANCE	CUTOFF CONCENTRATION (nanograms in each milliliter)
Marijuana metabolites	50
Cocaine metabolites	300
Opiate metabolites	2,000
Phencyclidine	1,000
Amphetamines	1,000

(2) for confirmatory testing of urine, as follows:

SUBSTANCE	CUTOFF CONCENTRATION (nanograms in each milliliter)
Marijuana metabolite (Delta-9-tetrahydrocannabinol-9-carboxylic acid)	15
Cocaine metabolite (Benzoylcegonine)	150
Opiates	
Morphine	2,000
Codeine	2,000
6-Acetylmorphine	10
(when morphine concentration exceeds 2,000 nanograms in each milliliter)	
Phencyclidine	25
Amphetamines	
Amphetamine	500
Methamphetamine	500

(when amphetamine concentration is
greater than or equal to 200 nanograms
in each milliliter)

(3) for testing of alternative specimens that is consistent with the
mandatory guidelines for the federal workplace drug testing program adopted by the
United States Department of Health and Human Services.

(c) Unless the department or an agent or employee of the department knew or
should have known that the results of a test conducted under this section were false
and took action that affected a person's eligibility for cash assistance based on the false
test results, a person may not bring an action for damages against the department or an
agent or employee of the department for

(1) good faith actions taken to conduct, or as a result of, alcohol
impairment or drug testing under this section;

(2) failure to test for alcohol impairment or drugs or for a specific
drug;

(3) failure to test, or if the test was undetected, failure to detect a
specific drug or medical or psychological condition or disorder;

(4) termination or suspension of an alcohol or drug prevention or
testing program or policy.

(d) In a claim for damages based on false test results,

(1) a rebuttable presumption exists that the test results were valid if the
department complied with this section and the regulations adopted under this section;
and

(2) the department may not be held liable for monetary damages for
good faith reliance and reasonable actions taken as a result of false test results.

(e) A person may not bring an action against the department based on the
failure of the department to establish a program or policy on substance abuse
prevention or to implement alcohol impairment or drug testing.

Sec. 47.05.420. Confidentiality; liability. (a) The results of a test conducted
under AS 47.05.410 are confidential, except that the results may be revealed to the
recipient of cash assistance who was tested and to agents and employees of the

1 department as required to determine eligibility for cash assistance.

2 (b) A person may not bring an action for defamation of character or reputation
3 as a result of disclosure of the results of an alcohol impairment or drug test under the
4 alcohol impairment or drug testing program established under AS 47.05.410 unless

5 (1) the results were disclosed to a person, other than an agent or
6 employee of the department for the purpose of the testing program or under court or
7 administrative order;

8 (2) the information disclosed included false test results;

9 (3) the information was negligently or intentionally disclosed; and

10 (4) the elements of the tort claim are met.

11 **Sec. 47.05.430. Testing policies and procedures.** (a) The department shall
12 adopt testing policies that include

13 (1) a list of substances tested;

14 (2) a description of the testing methods and collection procedures,
15 including on-site testing;

16 (3) a right to confirmatory testing and the procedures for confirmatory
17 testing;

18 (4) the consequences for refusal to test or retest that are consistent with
19 the provisions in AS 47.05.450;

20 (5) the right of an applicant for or recipient of cash assistance to
21 receive test results within five working days after the department receives the test
22 results or the written request, whichever is later, if a written request is made by the
23 applicant or recipient within six months after the test;

24 (6) the right of an applicant and a recipient, on the applicant's or
25 recipient's request, to receive, within 72 hours or before an adverse action is taken,
26 whichever occurs first, a confidential explanation of the applicant's or recipient's test
27 results;

28 (7) providing the department's confidentiality and testing policies to
29 applicants for and recipients of cash assistance not less than 30 days before initiating
30 testing on the applicant or recipient.

31 (b) The department shall pay the cost of testing and, if the testing is performed

1 at a location other than a location of the department, the cost of transportation to and
2 from the testing center.

3 (c) Sample collection and testing must

4 (1) comply with scientifically accepted methods and procedures;

5 (2) be performed at a location identified by the department and
6 analyzed by a laboratory approved or certified by the Substance Abuse and Mental
7 Health Services Administration or by the College of American Pathologists;

8 (3) be conducted under reasonable, sanitary, and private conditions
9 that are consistent with reliability;

10 (4) be properly controlled and samples must be properly labeled; and

11 (5) include relevant medical information.

12 (d) A positive drug test must be confirmed using a different analytical process
13 than was used in initial testing. A positive drug test must be reported as a negative
14 result if a licensed physician verifies that the test was affected by medication
15 prescribed for the applicant or recipient tested.

16 (e) The department may not rely on a positive test result without confirmatory
17 testing.

18 **Sec. 47.05.440. Training of test administrators.** (a) The department shall
19 ensure that not less than one designated employee of the department receives not less
20 than one hour of training on alcohol abuse and an additional one hour of training on
21 the use of controlled substances for the purpose of finding reasonable suspicion for
22 testing under AS 47.05.400 - 47.05.500.

23 (b) If the department provides on-site testing for alcohol impairment or illegal
24 drug use under AS 47.05.410, the department shall employ on-site administrators who

25 (1) have received training in person and written certification of the
26 training by the test manufacturer's representative on the proper procedure for
27 administering the test and on accurate analysis of the on-site test results; the training
28 must include recognition of adulteration of a sample collected on-site;

29 (2) agree in writing to maintain confidentiality under the testing
30 policies adopted by the department.

31 **Sec. 47.05.450. Consequences of confirmatory positive testing.** (a) Except as

1 provided in (b) of this section, the department shall deny or suspend cash assistance to
2 an applicant for or recipient of the assistance who, under AS 47.05.400 - 47.05.500,
3 has

4 (1) been tested and received a confirmatory positive result for alcohol
5 impairment or use of illegal drugs and fails to comply with a treatment program
6 approved by the department; or

7 (2) refused alcohol impairment or drug testing required by the
8 department.

9 (b) The department may provide cash assistance on behalf of an eligible
10 recipient who is subject to denial or suspension under (a) of this section if the
11 department has in place an option for third-party receipt of the cash assistance for
12 which the recipient or the recipient's family is otherwise eligible and the third party
13 provides care, shelter, or food to the recipient or the recipient's dependent children.

14 **Sec. 47.05.500. Definitions.** In AS 47.05.400 - 47.05.500, "cash assistance"
15 means money received under Alaska Temporary Assistance under AS 47.27.010 -
16 47.27.085, Alaska Native Family Assistance under AS 47.27.200, and regional public
17 assistance programs under AS 47.27.300.

18 * **Sec. 2.** AS 47.25.120 is amended by adding a new subsection to read:

19 (b) A person must be a citizen of the United States or a legal alien as described
20 in 8 U.S.C. 1181 - 1186 and not otherwise precluded from eligibility under state or
21 federal law to be eligible for assistance under AS 47.25.120 - 47.25.300.

LEGAL SERVICES

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LEGISLATIVE AFFAIRS AGENCY
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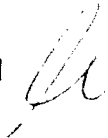
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 22, 2010

SUBJECT: Sectional Summary of CSHB 259(),
(Work Order No. 26-LS1126\S)

TO: Representative Wes Keller
Chair of the House Health and Social Services Committee
Attn: Jim Pound

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Establishes a program within the Department of Health and Social Services that provides for random and suspicion-based testing of recipients of cash assistance, as defined, for use of alcohol that impairs a recipient's ability to work or to seek work and of applicants for and recipients of cash assistance for the use of illegal drugs. Requires the adoption of regulations to carry out the program and provides cutoff concentrations for drug testing and for specified testing and retesting procedures. Provides for confidentiality of test results and for limits on state liability.

Section 2. Requires a person to be a citizen of the United States or a legal alien to be eligible for specified cash assistance.

JMM:med
10-024:med

ALASKA STATE LEGISLATURE

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REPRESENTATIVE WES KELLER DISTRICT 14

Sponsor Statement House Bill 259

“An Act relating to citizenship requirements and an alcohol impairment and drug testing program for applicants for and recipients of adult public assistance.”

The cost of substance abuse in Alaska is staggering. Crime, child abuse, broken homes, domestic violence, cost of business, auto and industrial accidents, poor productivity, chronic health problems all have a causal relationship with substance abuse. It is irrational to expect the government to provide compassionate assistance without giving it the ability to identify substance abuse problems.

When we apply for a job we must provide proof of citizenship and in some cases we may also be required to submit to drug and alcohol testing. We comply because it is part of ensuring that we are qualified to work and because it is part of the package that returns a paycheck. Transportation, public safety, civil service, construction workers, and children who participate in sports are regularly asked to submit to drug and alcohol testing. Arguments in the public square against requirements for drug testing do not stand up to the arguments for the need to ensure safety.

Our Department of Health and Social Services is mandated to provide public assistance to those who need it. It is not appropriate to simply provide assistance without knowing whether the assistance will actually be fueling an addiction problem. HB 259 gives the department a tool they need to determine if substance or alcohol abuse is part of the equation. HB 259 leaves the initiative with the Department regarding how to specifically respond to a person requesting aid according to best practices to restore them to a productive life in their community.

HOUSE BILL NO. 259

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE KELLER

Introduced: 1/8/10

Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to citizenship requirements and an alcohol impairment and drug**
2 **testing program for applicants for and recipients of adult public assistance."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 47.25.430(a) is amended to read:

5 (a) Financial assistance shall be given under AS 47.25.430 - 47.25.615, so far
6 as practicable under appropriations made by law, to every aged, blind, or disabled
7 needy resident who has not made a voluntary assignment or transfer of property to
8 qualify for assistance. In this subsection, "resident" means a person who is

9 **(1) a citizen of the United States or a legal alien as described in 8**
10 **U.S.C. 1181 - 1186;**

11 **(2)** living in the state voluntarily with the intention of making the state
12 the person's home; and

13 **(3)** [WHO IS] not living in the state for a temporary purpose.

14 * **Sec. 2.** AS 47.25.430(b) is amended to read:

(b) The department shall determine the amount of assistance with regard to the resources and needs of the person and the conditions existing in each case. Assistance shall be in an amount that will provide the applicant with reasonable subsistence compatible with decency and health in accordance with standards established by the department and with the standards established under 42 U.S.C. 1381 - 1383 (Title XVI, Social Security Act Supplemental Security Income Program). Direct payments for medical services and remedial care may not be considered in determining the maximum amount payable. When benefit amounts under 42 U.S.C. 1381 - 1383 are increased as a result of an increase in the cost of living, the state shall pass along the increase to recipients and, to the extent federal funds are provided for the federal benefit, shall increase the amount of the state contribution to recipients, other than those receiving a personal needs allowance, by a percentage of the state contribution equal to the percentage increase in the benefit amounts under 42 U.S.C. 1381 - 1383 if the legislature has appropriated money specifically for the purpose of increasing the state contribution because of an increase in federal benefit amounts under 42 U.S.C. 1381 - 1383; this increase in the state contribution takes effect on the same day that the corresponding federal increase in benefits under 42 U.S.C. 1381 - 1383 takes effect.

* **Sec. 3.** AS 47.25 is amended by adding new sections to read:

Sec. 47.25.461. Alcohol impairment and drug testing; legislative findings and purpose. The legislature finds that a statewide threat to public safety exists with regard to the use of adult public assistance for the purchase of alcohol and illegal drugs. The purpose of the testing program established under AS 47.25.463 - 47.25.467 is to reduce that risk and to protect the residents of the state.

Sec. 47.25.463. Alcohol impairment and drug testing for eligibility; regulations; immunity. (a) The department shall implement a program consistent with AS 47.25.463 - 47.25.467 that provides for random and suspicion-based testing of recipients of adult public assistance for use of alcohol that impairs a recipient's ability to work or to seek work and of applicants for and recipients of adult public assistance for the use of illegal drugs.

(b) The department shall adopt regulations to implement this section. The

1 regulations must include testing policies consistent with AS 47.25.465 and specify the
 2 type of testing to be conducted and the illegal drugs to be included in the testing
 3 program. The drug tested must have a cutoff level that yields a positive test result
 4 established, as of November 1, 2004, by the United States Department of Health and
 5 Human Services under 69 C.F.R. 19644.

6 (c) Unless the department or an agent or employee of the department knew or
 7 should have known that the results of a test conducted under this section were false
 8 and took action that affected a person's eligibility for adult public assistance based on
 9 the false test results, a person may not bring an action for damages against the
 10 department or an agent or employee of the department for

11 (1) good faith actions taken to conduct, or as a result of, alcohol
 12 impairment or drug testing under this section;

13 (2) failure to test for alcohol impairment or drugs or for a specific
 14 drug;

15 (3) failure to test, or if the test was undetected, failure to detect a
 16 specific drug or medical or psychological condition or disorder;

17 (4) termination or suspension of an alcohol or drug prevention or
 18 testing program or policy.

19 (d) In a claim for damages based on false test results,

20 (1) a rebuttable presumption exists that the test results were valid if the
 21 department complied with this section and the regulations adopted under this section;
 22 and

23 (2) the department may not be held liable for monetary damages for
 24 good faith reliance and reasonable actions taken as a result of false test results.

25 (e) A person may not bring an action against the department based on the
 26 failure of the department to establish a program or policy on substance abuse
 27 prevention or to implement alcohol impairment or drug testing.

28 **Sec. 47.25.464. Confidentiality; liability.** (a) The results of a test conducted
 29 under AS 47.25.463 are confidential, except that the results may be revealed to the
 30 recipient of adult public assistance who was tested and to agents and employees of the
 31 department as required to determine eligibility for adult public assistance.

1 (b) A person may not bring an action for defamation of character or reputation
2 as a result of disclosure of the results of an alcohol impairment or drug test under the
3 alcohol impairment or drug testing program established under AS 47.25.463 unless

4 (1) the results were disclosed to a person, other than an agent or
5 employee of the department for the purpose of the testing program or under court or
6 administrative order;

7 (2) the information disclosed included false test results;

8 (3) the information was negligently or intentionally disclosed; and

9 (4) the elements of the tort claim are met.

10 **Sec. 47.25.465. Testing policies and procedures.** (a) The department shall
11 adopt testing policies that include

12 (1) a list of substances tested;

13 (2) a description of the testing methods and collection procedures,
14 including on-site testing;

15 (3) a right to confirmatory testing and the procedures for confirmatory
16 testing;

17 (4) the consequences for refusal to test or retest;

18 (5) the right of an applicant for or recipient of adult public assistance
19 to receive test results within five working days after the department receives the test
20 results or the written request, whichever is later, if a written request is made by the
21 applicant or recipient within six months after the test;

22 (6) the right of an applicant and a recipient, on the applicant's or
23 recipient's request, to receive, within 72 hours or before an adverse action is taken,
24 whichever occurs first, a confidential explanation of the applicant's or recipient's test
25 results;

26 (7) providing the department's confidentiality and testing policies to
27 applicants for and recipients of adult public assistance not less than 30 days before
28 initiating testing on the applicant or recipient.

29 (b) The department shall pay the cost of testing and, if the testing is performed
30 at a location other than a location of the department, the cost of transportation to and
31 from the testing center.

(c) Sample collection and testing must

(1) comply with scientifically accepted methods and procedures;

(2) be performed at a location identified by the department and analyzed by a laboratory approved or certified by the Substance Abuse and Mental Health Services Administration or by the College of American Pathologists;

(3) be conducted under reasonable, sanitary, and private conditions that are consistent with reliability;

(4) be properly controlled and samples must be properly labeled; and

(5) include relevant medical information.

(d) A positive drug test must be confirmed using a different analytical process than was used in initial testing. A positive drug test must be reported as a negative result if a licensed physician verifies that the test was affected by medication prescribed for the applicant or recipient tested.

(e) The department may not rely on a positive test result without confirmatory testing.

Sec. 47.25.466. Training of test administrators. (a) The department shall ensure that not less than one designated employee of the department receives not less than one hour of training on alcohol abuse and an additional one hour of training on the use of controlled substances for the purpose of finding reasonable suspicion for testing under AS 47.25.463 - 47.25.466.

(b) If the department provides on-site testing for alcohol impairment or illegal drug use under AS 47.25.463, the department shall employ on-site administrators who

(1) have received training in person and written certification of the training by the test manufacturer's representative on the proper procedure for administering the test and on accurate analysis of the on-site test results; the training must include recognition of adulteration of a sample collected on-site;

(2) agree in writing to maintain confidentiality under the testing policies adopted by the department.

Sec. 47.25.467. Consequences of confirmatory positive testing. The department may deny or suspend adult public assistance to an applicant for or recipient of the assistance who, under AS 47.25.463 - 47.25.467, has

- 1 (1) been tested and received a confirmatory positive result for alcohol
- 2 impairment or use of illegal drugs; or
- 3 (2) refused alcohol impairment or drug testing required by the
- 4 department.


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State

Compare Years



Compare States



Rankings by Measure



Researcher's Choice: Direct Health Care Spending for the State of Alaska
 Spending for health care by state is measured as a percentage of state personal income. States with higher spending are generally healthier.



Alaska (2009)

[View Data for Alaska \(2009\)](#)

Strengths

Alaska's health care system has several strengths:

Challenges

Alaska's health care system also faces several challenges:

Significant Changes

In 2009, Alaska's health care system experienced several significant changes:

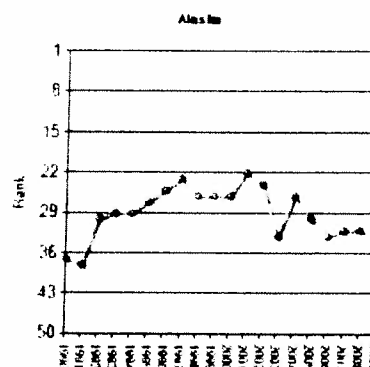
Health Disparities

Alaska's health care system faces several health disparities:

State Health Department Web Site

[www.alaska.gov/health](#)

Overall Rank : 34



New Supplemental Measures

Alaska's health care system has several new supplemental measures:

	2009		2008		No. 1
Behaviors	Value	Rank	Value	Rank	State
High School Graduation (Percent of incoming ninth graders)	66.5	43	64.1	45	87.5
Prevalence of Obesity (Percent of population)	27.0	29	18.2	35	19.1
Prevalence of Smoking (Percent of population)	21.5	40	22.2	18	9.3
Prevalence of Binge Drinking (Percent of population)	17.8	37	18.3	44	9.0
Community & Environment					
Infant Mortality Rate (Deaths per 1,000 live births)	10.0	10	11.9	16	1.1
Infant Mortality Rate (Deaths per 1,000 live births)	15.8	10	14.9	17	1.4
Infant Mortality Rate (Deaths per 1,000 live births)	16.9	5	12	5	4.9
Infant Mortality Rate (Deaths per 1,000 live births)	17.8	1	18.5	2	1.6
Infant Mortality Rate (Deaths per 1,000 live births)	18.1	44	18.1	43	1.7
Public & Health Policies					
Infant Mortality Rate (Deaths per 1,000 live births)	19.3	46	19.4	49	4
Infant Mortality Rate (Deaths per 1,000 live births)	19.2	2	19.6	15	15.1
Infant Mortality Rate (Deaths per 1,000 live births)	19.7	1	19.75	2	10.13
Clinical Care					
Infant Mortality Rate (Deaths per 1,000 live births)	19.8	18	19.8	14	1.1

Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	62.4	14	58.2	8	29.3
Primary Care Physicians (Number per 100,000 population)	112.3	28	114.1	26	190.0
Health Outcomes					
Premature Death (Years lost per 100,000 population)	7898	32	7617	26	5595
Poor Physical Health Days (Days in the previous 30 days)	3.4	21	3.5	23	2.7
Infant Mortality (Deaths per 1,000 live births)	6.4	20	6.1	17	4.8
Poor Mental Health Days (Days in the previous 30 days)	3.2	19	3.2	16	2.2
Geographic Disparity (Relative standard deviation)	19.4	48	17.1	43	4.3
Cancer Deaths (Deaths per 100,000 population)	185.7	17	188.2	16	144.7
Cardiovascular Deaths (Deaths per 100,000 population)	235.8	5	248.5	6	212.6
Summation					
All Determinants	-0.130	34	-0.079	34	0.827
All Outcomes	0.039	28	0.074	26	0.348
Overall	-0.091	34	-0.005	32	1.064

Alaska - Supplemental Measures

Behaviors	2009		2008		No. 1
	Value	Rank	Value	Rank	State
Cholesterol Check (Percent of adult population)	71.2	43	71.2	43	84.6
Recent Dental Visit (Percent of adult population)	66.3	39	66.9	37	80.2
Daily Vegetables and Fruit (Percent of population)	24.2	26	24.2	26	30.0
Physical Activity (Percent of adult population)	75.9	21	80.0	13	81.9
Chronic Diseases					
Stroke (Percent of adult population)	2.0	3	1.9	5	1.8
High Cholesterol (Percent of adult population)	37.6	24	37.6	24	32.4
High Blood Pressure (Percent of adult population)	24.9	7	24.9	7	19.7
Heart Attack (Percent of adult population)	3.0	2	2.3	1	2.9
Coronary Heart Disease (Percent of adult population)	3.0	2	2.5	2	2.7
Diabetes (Percent of adult population)	6.8	7	6.1	4	5.9
Economic					
Per Capita Personal Income (Dollars per person)	\$43321	7	\$40042	15	\$56248
Underemployment Rate (Percent)	12.0	45	11.2	49	5.7
Annual Unemployment Rate (Percent)	6.7	44	6.2	48	3.0
Median Household Income (Dollars per household)	\$63989	4	\$65413	5	\$66176
August 2009 Unemployment Rate (Percent)	8.3	23	6.7	41	4.3
Health Outcomes					
Health Status (Percent report fair or poor health)	14.3	24	13.8	19	10.7

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Influences on Substance Use in Alaska

Significant Risk and Protective Factors Influencing
adolescent substance use and their Indicators

Submitted to
Alaska Division of Behavioral Health
by
State Behavioral Health Epidemiology Workgroup

November 30, 2007

Special thanks to the “Epi– Influences” subcommittee

Becky Judd - Chair, Association of Alaska School Boards
James Gallanos, Alaska Division of Behavioral Health
Carol Greenough, Advisory Board on Alcoholism and Drug Abuse
Bill Herman, Mental Health Trust Authority
Marilyn Irwin, Advisory Board on Alcoholism and Drug Abuse
Rhonda Johnson, University of Alaska, Department of Health Sciences
Cristy Willer, Cook Inlet Tribal Council Inc.

Influences on Substance Use in Alaska

Extensive national research spanning over fifty years¹⁻³⁰ has demonstrated a strong association between specific social conditions, personal experiences and the use of tobacco, alcohol and other drugs in adolescence. Most states track substance use by monitoring data on tobacco, alcohol and other drug consumption (e.g. 30 day use, binge use, ever use) or the consequences of use (e.g. drinking driving crashes, hospital visits, school suspensions.) Instead of tracking consumption and consequence data exclusively, Alaska must monitor research-based influences that impact substance use, as well. The more protective factors are increased (and risk factors reduced) the more likely substance abuse and suicide can be prevented. The priority influences on adolescent substance use are as follows (definitions and citations may be found on pages 4-6.)

Priority Factors	Alaska Data
Protective Factor Indicators	Protective Indicators with Baseline Data
Connection to Family	<i>Developmental Indicator Stage I</i>
Connection to School	33.4% of students agree that their school has a positive climate 9.5% of students are connected to their school <small>SCCS 2007</small>
Positive Connection to <i>Other</i> Adults	87% of students have a positive connection with at least one other adult outside of their home. <small>YRBS 2007</small>
Engagement in Meaningful Activities	51% of students are involved in volunteer and helping activities one or more times per week. <small>YRBS 2007</small>
Social, Emotional and Employability Skills	28.3% of students report they have social, emotional and employability skills. <small>SCCS 2007</small>
Cultural Identity	<i>Developmental Indicator Stage I</i> (Loss of cultural identity can be a risk factor, see below)
Risk Factor Indicators	Risk Indicators with Baseline Data
Experienced child abuse (neglect, physical, sexual abuse)	Alaska children are abused or neglected at a substantiated rate of 24.5 cases per 1,000 children, ages 0-17. <small>OCS new database 2007</small> Family violence rate: <i>Developmental Indicator Stage II</i>
Early initiation of substances	20.4% of students have used alcohol before the age of 13. <small>YRBS 2007</small>
Death by suicide of a family member	20.6 suicides were completed per 100,000 Alaskans <small>BVS 2007</small> Death rate of family members by suicide: <i>Developmental Stage II</i>
Availability of alcohol and other drugs	<i>Developmental Indicator Stage II</i>
Community norms and laws related to alcohol, drug use	<i>Developmental Indicator Stage II</i>
Loss of Cultural Identity	<i>Developmental Indicator Stage I</i>
<i>Developmental stage I: Indicator needs to be defined and measurement system put into place</i> <i>Developmental stage II: Potential indicator in place, existing data system needs further support and refinement</i>	
Note: The risk and protective factor indicators are state and federal indicators. The data for the risk and protective factor indicators may be collected by prevention programs and the various community-based organizations.	

Influences of Substance Abuse in Alaska

Scope of project

In 2006 a State Epidemiological Outcomes Workgroup (SEOW) was created to collect, analyze, and report substance use incidence, prevalence and other related data. An "influences subcommittee" was created to: 1) identify and prioritize the factors that influence substance use and abuse, and 2) identify existing and recommend new indicators to monitor over time.

Process: The "influences subcommittee" began with the adolescent population while recognizing the significant need to look at younger and older populations as well. The risk and protective factor national research for adolescent substance use (and other risk behaviors) provided the working foundation. Additional factors were considered that had a strong research base of support. The priority factors were selected based on: 1) strength of the research; 2) relevance to Alaska; and 3) ability of a community /state partnerships to change that factor. To assure a comprehensive review, we examined factors across the social domains (family, community, school, and individual.) The availability of the data did not exclude a factor if it was considered to be of major significance to the Alaska population. For example, poverty is highly correlated with substance abuse, but not easily amenable to change.

Through this process five protective factors and five risk factors were prioritized. In addition, cultural identity or loss of culture was selected as factor that has tremendous influence on one's sense of self and subsequent behavior. Next the group turned to identifying population-based indicators for each of the selected factors. This process was divided into 1) factors with existing indicators and data; 2) factors with some indicators, but not reliable data at this point data; 3) factors that remain of high significance without indicators or data, at this time.

The *Influences on Substance Abuse in Alaska* was further reviewed by the data analyst for the Division of Behavioral Health as well as the full State Epidemiological Outcomes Workgroup.

This report is comprised of baseline data for the priority factors and their indicators. Three factors (family violence, availability of alcohol, community norms and laws) have indicators needing further refinement and/or support for data collection. Two factors (connection to family, cultural identity) do not have indicators at this time. The subcommittee urges the state to partner with interested organizations to further define indicators and develop accurate measurement tools for both of these factors.

Although the indicators are population-based Alaska measures, they are not meant to take precedent over community or program-based measures. This is important to note so that community planning efforts to deliver programs and services continue to be community-driven. The identified indicators reflect the need for a consistent source of population-based data that can be monitored over time across Alaska. Other community and program-based indicators continue to be developed and provide further support for advancing our efforts for data collection and evaluation in Alaska.

As noted previously, while the risk and protective factors identified in this report are based on research for adolescent substance use, many of the factors have implications for adult and older populations as well. A review of the literature was not conducted specifically for adults and may need additional scrutiny and peer review to determine both the availability and reliability of the research. Research on loss of culture and cultural identity was more thoroughly reviewed to apply across the lifespan, to children, youth and adults, and is cited here. Unfortunately, indicators in this area were difficult to locate, although promising as new measures are being developed.

In closing, two studies^{1,10} found the presence of both protective factors: family support and school support in adolescents who have been physically abused, will reduce the likelihood of suicide attempts more than the mere removal of the risk factor of substance use (e.g. alcohol, drugs) regardless of gender. While communities must continue to reduce the factors that put children at risk, these studies point to the powerful impact protective factors can play in helping children cope with life experiences, they have no control over.

Risk and Protective Factor Definitions and their Indicators

The definition for each factor is derived from its research. Indicators are based on existing Alaska data sources that best match the definition. Some indicators are in a “developmental” stage, they have yet to be formalized. A brief summary of the developmental stage is offered.

Indicators of Protection

Connection to Family (bonding) - Family connectedness has several components. Connectedness refers to the feelings of warmth, love and caring children get from their parents. Children who feel support and connection report a high degree of closeness, feelings of being understood, loved, and wanted. A parental presence is related to connection; it refers to a parent being present during key times: before school, after school, dinner, bedtime and doing activities together. A “positive parenting style” involves high expectations, clear family rules, fair and consistent discipline practices and age appropriate supervision and monitoring of behavior, friends and whereabouts. The Add-Health study found this to be one of the strongest protective factors against all risk behaviors. ^{1,4,6,8,7,8,11,15, 21, 25}

Indicator Developmental Stage I: Indicator needs to be defined and measurement system put into place.

Status: Alaska does not collect population-based data related to parent/family connectedness. Indicators for this protective factor include: percent of families that - engage in regular routines (i.e. eating dinner together); participate in activities together; discuss current events/activities; or monitor children's behavior and set rules. Recommendation: The subcommittee urges the state to partner with interested organizations to further define family connectedness and develop indicators and measurement tools.

Connection to School - Students feel “connected” (attached or bonded) to their school based on their feelings about the people at school, both staff and other students. School connectedness is closely related to a caring positive school climate. School connectedness protects adolescents against many health risks, including smoking, alcohol, drug use, and early sexual initiation. Positive school climate and connectedness have been shown to contribute positively to academic achievement. ^{1,6,8,9,10,15,22 26}

Two Indicators: Percent of students agreeing that their school has a positive climate and percent of students that report being connected to their school. Data source: School Climate and Connectedness Survey 2007. (AASB)

Positive Connection to Other Adults - This factor refers to the student's perception that they receive support and caring in relationships with adults, other than family members i.e. neighbors, coaches, teachers, mentors or ministers. As children grow, they become involved in an expanded network of significant relationships. This enlarged network includes many adults who can provide regular contact, mentoring, support, and guidance. ^{1,3,4,5,9,10,11,13a,14, 21,25}

Indicator: Percent of students who have a positive connection with at least one other adult outside of their home.

Data source: Youth Risk Behavior Survey 2007 (DEED/DHSS)

Engagement in Meaningful Activities - This refers to activities involving volunteering and helping others in community or peer-based programs, or service-learning projects. This protective factor is associated with the reduction of several risk-taking behaviors (alcohol, tobacco or drug use, delinquency, anti-social behaviors, teen pregnancy, school suspensions or school drop-out. Programs increase skills and positive development when youth are involved in all phases: planning, organizing, implementation and evaluation. ^{2,3,4,6,7,6,8,9,11,15, 25, 28, 27,29}

Indicator: Percentage of students are involved in volunteer and helping activities one or more times per week.

Data source: Alaska Youth Risk Behavior Survey 2007 (DEED/DHSS)

Social, Emotional and Employability Skills - This refers to the abilities that equip young people to make positive choices, maintain healthy relationships and succeed in life; the skills include: communication, conflict resolution, empathy, resistance, problem solving/decision making and cultural competence. ^{14, 89}

Indicator: Percent of students who report they have social, emotional and employability skills.

Data source: School Climate and Connectedness Survey 2007 (AASB)

Indicators of Risk

Experienced Child Abuse (neglect, physical, sexual) or other family violence - Research suggests that children or youth who have been physically abused or neglected are more likely than others to commit violent crimes and/or become pregnant. Exposure to high levels of marital and family discord or conflict also appears to be a risk factor for social and mental health problems by adults and youths.

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Definitions (continued)

Experienced Child Abuse (neglect, physical, sexual) or other family violence (continued)

Family Violence Indicator Developmental Stage II: Existing measurement system needs further support and refinement.
Status: The reporting of interpersonal violence remains incomplete. Victim services data, from the Council on Domestic Violence and Sexual Assault (CDVSA), is not representative of all incidents of family violence--only those who seek services. The CDVSA 2006 Annual Report identifies victim services data by total number, type of services (including age, gender and incident types) and by region. **Recommendation:** This indicator may become more representative if data collected from women's shelters and crisis centers are aggregated along with domestic violence reports from police and law enforcement records. This would not account for many rural and remote areas where there is no law enforcement or no reporting methods designed to collect this information. Furthermore, the addition of standardized questions about interpersonal violence to existing population-based surveys (e.g. PRAMS, YRBS, BHRFS) will enhance the development of a reliable indicator.

Early Initiation of Substances - The earlier young people begin using drugs, committing crimes, engaging in violent activity, dropping out of school and becoming sexually active, the greater the likelihood that they will have problems with these behaviors later on. For example, research shows that young people who initiate drug use before the age of 15 are at twice the risk of having drug problems as those who wait until after the age of 19.^{6,8,18}

Indicator: Percent of students that have used alcohol before the age of 13. Data Source: Youth Risk Behavior Survey 2007(DHSS)

Availability of Alcohol and other Drugs - The more available alcohol and other drugs are in a community, the higher the risk that young people will use and abuse these substances. The perceived availability of drugs is also associated with greater risk of use. In schools where students believe drugs are more available, a higher rate of drug use occurs.^{8,12,18}

Indicator: Developmental Stage II: Existing measurement system needs further support and refinement.

Status: The Office of Public Safety, Alcoholic Beverage Control Board (ABC) conducts ongoing compliance checks (of sales to minors) of package stores, bars, lounges and restaurants across Alaska. The ABC board also collects data related to failure rates, but it has not consistently tracked this information until 2007. **Recommendation:** The data needs further analysis and the system of compliance checks needs additional support. *Other indicators related to access may need to be considered as well.*

Family History of Suicide or Attempts - Youth who have a suicide among any family member in the past 12 months are at greater risk for attempting suicide.^{1,7,11}

Indicator: Completed suicide rate per 100,000 Alaskans (all ages) based on 2000-2004 data.

Data Source: Alaska Bureau of Vital Statistics, February 2007

Death rate of family members by suicide Indicator: Developmental Stage II. Vital Statistics is beginning to analyze mortality data and familial relationships.

Community Norms and Laws related to Alcohol and Drug Use - Community norms (the attitudes and policies a community holds about alcohol/drug use) are communicated in a variety of ways: through laws and written policies, informal social practices, and through the expectations parents and community members have of young people. (e.g. alcohol taxes, local option or drunk driving laws, perceptions of disapproval)^{8,11,12,18}

Indicator: Developmental Stage II: Existing measurement system needs further support and refinement.

Status: The Office of Public Safety, Alcoholic Beverage Control Board (ABC) has information on local alcohol laws and controls (e.g. licenses, sales and local option restrictions). The current and available data on social norms and attitudes of drug and alcohol use in Alaska, is collected through the National Surveys on Drug Use and Health. **Recommendation:** The statistics from the ABC board needs to be reviewed to identify if there is enough data to compile a statewide indicator related to alcohol control laws. The data from the National Surveys on Drug Use & Health need to be reviewed for its strength as a population-based Alaska indicator.

Loss of Cultural Identity (Protective Factor: Cultural Identity) - Alaska Native and American Indian people may face additional risks associated with alcohol and other drug use. The increased vulnerability may be due to marginalization, stigmatization, and loss or devaluation of language, culture, spiritual and traditional healing practices, and subsistence living. Another problem may be lack of access to culturally appropriate health care. Alaska Native and American Indian communities also experience higher levels of stress due to historical trauma and rapid cultural change. Other ethnic persons or groups may experience similar risk factors.^{4,6,12,19}

Indicator: Developmental Stage I: Indicator needs to be defined and measurement system put into place.

Status: Information related to cultural identity such as percentage of Native language speakers and the number of rural households practicing subsistence lifestyles, exists primarily at the regional or local level. There are several ongoing research projects exploring the factors related to loss or preservation of cultural identity in Alaska. This research is in various stages of completion. Strategies to preserve and revitalize Alaska Native and American Indian culture and identity are being implemented. The current research is limited to a few studies, primarily with elders, and does not address the needs of youth. The subcommittee has the role to partner with interested organizations to further define cultural identity and develop indicators.

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Alaska Influence Indicator Data Sources

- ♦ Child Abuse Rate 2007 – Calculated by the Office of Children's Services, ORCA investigation for SFY07
- ♦ School Climate and Connectedness Survey 2007 – Association of Alaska School Boards (AASB)
- ♦ Suicide Rate 2000-2004 – The Center for Alaska Research & Statistics, BSEB February 2007
- ♦ Youth Risk Behavior Survey 2003 – Alaska Department of Health & Social Services, Alaska Youth Risk Behavior Survey 2003, <http://www.adhs.state.ak.us/yrbes/>

Press Release

State of Alaska > Department of Health & Social Services > News



PRESS RELEASE - For Immediate Release
November 29, 2001

SUBSTANCE ABUSE COSTS ALASKA \$614 MILLION A YEAR

New Study from McDowell Group Shows Economic Impacts

The negative economic impacts of alcohol and other drug abuse amount to about \$614 million a year in Alaska, according to a new study completed by the McDowell Group for the Governor's Advisory Board on Alcoholism and Drug Abuse (ABADA).

"This is a staggering blow to Alaska's economy, communities and families," said Advisory Board chair Eric Tomasino of Palmer. "Year after year, substance abuse and chemical dependency drain our human and economic resources."

The study looked at five basic ways in which alcohol and other drug abuse cost money: productivity losses, traffic crashes, criminal justice system and protective services, health care and public assistance. Alcohol abuse costs accounted for \$453 million per year, while other drug abuse costs were estimated at \$161 million annually.

"We have always known that alcohol and other drug abuse exacts a high human toll in Alaska," said Pam Watts, Executive Director of ABADA. "But until now, we had to rely on national studies to estimate the economic costs to our state. This report gives us strong, Alaska-specific data to use."

According to the study, lost worker productivity accounted for more than half of the annual economic impact, \$319 million per year. These losses occur when alcohol and other drug abuse results in premature death, reduced efficiency at work or through physical or mental impairment, incarceration for a criminal offense, or inpatient treatment or hospitalization. Of the productivity losses, nearly half were due to premature death from alcohol and other drug abuse. The economic cost of drug abuse was \$161 million, or 26 percent of the total. The average number of deaths by drug abuse in 1999 was 127, or 1.2 deaths per 100,000 people. The average number of deaths by alcohol abuse in 1999 was 127, or 1.2 deaths per 100,000 people. The average number of deaths by drug abuse in 1999 was 127, or 1.2 deaths per 100,000 people.

The Economic Costs of Alcohol and Other Drug Abuse in Alaska was prepared by the McDowell Group for ABADA by ABADA's grant. The study was funded by a grant from the Alaska Department of Health and Social Services, Division of Substance Abuse, to advise the Alaska Department of Health and Social Services on the economic costs of substance abuse.



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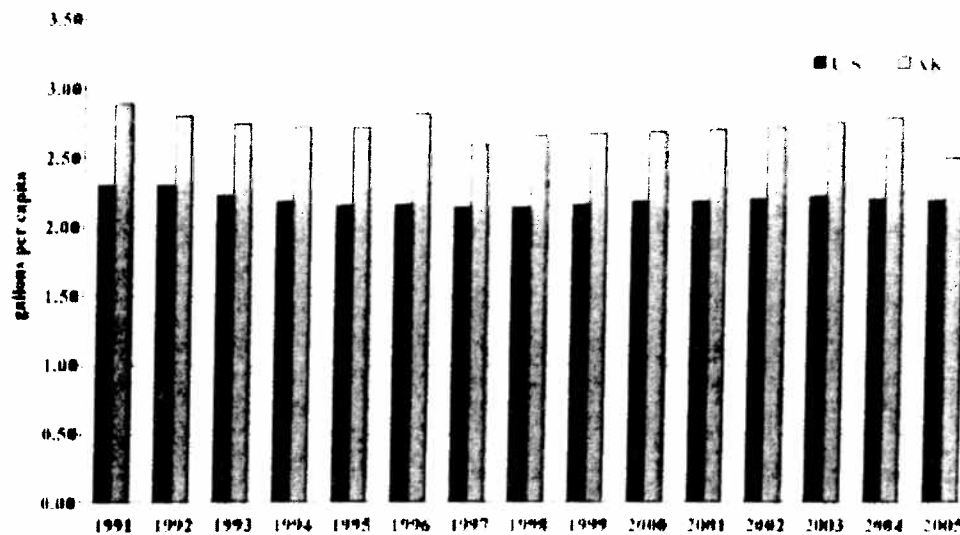
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Figure 2
U.S. and Alaska Alcohol Consumption Comparisons



Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. The alcohol consumption rate in Alaska has been higher than the rate in the rest of the nation during each of the last 14 years, and is well above the *Healthy Alaska's 2010* goal of 2.2 gallons or less per person per year. Data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicates that Alaska remains in the highest group for alcohol consumption in the nation (per capita ethanol consumption per 10,000 people aged 14 and over). Consumption rates are calculated with in-state sales of alcoholic beverages and the state population of persons 14 years and older.

Source: Alaska Department of Revenue, Alaska DMSS, Division of Behavioral Health, compiled by NCADD.

Alaska receives \$10.7 million for substance abuse prevention infrastructure

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a five-year, \$10.7 million grant to DHSS, Division of Behavioral Health. The grant will focus on Alaska's ability to develop and promote community health and wellness by building regional and community prevention infrastructure and capacity, with a specific emphasis on prevention of substance use and abuse.

The state is required to utilize the five steps of the Strategic Prevention Framework – assessment, capacity building, planning, implementation and evaluation. The goal is to have the first three steps completed by June 2010. Once the state's implementation plan has been approved by SAMHSA's Center for Substance Abuse Prevention, the state will solicit proposals from regional and/or community coalitions to develop a prevention infrastructure and capacity at the local level. These grant awards will not be for direct services, but for building sustainable infrastructure and capacity to prevent the consequences of alcohol and other drug use at the community and regional level. Each sub-recipient will be required to also use the five steps of the SPF, and to develop strategies based on what the assessment data tells them—a true data driven process. Proposals will be accepted from regional/community coalitions with the ability to conduct a thorough needs and capacity assessment; drawing on the input and commitment of the region/community at-large.

While direct program services will not be funded through these grant awards, we will encourage the utilization of environmental strategies that promote changing social and community norms, practices and policies.

We are very excited about the SPF SIG and the prevention opportunities these funds will provide to Alaska. Focusing on coalition building, community assessments, data-driven decision making, infrastructure, capacity and sustainable systems change will enhance our overall prevention efforts and assist us in changing the trends of alcohol and drug use in Alaska and the devastating consequences that occur.

Working through and with coalitions is how we envision the future for community-driven prevention activities. The old way of doing business isn't getting us where we want to go—human and dollar resources are not abundant enough to allow individual agencies to work in isolation on a single issue. We know that social issues are intertwined, yet we continue to approach these problems as independent silos of activity.... By putting our energy and emphasis on building and sustaining community coalitions, the ability to promote healthy communities; to build strong protective factors; and to reduce risk factors will be greatly increased and the outcomes more positive and hopeful. We thank everyone who attended the training and look forward to following up with future training to continue building a strong coalition framework for

Family Risk Factors

Family history of the problem behavior - If children are raised in a family with a history of alcohol/ drug addiction, it increases the likelihood that children will also have alcohol and other drug problems. If children are raised in a family with a history of criminal activity, the risk of juvenile delinquency increases. Similarly, children who are raised by a teenage mother are more likely to become teen parents, and children of dropouts are more likely to drop out of school themselves. ²⁴⁸¹¹¹⁸

Family management problems - Poor family management practices include lack of clear expectations for behavior, failure of parents to monitor their children – knowing where they are and whom they are with, and excessively severe or inconsistent punishment.^{8,18}

Family violence and conflict - Persistent, serious conflict between primary caregivers or between caregivers and children appears to increase children's risk for all of the problem behaviors. Whether the family consists of two biological parents, a single parent, or some other primary caregiver appears to matter less than whether the children experience much conflict in their families. For example, domestic violence in a family increases the likelihood that young people will engage in delinquent behaviors and substance abuse, as well as become pregnant or drop out of school.^{8,18}

Parental attitudes favorable to substance use and other problem behavior - Parental attitudes and behaviors toward drugs, crime, and violence influence the attitudes and behaviors of their children. Parental approval of young people's moderate drinking, even under parental supervision, increases the risk that the young person will use marijuana. Similarly, children of parents who excuse them for breaking the law are more likely to develop problems with juvenile delinquency. In families where parents display violent behavior, children are at greater risk of becoming violent.^{8,18}

The Advisory Board on Alcoholism and Drug Abuse, through the Alaska Department of Health and Social Services, contracted with McDowell Group in April 2005 to update a prior study on the economic costs of alcohol and other drug abuse in Alaska.

Alcohol and other drug abuse impacts the economy in many ways. Public safety, health care, and public assistance are among the areas impacted by alcohol and other drug abuse. The extent of these impacts is evident in the level of alcohol and other drug dependency and its associated cost on the Alaska economy. According to a 1998 study, 9.7 percent of Alaska's population is dependent upon or abuses alcohol (39,596 residents), while 1.5 percent is other drug dependent (14,238 residents). The total cost of this dependence to the Alaska economy is estimated to be \$738 million during 2003. Alcohol abuse costs accounted for \$525.5 million (71 percent). Other drug abuse costs were estimated at \$212.5 million (29 percent). Costs by category include:

- \$367 million from productivity losses.
- \$154 million from criminal justice and protective services.
- \$178 million from health care.
- \$35 million from traffic crashes.
- \$4 million from public assistance.

Public Assistance and Social Services

A portion of public assistance expenditures can be attributed to alcohol and other drug abuse. *Alcohol and other drug-dependent persons may qualify for public assistance because of reduced income, inability to hold a job, or disability caused by substance abuse.* Costs attributed to abuse (program administration costs only) were an estimated \$4.1 million in 2003.

Iditarod to drug test on the trail *BY TODD L. DISHER Frontiersman*

WASILLA — In a rule change that directly affects the event's three-time reigning champion, the governing body of the Iditarod Trail International Sled Dog Race will impose a strict drug testing policy on mushers starting in 2010.

Rule 29 now allows race officials to test mushers with or without cause, individually or as a group, and on a fixed or random schedule for the presence of prohibited drugs or alcohol.

The Iditarod Trail Committee Executive Director Stan Hooley said the rule change comes in response to a request from mushers.

"(The Iditarod Official Finishers' Club) said to us, 'We want you to implement a drug testing program to make sure no unfair advantage is gained. We are interested in the safety and the integrity of everyone in the race,'" Hooley said.

But for Lance Mackey, the musher who has dominated the sport for the last three years, the rule change is purely political.

"Some of the people who are pushing the issue are the people who can't beat me on the trail, so they are trying to beat me off it," Mackey said.

Mackey survived a battle with throat cancer in 2001 and openly admits to using marijuana for what he says are medicinal purposes and with a doctor's approval.

"I have no taste buds and no real appetite," Mackey said, as one of the purported benefits of marijuana is to improve food consumption. "It also helps me pay attention and focus on what I'm doing."

It's that last part that irks fellow musher Ken Anderson. Anderson said he understands if Mackey uses marijuana to maintain his health, but if it really does help him stay focused, then it offers an unfair advantage.

"I guess that is a little bit troubling, that he was getting a leg up," Anderson said. "And, that was against race rules."

Anderson is referring to the rule that has been in place banning substances like marijuana even before the rule was recently changed. However, what the past rule lacked, Hooley said, was enforcement.

"There wasn't a protocol in place for (drug testing) that would stand up," Hooley said. "You need to have professionals in place to carry out a program like that."

After the request from the IOIC, Hooley said the rule became formalized with an agreement with WorkSafe Inc., a company that does drug testing for companies around the state. By offering WorkSafe a sole partnership, the committee was able to get a contract for the tests at a reduced rate for itself.

The urine samples can be taken anywhere along the trail and flown to the testing facility in the Lower 48. Hooley said the turnaround time from sample taken to results should be about 48 hours, and the results will indicate levels of both illegal drugs and performance-enhancing substances.

As to why marijuana was included on the list of substances prohibited, Hooley said the committee was following federal guidelines. Alaska state law allows possession of up to 1 ounce of marijuana, but "by federal standards, marijuana is still an illegal drug," Hooley said.

What's more, marijuana is not eligible for the therapeutic exemption clause in the new rule. Hooley said marijuana only requires a physician's recommendation, not necessarily a prescription. Also, there is no regulated dispensing system that controls the dose because the federal government does not recognize marijuana as a medicine, Hooley said.

"Is marijuana considered performance-enhancing? I think most scientific folks would say no. But, it is an illegal drug that is not dispensed by the FDA through a prescription," Hooley said.

For his part, Mackey said he would not seek the therapeutic exemption even if it was offered, saying he does not want to use his medical marijuana card as a crutch. However, he said he still does not understand the reasoning behind the ruling.

"It's a dog race. They are the ones performing to get us to Nome. It didn't jeopardize their performance last year," Mackey said. "I finished with 15 of my 16 dogs and with a 12-hour lead in the toughest conditions the Iditarod has ever seen. It didn't do anything to hinder my outcome."

Asked if this means he used marijuana on the Iditarod trail last year, Mackey hesitated, but said yes.

"I wasn't dependent on it everyday. There was a little bit here and there. But it is irrelevant," he said.

What people don't understand, he said, is the effect cancer and the following chemotherapy and radiation treatment had on his body, and how marijuana alleviates this pain.

"I do not condone kids using pot. This is something I have had to deal with because of my medical history," Mackey said. "I don't know how to explain this. It seems like it is one of the reasons I'm still breathing."

Looking forward, Mackey said he is going to run a clean race in 2010 and likes his chances of becoming the first musher to win four Iditarod races in a row.

"I'm pretty confident. If I come in 50th this year, of course people are going to start pointing fingers," Mackey said. "But if they think my success in the past has been based on my marijuana use, they have more problems than me."

Social effects

The social problems arising from alcoholism can be massive and are caused in part due to the serious pathological changes induced in the brain from prolonged alcohol misuse and partly because of the intoxicating effects of alcohol.^{[1][23]} Alcohol abuse is also associated with increased risks of committing criminal offences including child abuse, domestic violence, rapes, burglaries and assaults.^[24] Being drunk or hung over during work hours can result in loss of employment, which can lead to financial problems including the loss of living quarters. Drinking at inappropriate times, and behavior caused by reduced judgment, can lead to legal consequences, such as criminal charges for drunk driving or public disorder, or civil penalties for tortious behavior. An alcoholic's behavior and mental impairment while drunk can profoundly impact surrounding family and friends, possibly leading to marital conflict and divorce, or contributing to domestic violence. This can contribute to lasting damage to the emotional development of the alcoholic's children, even after they reach adulthood. The alcoholic could suffer from loss of respect from others who may see the problem as self-inflicted and easily avoided.

Within the medical and scientific communities, there is broad consensus regarding alcoholism as a disease state. For example, the American Medical Association considers alcohol a drug and states that "drug addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use despite often devastating consequences. It results from a complex interplay of biological vulnerability, environmental exposure, and developmental factors (e.g., stage of brain maturity)."

Drug abuse

Further information: Drug abuse

Unemployment, underemployment, and distance from rural areas are where most drug abuse occurs. Some results of drug abuse are stealing, killing, theft, assault, prostitution, poor grades in school, and poor conduct at work. Some poverty is cause by people who have abused drugs and have spent all of their money buying them. When they have no other way to support their addiction, they result to other measures to obtain them. The urge for the drugs began to take over their lives. People lose there their families, friends and homes leaving them alone and in poverty.

Neurobehavior Disinhibition in Childhood Predicts Substance Use Disorder in Young Adulthood

The development of substance use disorder (SUD) was prospectively investigated in 66 boys having fathers with SUD and 104 boys having fathers with no adult psychiatric disorder. Evaluations were conducted to determine the context in which neurobehavior disinhibition in relation to parental SUD, parental neglect of the child and child's social maladjustment culminated in a DSM-III-R diagnosis of SUD. A neurobehavior disinhibition latent trait

reflecting prefrontal cortex disturbance was derived using indicators of behavior undercontrol, affect dysregulation and executive cognitive functioning in the boys when they were 10-12 and again at 16 years of age. The data were analyzed to determine whether the score on the neurobehavior disinhibition construct mediates the association between father's and mother's SUD and son's SUD. Several key results emerged. First, SUD in the mother and father predicted neurobehavior disinhibition in the son. Second, the neurobehavior disinhibition score of the sons at ages 10-12 predicted SUD at age 19. Third, neurobehavior disinhibition, in conjunction with social maladjustment and drug use frequency, mediated the association between paternal and maternal SUD and son's SUD. Fourth, neurobehavior disinhibition was unrelated to neglect of the child by either the father or mother; however, paternal but not maternal neglect at age 10-12 predicted SUD at age 19. These findings suggest that prefrontal cortex dysfunction contributes to SUD liability. Tarter R.E., Kirisci L., Habeych M., Reynolds M. and Vanyukov M. Neurobehavior Disinhibition in Childhood Predisposes Boys to Substance Use Disorder by Young Adulthood: Direct and Mediated Etiologic Pathways. *Drug and Alcohol Dependence*, 73, pp. 121-132, 2004.

Testing the Effectiveness of a Public Health Approach to Treating Substance-Abusing Women on Welfare

Jonathan Morgenstern, Ph.D.

Substance abuse (SA) among disadvantaged, parenting women has long been identified as a major public health problem. However, as States move to implement welfare reform, efforts to effectively address this problem take on greater urgency. This report describes preliminary findings from a study currently in progress to test the effectiveness of a public health approach to intervening with this population. The report will (1) describe the study rationale, design, and interventions, (2) compare baseline characteristics of substance-abusing women on welfare with a nonaffected comparison group, and (3) report on SA treatment entry and retention data for an initial cohort of participants. A standardized battery was administered to women (N=220) recruited in a welfare setting who either met current DSM-IV substance-dependence criteria or did not meet criteria for a substance use disorder in the prior 5 years. Substance-dependent women had significantly greater employment, mental health, family, medical, and housing problems, suggesting they would experience substantially greater barriers to employability. Substance-dependent women were then randomly assigned to receive a referral either to SA treatment or to an intensive case management intervention (ICM). Women assigned to ICM had significantly higher rates of SA treatment entry and attendance. Overall, women who received a referral only to SA treatment had low rates of treatment attendance. Findings are discussed in the context of the current interface between substance abuse and welfare-to-work services.



Science of Addiction

Nora Volkow, M.D.
Director of the National Institute on Drug Abuse (NIDA)
National Institutes of Health

When scientists first started to study drug abuse, people addicted to drugs were thought to be morally flawed and lacking in willpower. This view has shaped society's response to drug abuse, treating it as a moral failing rather than a health problem, resulting in punitive rather than preventative and therapeutic actions. Due to groundbreaking scientific discoveries, we now recognize drug addiction as a brain disease that can be successfully prevented and treated.

What is Drug Addiction?

Drug addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use despite often devastating consequences. It results from a complex interplay of biological vulnerability, environmental exposure, and developmental factors (e.g., stage of brain maturity).

As with many other diseases, vulnerability to addiction stems partly from a person's genetic makeup. Scientists estimate that genetic factors account for 40–60 % of an individual's vulnerability to addiction, with environmental and developmental variables influencing whether and how particular genes are expressed. Additional factors, such as conditions at home, at school, or in the neighborhood, can heighten addiction vulnerability. Research also shows that early drug use increases the likelihood of addiction and that people with psychiatric disorders have a higher risk of drug abuse and addiction than the general population.

Research has improved our understanding of the biological mechanisms underlying drug abuse and addiction. All drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine—the neurotransmitter that regulates feelings of pleasure, as well as movement, emotion, cognition, and motivation. Overstimulation of this system produces the euphoric effects sought by people who abuse drugs and teaches them to repeat the behavior. Our brains are wired to repeat activities that bring us pleasure or reward (e.g., eating or having sex) as a way of ensuring our survival. Because taking drugs of abuse stimulates the same circuit, our brains urge repetition of the behavior, and thus people "learn" to abuse drugs without thinking about it. These intense impulses can overcome a person's willful intent not to take drugs, despite catastrophic consequences—which is really the essence of drug addiction.

Therefore, even though the initial decision to take drugs is mostly voluntary, once drugs take over, they cause brain changes that acutely impair a person's ability to exert self-control. Brain imaging studies of drug-addicted individuals have revealed physical changes in brain areas critical to judgment, decision-making, learning, memory, and behavior control, which may help explain the compulsive and destructive behaviors associated with drug addiction.

Preventing Drug Abuse

The National Survey on Drug Use and Health (NSDUH) estimated that 22.6 million persons (9.2 % of the U.S. population aged 12 or older) were classified with substance abuse or dependence in 2006 (based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th* edition). Of these

- 3.2 million abused or were dependent on both alcohol and illicit drugs.

- 3.8 million abused or were dependent on illicit drugs but not alcohol; and
- 15.6 million abused or were dependent on alcohol but not illicit drugs.

Data on teen drug use reflect both encouraging and troubling trends. Although statistics show a 23 % decline from 2001–2006 in past-month use of any illicit drug by students in 8th, 10th, and 12th grades, abuse of marijuana continues to be a problem with approximately 12 % of 8th graders, 25 % of 10th graders, and 32 % of 12th graders reporting use in the past year. Prescription painkillers also continue to be abused at unacceptably high levels, with 1 in 10 high school seniors reporting abuse in the past year. In addition, while past-year abuse of OxyContin was down among 12th graders, the rate nearly doubled among 8th graders between 2002 and 2006—going from 1.3 % to 2.6 %. Prescription drugs are easily accessible and are often obtained from a friend or relative for free. Moreover, there is a common misperception that, because they are prescribed by a doctor, prescription medications are safe, even when used in ways not intended.

Because early use of drugs increases a person's chance of more serious abuse and addiction, prevention is crucial. NIDA studies have shown that prevention programs backed by science (rationally designed and rigorously tested) can be effective in youth. Such programs work to boost protective factors, reduce risk factors for drug use, and help shape youths' perceptions about drug abuse risk.

Medical Consequences of Addiction

Illicit drug abuse causes 17,000 deaths annually in the United States and more than \$180 billion in annual economic costs. Abuse of nicotine, alcohol, and/or prescription drugs causes additional morbidity and mortality. Although some medical consequences of drug abuse and addiction are temporary and can be essentially reversed with treatment, others may be more persistent, diminishing the quality of individuals' health long after drug use has stopped. Whether short-lived or chronic, the many potential health effects from drug abuse and addiction underscore the fact that drug abuse does not exist in medical isolation—it causes a broad array of medical consequences throughout the body (<http://www.nida.nih.gov/consequences/>). A few examples follow:

- **Cardiovascular effects.** Researchers have found a connection between the abuse of most drugs and adverse cardiovascular effects, ranging from abnormal heart rate to heart attacks. Injection drug use can also lead to cardiovascular problems such as collapsed veins and bacterial infections of the blood vessels and heart valves. Use of marijuana, cocaine, methamphetamine, and inhalants can result in cardiovascular effects.
- **Neurological effects.** All drugs of abuse act in the brain to produce euphoric effects; however, some drugs also cause severe negative consequences in the brain such as seizures, stroke, and widespread brain damage that can impact all aspects of daily life. Drug use can also cause brain changes that lead to problems with memory, attention, and decision-making. Examples of drugs with neurological effects include cocaine, methamphetamine, inhalants, and ecstasy.
- **HIV, hepatitis, and other infectious diseases.** Drug abuse increases the spread of infectious diseases. Injection of heroin, cocaine, and methamphetamine causes more than a third of new AIDS cases and is a major contributor to the spread of hepatitis C. In addition, all drugs of abuse interfere with judgment and increase the likelihood of risky behaviors, which also contribute to the spread of HIV/AIDS and other sexually transmitted diseases.
- **Other health effects.** In addition to the effects various drugs of abuse may have on specific organs of the body, many drugs produce global body changes such as dramatic changes in appetite and increases in body temperature, which may impact a variety of health conditions. Withdrawal from drug use also may lead to numerous adverse health effects, including restlessness, mood swings, fatigue, muscle and bone pain, insomnia, cold flashes, diarrhea, and vomiting.

In addition to harmful effects for the addicted individual, drug abuse can result in serious health consequences for others. For example, while the full extent of the effects of prenatal drug exposure on a child is not known, studies show that various drugs of abuse may result in premature birth, miscarriage, low birth weight, and a variety of behavioral and cognitive problems in infants and children. Secondhand exposure to tobacco smoke is another example. According to the 2006 Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, exposure to environmental tobacco smoke increases the risk of heart disease and lung cancer in persons who have never smoked by 25–30% and 20–30%, respectively. Exposure to tobacco smoke in the home increases severity of childhood asthma and has been associated with sudden infant death syndrome.

Treatment and Recovery

Discoveries about the science of addiction have led to advances in drug abuse treatments that enable people to counteract addiction's powerful effects on the brain and behavior and regain control of their lives. Despite the availability of many forms of effective treatment for addiction, the problem of relapse remains the major challenge to achieving sustained recovery. However, relapse rates for addiction are similar to those for other well characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves changing deeply embedded behaviors, and relapse does not mean treatment failure. For the addicted patient, lapses back to drug abuse indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed. For most individuals, combining medications with behavioral therapies is the most successful approach.

Different types of medications may be useful at different stages of treatment—during withdrawal to ease symptoms; during treatment to help people stay engaged; and following treatment to prevent relapse. Medications currently available include those used to treat:

- **Tobacco addiction.** Nicotine replacement therapies (patch, inhaler, gum), bupropion, varenicline.
- **Opioid addiction.** Methadone, buprenorphine.
- **Alcohol and drug addiction.** Naltrexone (helps prevent relapse to alcohol and heroin abuse), disulfiram (helps prevent relapse to alcohol abuse and is currently being tested for treating cocaine abuse), acamprosate (helps prevent relapse to alcohol abuse).

Behavioral treatments help people modify attitudes and behaviors related to drug abuse and increase their ability to handle stressful situations and environmental cues that may trigger intense craving for drugs and prompt relapse. For example,

- **Cognitive behavior therapy** helps people recognize, avoid, and cope with situations in which they are most likely to abuse drugs.
- **Motivational incentives treatment** uses positive reinforcements (i.e., rewards or privileges) to help people remain drug free.
- **Motivational interviewing** is conducted at treatment entry to stoke an individual's desire to fully participate in treatment and change his or her behaviors.
- **Group therapy** helps people face their drug abuse realistically, acknowledge the harm it can cause, and increase motivation to not use drugs.

Behavioral therapies can also enhance the effectiveness of medications and help people remain in treatment.

The process of recovery from drug abuse or addiction can be long and complex. When people enter treatment, addiction has often taken over their lives. The compulsion to find and use drugs may have disrupted their families, their professional lives, and their standing in the community. It also may have

made them vulnerable to other serious illnesses. Because the effects of drug abuse are far reaching, treatment must address the needs of the whole person to have the best chance for success. The most effective programs incorporate a variety of rehabilitation services to address a person's medical, psychological, social, vocational, and legal needs to enhance their recovery process.

At NIDA, we believe that a fuller understanding of the science of addiction will encourage adoption of research-based policies and programs to reduce drug addiction and will increase support for scientific research to improve the health of our citizens. Please visit our recently created Web site to access a wealth of resources designed to help physicians recognize, diagnose, and treat drug abuse and addiction: <http://www.nida.nih.gov/medstaff.html>. Together, we can continue to leverage the power of science against this devastating disease that causes so much suffering for individuals, communities, and society at large.

The New York Times

August 30, 1987

Rich vs. Poor: Drug Patterns Are Diverging

By **PETER KERR**

Americans generally appear to be turning away from the use of illegal drugs, but, at the same time, the poor face mounting deaths and an ever bleaker future because of drug abuse, according to Government statistics and interviews with drug experts.

What may be emerging, some experts believe, is a tale of two drug problems: one in middle-class America, which may be past the worst of a 20-year mass experiment with illegal drugs; the other in the America of the poor, where, amid hopelessness and lack of education, people will suffer the worst consequences of cocaine, heroin and AIDS.

"We are dealing with two different worlds here," said Dr. David F. Musto, a professor of psychiatry and history of medicine at Yale University who has written extensively on the history of drug-use epidemics. Incentives to Stop

"The question we must be asking now is not why people take drugs, but why do people stop," Dr. Musto said. "In the inner city, the factors that counterbalance drug use - family, employment, status within the community - often are not there. It is harder for people with nothing to say no to drugs."

In recent years, the focus of greatest concern among drug experts has been cocaine, for while the use of other drugs was dropping or remaining stable, cocaine grew widely in popularity throughout the nation in the late 1970's and early 1980's.

Findings from two major Federal studies on drug use in America show that in the last few years, better-educated young people have been reducing their use of cocaine and other drugs. Meanwhile, the least-educated have increasingly used cocaine.

Experts caution that their conclusions are tentative and that the rise of a new drug or the appearance of other unpredictable factors could easily upset current trends. And, whatever the trends, they say, drug use is so widespread that it will remain a problem in all sectors of society for years. A Mixed Message

However, they point to a newly emerging picture of drug use in America that, they say, carries a mixed message of hope for the well-off and despair for the poor. Among their major conclusions are these:

* With the exception of heroin and crack among the poor, the use of illegal drugs in the nation appears to have peaked, including the snorting of powdered cocaine.

- * Federally financed studies show that the people turning away from drugs are the most educated and affluent. The poorest and least-educated have continued or increased their drug use.

- * Crack, a smokable form of cocaine, has largely remained a poor people's drug. Its rise in the past two years has had devastating effects on poor neighborhoods, but it has failed to make the same inroads into the middle class.

- * The most deadly impact of illegal drug use is probably yet to come, as tens of thousands of intravenous drug users, their sexual partners and their children contract acquired immune deficiency syndrome. Most of those people will be poor.

Several drug treatment experts voiced concern that as the casualties of drug abuse shift increasingly into the ghetto, the drug issue may become less visible to many Americans and receive less attention from government. Putting Pressure on Legislators

"In the heroin crisis of the late 1960's and again with crack in recent years it was the threat to the middle- and upper-middle-class kids that put pressure on legislatures and Congress," said Dr. Mitchell S. Rosenthal, the president of Phoenix House, the operator of drug treatment centers in New York and California. "There is a danger that if they feel less of a threat, the resources won't stay with the problem."

Some scholars say societies experience widespread drug use in historic cycles. From 1885 to 1920, the United States experienced an epidemic of narcotics and cocaine use. Dr. Musto argues that a similar epidemic began in about 1965, but that it took years for casualties to mount and for society to react against drugs.

Statistics indicate that outside of the poorest neighborhoods, the nation's 20-year affair with illegal drugs is on the decline.

According to the National Institute on Drug Abuse, marijuana use peaked in 1978, and by 1985, 7 out of 10 high school seniors believed marijuana use to be harmful. Young people's use of hallucinogens, like LSD and PCP, or "angel dust," has fallen since 1979. A Different Generation

In 1985, a national household survey conducted by the University of Kentucky for the National Institute on Drug Abuse asked 18-to-25-year-olds if they had smoked marijuana in the last month. It found that people who never graduated from high school were most likely to be using the drug. The better educated the young people were, the survey found, the less they were using marijuana.

Among an earlier generation of smokers - people 35 and over, who probably developed their attitudes toward marijuana in the late 60's and early 70's - the findings were just the reverse. It was the college-educated who were most likely to be smoking marijuana.

Another study found similar results. The survey, conducted for the National Institute on Drug Abuse by the University of Michigan Institute for Social Research, asked high school seniors whether they had used drugs other than marijuana in the previous year.

The survey found that in 1986, seniors of all economic backgrounds were using drugs less than seniors were in 1981. But the greatest change took place among students whose parents had some graduate education: a drop of 13 percentage points, to 23.7 percent, from 36.7 percent. The least change took place among students whose parents had never been to high school: a drop of 2.7 percentage points, to 22.7 percent, from 25.4 percent. Flooding Across the Border

What confused the situation last year was cocaine, which had been rising in use since the late 70's. By last year, the white powder was flooding across the nation's southern border and was suddenly appearing in urban areas in the new smokable form of crack; from 1982 to 1986, the number of deaths and emergency room reports involving cocaine quadrupled.

For a time, experts feared that the pellet form of cocaine, which is much more quickly addicting than cocaine powder, would spread to all segments of society, including the middle class and affluent, who were using powdered cocaine. But it now appears that the growth of crack has leveled off in New York and many other cities around the country, law-enforcement and treatment officials say.

"In general we believe that cocaine has reached its peak," said David L. LeRoy, the chief of domestic intelligence with the cocaine desk of the Federal Drug Administration. "It is going to take a few months to have the numbers to prove it, but we feel fairly optimistic about it." Tracing the Growth in Appetite

The amount of cocaine entering the country could still be rising, Mr. LeRoy said, but the number of users appears to have leveled off or may be dropping. In other words, he said, the most recent growth in America's cocaine appetite can be traced to its most severe addicts, many of them inner-city crack addicts.

According to the household survey of 18-to-25-year-olds, the people most likely to have used cocaine in the previous month in 1982 were those who graduated from college. The least likely to have used cocaine were those who never finished high school. Among college graduates, 13 percent said they had used cocaine in the past month, while among those without high school diplomas, only 4 percent had used cocaine.

But by 1985, the situation was just the opposite. Only 3 percent of college graduates said they used cocaine in the last month. But 10 percent of people who never finished high school said they used the drug. Since the survey did not include people without homes, it may have understated drug use among the poorest and least-educated, according to Prof. Harwin Voss of the University of Kentucky, who helped direct the study. Severe Consequences

There is still evidence of middle-class crack use with severe consequences for those who have become addicted. In addition, treatment experts say "freebasing," or smoking of powdered cocaine, which has the same effect as smoking crack, is popular in some circles of middle-class and affluent drug users.

Nonetheless, the New York State Division of Substance Abuse Services and the Los Angeles County office of Drug Abuse report that most crack users appearing at hospitals and treatment centers are poor members of minority groups.

Such observations about crack and the poor are echoed by other drug treatment experts around the nation.

"Crack seems to have become entrenched in the inner-city areas," said James Hall, the director of Up Front Drug Information Inc., a foundation based in Miami. "With cocaine we are going to see a shrinking number of users who are going to be at greater risk from the drug. They are the poorest, the least educated, who have the least access to information."

But perhaps the most dire vision of the future concerns the intravenous users of heroin, a drug that has remained predominantly the preserve of the inner-city poor. AIDS Through Shared Needles

While the number of addicts around the nation has remained relatively stable, there has been an alarming rise in the proportion of addicts exposed to the AIDS virus from the sharing of needles.

While only a comparatively small fraction of heroin addicts died from overdoses, each year between 20 and 100 percent of those exposed to AIDS are expected to die from the disease.

Among heroin addicts entering drug treatment in New York, more than 50 percent are now testing positive for exposure to the virus, said Dr. Beny J. Primm, the executive director of the Addiction Research and Treatment Corporation, a drug treatment program in New York.

Dr. Primm described his vision of the future for the poorest black neighborhoods in New York, where homelessness and family disintegration are already rife.

"Five years from now, those people who are alive then will find their ranks devastated by AIDS, and there will be a type of hopelessness that is hard to imagine now," Dr. Primm said. "I am hearing people already say, 'I am infected with the virus, I might just as well shoot up drugs.' People will be turning more and more to drugs for solace."

Graph of percentage of nationwide high school seniors who said they used a drug other than marijuana in the last year (University of Michigan) (Page 28); photo of Dr. David F. Musto (NYT Rollin A. Riggs) (Page 28)

Frequently Asked Questions About Drug Testing in Schools

What is drug testing?

Some schools, hospitals, or places of employment conduct drug testing. There are a number of ways this can be done, including: pre-employment testing, random testing, reasonable suspicion/cause testing, post-accident testing, return to duty testing, and follow-up testing. This usually involves collecting urine samples to test for drugs such as marijuana, cocaine, amphetamines, PCP, and opiates.

Following models established in the workplace, some schools have initiated random drug testing and/or reasonable suspicion/cause testing. During random testing schools select, using a random process (like flipping a coin), one or more individuals from the student population to undergo drug testing. Currently, random drug testing can only be conducted among students who participate in competitive extracurricular activities. Reasonable suspicion/cause testing involves a school requiring a student to provide a urine specimen when there is sufficient evidence to suggest that the student may have used an illicit substance. Typically, this involves the direct observations made by school officials that a student has used or possesses illicit substances, exhibits physical symptoms of being under the influence, and has patterns of abnormal or erratic behavior.

Why do some schools want to conduct random drug tests?

Schools that have adopted random student drug testing are hoping to decrease drug abuse among students via two routes. First, schools that conduct testing hope that random testing will serve as a deterrent, and give students a reason to resist peer pressure to take drugs. Secondly, drug testing can identify adolescents who have started using drugs so that interventions can occur early, or identify adolescents who already have drug problems, so they can be referred for treatment. Drug abuse not only interferes with a student's ability to learn, but it can also disrupt the teaching environment, affecting other students as well.

Is student drug testing a stand-alone solution, or do schools need other programs to prevent and reduce drug use?

Drug testing should never be undertaken as a stand-alone response to a drug problem. If testing is done, it should be a component of broader prevention, intervention and treatment programs, with the common goal of reducing students' drug use.

If a student tests positive for drugs, should that student face disciplinary consequences?

The primary purpose of drug testing is not to punish students who use drugs but to prevent drug abuse and to help students already using become drug-free. The results of a positive drug test should be used to intervene with students who do not yet have drug problems, through counseling and follow-up testing. For students that are diagnosed with addiction, parents and a school administrator can refer them to effective drug treatment programs, to begin the recovery process.

Why test teenagers at all?

Teens are especially vulnerable to drug abuse, when the brain and body are still developing. Most teens do not use drugs, but for those who do, it can lead to a wide range of adverse effects on the brain, the body, behavior and health.

Short term: Even a single use of an intoxicating drug can affect a person's judgment and decisionmaking—resulting in accidents, poor performance in a school or sports activity, unplanned risky behavior, and the risk of overdosing.

Long term: Repeated drug abuse can lead to serious problems, such as poor academic outcomes, mood changes (depending on the drug: depression, anxiety, paranoia, psychosis), and social or family problems caused or worsened by drugs.

Repeated drug use can also lead to the disease of **addiction**. Studies show that the earlier a teen begins using drugs, the more likely he or she will develop a substance abuse problem or addiction. Conversely, if teens stay away from drugs while in high school, they are less likely to develop a substance abuse problem later in life.

How many students actually use drugs?

Drug use among high schools students has dropped significantly since 2001. In December, the 2007 Monitoring the Future study of 8th, 10th, and 12th graders showed that drug use had declined by 24 percent since 2001.

Despite this marked decline, much remains to be done. Almost 50 percent of 12th graders say that they've used drugs at least once in their lifetime, and 18 percent report using marijuana in the last month. Prescription drug abuse is high—with nearly 1 in 10 high school seniors reporting non-medical use of the prescription painkiller Vicodin in the past year.

What testing methods are available?

There are several testing methods available that use urine, hair, oral fluids, and sweat (patch). These methods vary in cost, reliability, drugs detected, and detection period. Schools can determine their needs and choose the method that best suits their requirements, as long as the testing kits are from a reliable source.

Which drugs can be tested for?

Various testing methods normally test for a "panel" of drugs. Typically, a drug panel tests for marijuana, cocaine, opioids, amphetamines, and PCP. If a school has a particular problem with other drugs, such as MDMA, GHB, or steroids, they can include testing for these drugs as well.

What about alcohol?

Alcohol is a drug, and its use is a serious problem among young people. However, alcohol does not remain in the blood long enough for most tests to detect recent use. Breathalyzers and oral fluid tests can detect current use. Adolescents with substance abuse problems are often polydrug users (they use more than one drug) so identifying a problem with an illicit or prescription drug may also suggest an alcohol problem.

How accurate are drug tests? Is there a possibility a test could give a false positive?

Tests are very accurate but not 100 percent accurate. Usually samples are divided so if an initial test is positive a confirmation test can be conducted. Federal guidelines are in place to ensure accuracy and fairness in drug testing programs.

Can students "beat" the tests?

Many drug-using students are aware of techniques that supposedly detoxify their systems or mask their drug use. Popular magazines and Internet sites give advice on how to dilute urine samples, and there are even companies that sell clean urine or products designed to distort test results. A number of techniques and products are focused on urine tests for marijuana, but masking products increasingly are becoming available for tests of hair, oral fluids, and multiple drugs.

Most of these products do not work, are very costly, are easily identified in the testing process and need to be on hand constantly, because of the very nature of random testing. Moreover, even if the specific drug is successfully masked, the product itself can be detected, in which case the student using it would become an obvious candidate for additional screening and attention. In fact, some testing programs label a test "positive" if a masking product is detected.

Is random drug testing of students legal?

In June 2002, the U.S. Supreme Court broadened the authority of public schools to test students for illegal drugs. Voting 5 to 4 in *Pottawatomie County v. Earls*, the court ruled to allow random drug tests for all middle and high school students participating in competitive extracurricular activities. The ruling greatly expanded the scope of school drug testing, which previously had been allowed only for student athletes.

Just because the U.S. Supreme Court said student drug testing for adolescents in competitive extracurricular activities is constitutional, does that mean it is legal in my city or state?

A school or school district that is interested in adopting a student drug testing program should seek legal expertise so that it complies with all federal, state, and local laws. Individual state constitutions may dictate different legal thresholds for allowing student drug testing. Communities interested in starting student drug testing programs should become familiar with the law in their respective states to ensure proper compliance.

What has research determined about the utility of random drug tests in schools?

There is not very much research in this area, and the early research shows mixed results. A study published in 2007 (Goldberg et al, *J. Adolesc Health*, 41: 421-29, 2007) found that student athletes who participated in randomized drug testing had overall rates of drug use similar to students who did not take part in the program, and in fact some indicators of future drug abuse increased among those participating in the drug testing program. Because of the limited number of studies on this topic more research is warranted.

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Explore Cost Benefits

Most interested parties agree that they seek to help patients become less destructive and more productive members of society. In our society, an individual's contribution often is measured in monetary terms -which is why transforming measures of effectiveness into measures of monetary benefits is so important, and why cost-benefit analysis can be so useful for decisionmakers.

According to research by Ball and Ross (1991) and Gerstein et al. (1994), substance abuse treatment can be expected to both save money and produce new income. In California, various drug treatments were estimated to save between \$245 million and \$1,284 million after subtracting the cost of treatment from cost savings and income generated in a single year in the early 1990s (Gerstein et al. 1994, p. 82). Of course, every treatment program differs in how much (and how quickly) this return on investment occurs, which is one reason to measure the benefits as well as the costs of individual programs.

Typical Benefits of Substance Abuse Treatment

New Income

Real income may be generated by substance abuse treatment due to increased productivity and employment of patients. This does not always occur, however. Researchers have found that employment prospects may not be as positive for former substance abusers as might be hoped (cf. Gerstein et al. 1994). This may be due to the stigma of being a former substance abuser as well as difficulties posed by criminal records. Also, the behavior patterns sometimes acquired in drug abuse lifestyles may need to change radically to meet expectations of potential employers (such as getting to work on time every day and following directives).

Cost Savings

Another benefit of substance abuse treatment is cost savings to society or taxpayers. These cost savings include -

- Funds that otherwise would have been spent on the illicit economy for drugs
- Criminal justice services not required
- Social and health services no longer required.

These cost-savings benefits are real and can be quite substantial. Substance abuse researchers (Langenbucher et al. 1993) have found profound reductions in a number of costly events after treatment, including the following decreases:

- Patients involved in driving while intoxicated/driving under the influence arrests decreased from 18 percent (pretreatment) to 3 percent (posttreatment).
- Patients involved in accidents decreased from 14 to 1 percent.
- Patients' families who sought counseling decreased from 31 to 5 percent.
- Patients' children who missed school decreased from 5 to 1 percent.
- Patients' spouses who missed work decreased from 10 to 1 percent.

Although different jurisdictions and different methods of assessment may provide different figures, the level of criminal activity patients exhibit can be expected to decrease by roughly two-thirds (Gerstein et al. 1994). Not every program produces a two-thirds reduction, however, so it is essential to measure how much criminal activity changes for each patient.

The reduction in criminal activity following substance abuse treatment may not produce a corresponding reduction in actual costs to society. Although costs to citizens drop in direct proportion to reductions in criminal acts perpetrated on those citizens, public expenses for criminal justice services may not decline in a similar manner. Typically, police, courts, and other components of the criminal justice system are on limited and fixed budgets, while the need for criminal justice services greatly surpasses the ability to deliver those services. For this reason, the impact of substance abuse treatment on criminal behaviors may not result in an actual reduction in criminal justice expenditures. Instead, criminal justice resources saved because of a reduction in crimes committed by former substance abusers may be diverted to other criminal justice services. The entire budget for criminal services probably will still be spent.

Similar problems may occur when cost savings benefits are measured for reduced health, mental health, and future drug treatment services. Because resources in these services typically are very limited, the actual reduction in expenditures may not be as much as might be expected from the reduction in patient use of services.

Nevertheless, transforming effectiveness findings into estimated cost savings still may have considerable value for a program evaluation. In particular, cost savings estimates can show the magnitude of criminal justice and treatment resources that are now available to help other drug abusers who previously could not be helped because of budget restrictions.

Crime-Related Cost Savings

Other research provides evidence for numerous cost savings that result from drug abuse treatment. For example, Rajkumar and French (1996) found that although total costs of crime averaged \$47,971 per patient in the year prior to treatment, that figure dropped to an average of \$28,657 per patient in the year following treatment. That drop of \$19,314 was far more than the cost of treatment, making cost savings in terms of crime alone worth the cost of treatment: \$2,828 for methadone maintenance, \$8,920 for residential treatment, and \$2,908 for outpatient treatment (Rajkumar and French 1996).

Employment- Related Cost Savings

French and associates (1990) found that drug treatment improved the employment and earning potential of drug abusers. Although only 31 percent of drug abusers were employed at the start of treatment, almost 45 percent were employed after treatment. There was a similar increase in the number of patients seeking work (from 9 to 13 percent). And, employed patients earned more after treatment. French and colleagues (1990) found that average personal earnings for employed patients rose from \$6,158 during the year before treatment to \$7,120 during the year after treatment.

The legality of employment and income also can be positively affected by drug treatment. French and Zarkin (1992) found that increasing time spent in methadone treatment by just 10 percent increases legal earnings by 1.5 percent and decreases illegal earnings by 3.2 percent. A 10-percent increase in time spent in residential programs increases legal earnings 2.4 percent and decreases illegal earnings 4.1 percent.

Health Service- Related Cost Savings

French and colleagues (1996) estimated the cost savings if one case of the following health problems could be avoided:

- \$1,100 for avoiding a case of severe venereal disease
- \$74,513 for avoiding a case of severe hypertension
- \$96,005 for avoiding a case of severe tuberculosis
- \$114,796 for avoiding a case of AIDS

Caveats on Benefit Assumptions and Calculations

Reductions in each of the above events are notable in their own right, as well as in terms of monetary savings to the individual and society. For your program, the average cost of each event can be requested from those providing criminal justice, health, or social services locally. It also may be possible to glean this cost information directly from records of expenditures of public funds. The cost savings benefit then can be calculated for each patient as the reduction directly experienced in these events.

Some important changes may be impossible to monetize. For example, patients who interrupted their education decreased from 12 to 4 percent. Although this is a substantial decrease, it is impossible to determine the monetary value of this reduction. Other changes may not occur during the time period used to collect outcome data. For example, patients' financial problems may continue to occur for years after treatment because of the length of time necessary to compensate victims and pay off accumulated debt.

Increased Expenditures From Outcomes

Substance abuse treatment can temporarily increase patients' use of social services, including welfare support, disability payments, and health services. Patients may become well enough to seek help for health problems and to seek financial support from licit as opposed to illicit sources.

According to the CALDATA study (Gerstein et al. 1994), enrollment and payments received from various social services (other than health services) increased 17 to 50 percent during treatment. Being in treatment also may increase eligibility to receive a variety of social support services.

These increases in expenditures need to be included in treatment outcome reports. They should not be excluded simply because they do not seem like benefits. They are monetary outcomes and must be considered. They will likely be canceled out by the cost savings and income generated after treatment.

A case in point: In the CALDATA study, the costs of health services decreased between 1-year periods prior and subsequent to treatment from a mean \$3,227 to a mean \$2,469 per person. Also, in a study reported by Holder and Hallan (1986), private health insurance costs dropped from approximately \$100 per month per patient in the 2 years preceding treatment to less than \$14 per month per patient in the fifth year following treatment (which is when most health sequelae of substance abuse should have subsided).

Cost savings and other benefits may vary considerably depending on the type of treatment. In the CALDATA study, residential treatment was associated with a 58-percent reduction in costs to taxpayers, whereas methadone discharge was associated with a 17-percent reduction in costs to taxpayers. Also, longer treatment generally corresponded to greater cost savings, although not for methadone maintenance.

Transform Effectiveness Findings Into Benefits

Effectiveness findings often can be transformed into benefit findings by multiplying effectiveness data by a cost value. For example, to estimate cost savings after treatment, the change in the number of thefts before versus after treatment can be multiplied by the average cost of drug-related thefts in terms of property loss, victim losses, and criminal justice expenses. Statistical analysis of data collected in an experimental design is the best way to determine whether these cost savings are significant and can be ascribed to treatment. Other research designs, including correlational methods, provide guidance and useful estimates. The transformation procedure for figuring benefits from effectiveness findings remains relatively straightforward.

The exact cost value used to transform effectiveness findings into benefit findings is ascertained by surveying local criminal justice and social and health service agencies. Ideally, you would find the cost of each criminal act, the cost of each health service used, and so on, for each patient individually. If you cannot get that information, you may be able to use estimates of average costs per patient for these effectiveness variables.

For example, suppose you know that the number of theft convictions for a patient dropped from three in the year preceding treatment to one in the year following treatment. Suppose, too, that the estimated cost of a theft totaled \$1,200 after adding costs of arrest, holding, and conviction to the cost to citizens of lost property and mental anguish. The total savings that could be attributed to treatment would be the cost of thefts during a period prior to treatment, minus the cost of thefts during a similar period following treatment. For this patient, that would be:

$$(3 \times \$1,200) - (1 \times \$1,200) = \$3,600 - \$1,200 = \$2,400 \text{ in cost savings.}$$

It would be more accurate to find the actual cost of each theft. It is conceivable that the one theft following treatment was quite minor compared to the thefts preceding treatment. On the other hand, that one theft after treatment could have cost more than all the thefts before treatment.

There also may be too much variation between jurisdictions (and over years) to allow a set cost for social services, health services, criminal justice services, and other cost items to be established for all drug treatment programs throughout the country for all time.

When cost savings and benefits involve health services, welfare, and other services for which cost data are available for individual patients, the cost for each patient needs to be contrasted for different periods of treatment. These services can vary greatly between patients; an estimate of the average health care cost per patient could result in over- or underestimation of cost-savings benefits.

Table 24 lists examples of the types of costs and potential cost savings that can be included in the survey. It is not meant to be complete. Note also that room for a range of estimates is provided, in recognition of the variability in costs of these services between patients and over time for the same patient. Costs of the specific criminal behaviors of individual patients then can be contrasted for the periods -

- Before versus after treatment.
- Before versus during treatment.
- During versus after treatment.

These costs can be examined separately for each category of potential cost savings or actual income produced and then summed across all categories to find the total benefit.

Table 24. Types of Costs and Potential Cost Savings

	Effectiveness measure	Effectiveness-benefit transformation	Benefit measures
Possible Cost Savings	Criminal acts not performed	Thefts at \$____ / misdemeanor \$____/ felony Assaults at \$____	Savings to potential victims due to income loss avoided, property not damaged or lost, and health and mental health services not needed
	Drugs not purchased	Opiates at \$____ to \$____/day Cocaine and crack at \$____ to \$____/day Other at \$____ to \$____/day	Money not spent on drug purchases
	Criminal justice services not used	Arrests at \$____/ arrest Jail at \$____/day Prosecution at \$____/ day	Expense of criminal justice services avoided
	Drug treatment no longer needed	\$__ per patient per day for the mixture of treatments provided	Cost of drug treatment no longer needed
	Welfare payments not provided	\$__ per patient per day in welfare payments	Amount of welfare payments not provided
	Disability payments not made	\$__ per patient per day in disability payments	Size of disability payments not made
	Health services not used	Sum health care cost use for 6 - 12 months before treatment and 6 - 12 months after treatment	Cost of health services not used
Possible Benefits Produced	Employment (licit)		Income earned from licit sources
	Entrepreneurship (licit)		New income (profit) from enterprise
	Income taxes paid on licit income		Amount of Federal, State, and local taxes paid on licit income
	Increased productivity in an existing job		Increased profit for employer, company, and sole proprietorship

Net Benefit

Cost-benefit analysis answers the question of whether the outcomes of a program are worth the costs by -

- Measuring outcomes in the same units -dollars, usually -as costs.
- Seeing whether the value of outcomes exceeds the value of costs (by subtracting total costs from total benefits, which is called the net benefit).

To calculate the total benefit per patient for a program, simply add up the benefit figures for each of the specific measures. Similarly, to calculate the total cost per patient for a program, add up the cost figures for each procedure. Then you can calculate the net benefit (total benefits minus total costs) for the patient. Add these up for all patients to find the net benefit for the treatment program.

To make cost-benefit analysis more specific, list the specific costs of achieving the benefits on each measure. Instead of adding up benefits for all measures for one patient, and then summing or averaging across patients, add up or average for all patients the benefits attained by a program for one measure.

Present-Value Benefits

Immediate positive outcomes are more valuable than delayed positive outcomes. Nonmonetary outcomes rarely are adjusted for the amount they are delayed, but monetary benefits often are. If costs and benefits are to be compared, monetary benefits delayed by more than a year from the time that costs occur can be adjusted for their delayed value.

The adjustment divides benefits by the sum of 1 plus a discount rate (often 0.08, 0.10, or 0.14). The discount rate closely resembles the interest rate that could be earned if the money spent on treatment were invested in another activity (such as a money market fund). Benefits delayed by 2 years are adjusted by dividing them by the result of multiplying the sum $1 + (\text{discount rate})$ by itself once (squared). Benefits delayed by 3 years are adjusted by dividing them by the result of multiplying the sum $1 + (\text{discount rate})$ by itself and then by itself again, and so on.

The result of applying net present value to delayed benefits can be striking. Consider, for example, a stream of cost-savings benefits of \$10,000 that occur at the end of the year for each of 3 years and a discount rate of 0.10. It is tempting simply to sum the benefits for a total of \$30,000. The net present value of the first end-of-the-year return is, however, $\$10,000 \div (1 + .10) = \$10,000 \div 1.10 = \$9,091$ following the calculation guidelines given above.

The net present value of the second year's cost-savings benefit is $\$10,000 \div [(1 + .10) \times (1 + .10)] = \$10,000 \div [1.10 \times 1.10] = \$10,000 \div 1.21 = \$8,264$. The net present value of the third year's cost-saving benefit is $\$10,000 \div [(1 + .10) \times (1 + .10) \times (1 + .10)] = \$10,000 \div [1.10 \times 1.10 \times 1.10] = \$10,000 \div 1.331 = \$7,513$. The total of these net-present-value benefits is far less than \$30,000. It is only \$24,868.

The resulting present-value benefits reflect the declining value of benefits that take longer to occur. The difficulties of making this adjustment are minor, although two to three discount rates (say, 0.08, 0.10, and 0.14) should be used. The resulting benefit adjustments provide a quantitative advantage of alternative procedures (and alternative treatment programs) that produce benefits more rapidly.

Time to Return on Investment

Net benefit is the result of subtracting costs from benefits. Present valuing benefits reduces the value of benefits. Using present-value benefits gives an appropriate advantage to programs that achieve their benefits sooner. Present valuing benefits still, however, gives an advantage (appropriately) to programs that take longer but achieve better benefits than programs that produce quick but small benefits.

Time to return on investment is the time at which investment equals monetary outcomes. The time it takes benefits to begin to exceed costs for substance abuse treatment is of concern to funders and other interest groups. Each patient can be monitored for the time actually elapsed before the monetary value of the outcomes achieved equals the monetary value of the resources used. The average time to return on investment then can be computed for all patients.

One way to do this is to keep each patient's figurative "bill" on a lined piece of paper or on a spreadsheet, such as the one shown in [table 25](#). "Investment" is the cost of treatment services delivered. "Return on Investment" is the monetary or monetized benefit resulting from treatment services. "Cumulative Investment" is the running total of all treatment and other service costs. "Cumulative Return on Investment" is the continuous total of all benefits (monetary and monetized) resulting from treatment. "Net Benefit" is the result of subtracting the Cumulative Investment from the Cumulative Return on Investment. An advantage of keeping these data on a computer spreadsheet is that the cumulative total and the net benefit can be automatically updated by the computer each time you enter new cost (investment) or benefit data.

[Table 25](#) could be completed just from the perspective of the present treatment program, or from the perspective of past as well as present treatments, or for society as a whole. In the "Return on Investment" column, one could add the patient's debt to society -restitution owed victims or the cost of criminal justice services. The balance unpaid from previous treatment programs also could be added here.

Table 25. Sample Cumulative Costs and Benefits and Net Benefit

Time	Investment	Return on investment	Cumulative investment	Cumulative return on investment	Net benefit
Date	Cost of treatment services delivered	Benefit to society, patient, or other individual	Running total of all treatment costs	Running total of all benefits of treatment	Cumulative return minus cumulative investment
1/3 start	\$376 (screening)		\$376	0	-\$376
1/5	\$145 (session)	\$21 (drug-free day)	\$521	\$21	-\$500
1/6		\$21 (drug-free day)	\$521	\$42	-\$479
1/8	\$95 (group)	\$21 (drug-free day)	\$616	\$63	-\$458
1/8	\$145 (session)		\$761	\$63	-\$698
1/9		\$124 (income for employed day)	\$761	\$187	-\$574
1/9		\$21 (drug-free day)	\$761	\$208	-\$553

Total investment in treatment expenses can be compared to the total monetary value of outcomes achieved for a cohort of patients (say, the first 100 patients entering the clinic following the first year of startup and operation).

Time to return on investment can be contrasted for different groups of patients, such as those receiving different procedures or exhibiting different processes. The cost-benefit of different procedures also can be compared by contrasting time to return on investment for patients treated by the different procedures.

Just as calculations of time to return on investment should include present-value benefits, more delayed costs also should be adjusted for present value. The latter procedure quantifies the judgment that programs that delay some costs are preferred over programs that require all expenditures up front.

Potential Problems With Cost-Benefit Analysis

Erroneous Assumptions of Linearity

The strength of cost-benefit analysis also is its weakness or, more accurately, its problem. Because ratios can be calculated very readily (since costs and outcomes are in the same monetary units in most cost-benefit analyses), funders may make all the erroneous assumptions noted earlier that are encouraged by cost-outcome ratios.

Net benefit and time to return on investment forms of cost-benefit analysis encourage similar, and similarly erroneous, assumptions. For example, funders may incorrectly assume that because the benefit for an investment of \$100,000 in a substance abuse treatment program is \$50,000, doubling the investment to \$200,000 will double the benefit to \$100,000.

The common pattern of diminishing returns on investment would diminish this anticipated benefit to less than double. It also is possible that increasing the initial investment so much would allow entirely different (and much more effective and beneficial) treatment procedures to be used.

Some funders also may believe that increasing the investment in treatment might yield a quicker return on investment, which might not occur given limitations on how rapidly current treatment technology can modify the behaviors, life skills, and lifestyles associated with substance abuse.

Overemphasis on Monetary and Monetized Outcomes

The major problem with all forms of cost-benefit analysis is that monetary outcomes are the only outcomes considered. Most service providers, many patients, and some other interested parties believe that the most important outcomes of substance abuse treatment can hardly be quantified, much less monetized (translated into monetary outcomes). To note that some nonmonetary outcomes, such as reduced crime, can be monetized does not eliminate, but only reduces, this problem. Many providers are unwilling to consider placing a monetary value on the outcomes of their services. These providers often resent attempts by persons outside the treatment program to monetize their outcomes.

Critics also note that cost-benefit analysis has been used to justify a number of decisions that proved to be not only erroneous but disastrously so. For example, cost-benefit analyses conducted by State mental health hospitals in the 1980s apparently were used to justify sudden deinstitutionalization without preparation of the patient or the community. This removal of many mental patients from hospitals and placement into communities that were not prepared to provide necessary services exacerbated homelessness and amounted to abandonment of some patients.

This unwise decision does not necessarily mean that cost-benefit analysis is itself unwise. Problems arise when only one perspective is considered: it is important to adopt multiple perspectives in cost-outcome analyses. For example, in the deinstitutionalization analysis, only the perspective of the State mental hospital was considered.

Resources for Cost-Benefit Analysis

Several good books discuss the value of using cost-benefit analysis to evaluate programs (Nas 1996; Thompson 1980). A classic cost-benefit analysis performed in mental health (deinstitutionalization of schizophrenic patients) is provided by Weisbrod (1983). The much-discussed CALDATA study (Gerstein et al. 1994) also deserves your attention, as it is directly related to substance abuse treatment.



States Consider Drug Tests for Welfare Recipients

Thursday , March 26, 2009

Associated Press

CHARLESTON, W.Va. —

Want government assistance? Just say no to drugs.

Lawmakers in at least eight states want recipients of food stamps, unemployment benefits or welfare to submit to random drug testing.

The effort comes as more Americans turn to these safety nets to ride out the recession. Poverty and civil liberties advocates fear the strategy could backfire, discouraging some people from seeking financial aid and making already desperate situations worse.

Those in favor of the drug tests say they are motivated out of a concern for their constituents' health and ability to put themselves on more solid financial footing once the economy rebounds. But proponents concede they also want to send a message: you don't get something for nothing.

"Nobody's being forced into these assistance programs," said Craig Blair, a Republican in the West Virginia Legislature who has created a Web site — notwithmytaxdollars.com — that bears a bobble-headed likeness of himself advocating this position. "If so many jobs require random drug tests these days, why not these benefits?"

Blair is proposing the most comprehensive measure in the country, as it would apply to anyone applying for food stamps, unemployment compensation or the federal programs usually known as "welfare": Temporary Assistance for Needy Families and Women, Infants and Children.

Lawmakers in other states are offering similar, but more modest proposals.

On Wednesday, the Kansas House of Representatives approved a measure mandating drug testing for the 14,000 or so people getting cash assistance from the state, which now goes before the state senate. In February, the Oklahoma Senate unanimously passed a measure that would require drug testing as a condition of receiving TANF benefits, and similar bills have been introduced in Missouri and Hawaii. A Florida senator has proposed a bill linking unemployment compensation to drug testing, and a member of Minnesota's House of Representatives has a bill requiring drug tests of people who get public assistance under a state program there.

A January attempt in the Arizona Senate to establish such a law failed.

In the past, such efforts have been stymied by legal and cost concerns, said Christine Nelson, a program manager with the National Conference of State Legislatures. But states' bigger fiscal crises, and the surging demand for public assistance, could change that.

"It's an example of where you could cut costs at the expense of a segment of society that's least able to defend themselves," said Frank Crabtree, executive director of the West Virginia chapter of the American Civil Liberties Union.

Drug testing is not the only restriction envisioned for people receiving public assistance: a bill in the Tennessee Legislature would cap lottery winnings for recipients at \$600.

There seems to be no coordinated move around the country to push these bills, and similar proposals have arisen periodically since federal welfare reform in the 1990s. But the appearance of a cluster of such proposals in the midst of the recession shows lawmakers are newly engaged about who is getting public assistance.

Particularly troubling to some policy analysts is the drive to drug test people collecting unemployment insurance, whose numbers nationwide now exceed 5.4 million, the highest total on records dating back to 1967.

"It doesn't seem like the kind of thing to bring up during a recession," said Ron Haskins, a senior fellow at the Brookings Institution. "People who are unemployed, who have lost their job, that's a sympathetic group. Americans are tuned into that, because they're worried they'll be next."

Indeed, these proposals are coming at a time when more Americans find themselves in need of public assistance.

Although the number of TANF recipients has stayed relatively stable at 3.8 million in the last year, claims for unemployment benefits and food stamps have soared.

In December, more than 31.7 million Americans were receiving food stamp benefits, compared with 27.5 million the year before.

The link between public assistance and drug testing stems from the Congressional overhaul of welfare in the 1990s, which allowed states to implement drug testing as a condition of receiving help.

But a federal court struck down a Michigan law that would have allowed for "random, suspicionless" testing, saying it violated the 4th Amendment's protections against unreasonable search and seizure, said Liz Schott, a senior fellow at the Center on Budget and Policy Priorities.

At least six states — Indiana, Massachusetts, Minnesota, New Jersey, Wisconsin and Virginia — tie eligibility for some public assistance to drug testing for convicted felons or parolees, according to the NCSL.

Nelson said programs that screen welfare applicants by assigning them to case workers for interviews have shown some success without the need for drug tests. These alternative measures offer treatment, but can also threaten future benefits if drug problems persist, she said.

They also cost less than the \$400 or so needed for tests that can catch a sufficient range of illegal drugs and rule out false positive results with a follow-up test, she said.