

HB

16

<TARGET><BILL>HB 16</BILL><SUBJECT>HB
16</SUBJECT><COMM>HHSS28</COMM></TARGET>

ALASKA STATE LEGISLATURE

Interim:

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Wasilla, Alaska 99654
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Session:

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REPRESENTATIVE WES KELLER DISTRICT 7

HOUSE BILL 16 SPONSOR STATEMENT

“An Act relating to citizenship requirements and an alcohol impairment and drug testing program for applicants for and recipients of special cash 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 16 gives the department a tool they need to determine if substance or alcohol abuse is part of the equation. HB 16 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.

E-Mail: Representative.Wes.Keller@aklrg.gov
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Amendment

OFFERED IN THE HOUSE
TO: HB 15

BY: REPRESENTATIVE KELLER

Page 5, line 24

24 **Sec. 47.27.430. Testing policies and procedures.** (a) The department shall
25 adopt testing policies **and procure services under AS 36.30** that include
26 (1) a list of substances tested;
27 (2) a description of the testing methods and collection procedures,
28 including on-site testing;
29 (3) a right to confirmatory testing and the procedures for confirmatory
30 testing;
31 (4) the consequences for refusal to test or retest that are consistent with
01 the provisions in AS 47.27.450;

Page 7, Line 5

05 (b) If the department provides on-site **test administering** [*testing*] for alcohol
06 impairment or illegal drug use under AS 47.27.410, the department shall **insure**
07 **that the** [*employ*] on-site administrator(s) [*who*]
08 (1) have received training in person and written certification of the
09 training by the test manufacturer's representative on the proper procedure for
10 administering the test [*and on accurate analysis of the on-site test results*]; the training
11 must include recognition of adulteration of a sample collected on-site;
12 (2) agree in writing to maintain confidentiality under the testing
13 policies adopted by the department.

CS FOR HOUSE BILL NO. 16()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-EIGHTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES KELLER, Peggy Wilson

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 specified cash assistance."**

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

4 *** Section 1. AS 47.25.120 is amended by adding a new subsection to read:**

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

8 *** Sec. 2. AS 47.27.200(e) is amended to read:**

9 (e) An organization's plan for operation of the Alaska Native family assistance
10 grant must

11 (1) be designed to facilitate self-sufficiency of assistance recipients in
12 the region specified in the federally approved tribal family assistance plan by
13 addressing the conditions specific to that region;

14 (2) provide for a reasonable pattern of service delivery from all

1 providers serving that region;

2 (3) serve a specified region that consists of a geographically cohesive
3 group of communities that share similar interests, resources, and traditions;

4 (4) establish the same maximum number of months of benefits as is
5 established for the state program under AS 47.27.015(a)(1); [AND]

6 (5) provide for administration of the grant money received under this
7 section to establish a program in accordance with the plan accepted by the department
8 and in compliance with other requirements of this section; the program must include
9 the following standards for providing assistance to eligible families:

10 (A) only families with at least one dependent child or a woman
11 in the last trimester of pregnancy are eligible for assistance paid from an
12 Alaska Native family assistance grant;

13 (B) amounts for assistance provided from an Alaska Native
14 family assistance grant to eligible families may not exceed the amounts
15 specified under AS 47.27.025(b) when combined with assistance provided
16 under the federally approved tribal family assistance grant;

17 (C) to remain eligible for assistance paid from an Alaska
18 Native family assistance grant, a minor parent of a dependent child must meet
19 the requirements of AS 47.27.027;

20 (D) families receiving assistance paid from an Alaska Native
21 family assistance grant shall comply with the provisions of AS 47.27.035(a)
22 regarding participation in work activities;

23 (E) families receiving assistance paid from Alaska Native
24 family assistance grant money shall comply with the provisions of (f) - (n) of
25 this section regarding assignment of support rights and cooperation with the
26 child support services agency;

27 (F) the organization has an impartial appeals process to allow
28 affected families in the region of the state covered by the plan accepted by the
29 department to have a fair hearing;

30 (6) establish an alcohol and drug testing program as required
31 under AS 47.27.400 - 47.27.499.

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* Sec. 3. AS 47.27 is amended by adding new sections to read:

Article 4A. Alcohol and Drug Testing.

Sec. 47.27.400. Alcohol impairment and drug testing; legislative findings and purpose. The legislature finds that a statewide threat to public safety exists with regard to excessive use of alcohol and illegal drugs. The purpose of the testing program established under AS 47.27.400 - 47.27.499 is to reduce that risk, to provide an opportunity for rehabilitation, and to protect the residents of the state.

Sec. 47.27.410. Alcohol impairment and drug testing for eligibility; regulations; immunity. (a) The department shall establish and administer a program consistent with AS 47.27.400 - 47.27.499 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 seek work and of applicants for and recipients of cash assistance for the use of illegal drugs. In this subsection, "recipient of cash assistance" does not include a dependent child, a caretaker of a dependent child who is not a recipient of public assistance based on the caretaker's financial need, or a protective payee, 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 47.27.430 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)
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1	Marijuana metabolite	15
2	(Delta-9-tetrahydrocannabinol-9-carboxylic acid)	
3	Cocaine metabolite (Benzoylecgonine)	150
4	Opiates	
5	Morphine	2,000
6	Codeine	2,000
7	6-Acetylmorphine	10
8	(when morphine concentration exceeds	
9	2,000 nanograms in each milliliter)	
10	Phencyclidine	25
11	Amphetamines	
12	Amphetamine	500
13	Methamphetamine	500
14	(when amphetamine concentration is	
15	greater than or equal to 200 nanograms	
16	in each milliliter)	
17	(3) for testing of alternative specimens that is consistent with the	
18	mandatory guidelines for the federal workplace drug testing program adopted by the	
19	United States Department of Health and Human Services.	
20	(c) Unless the department or an agent or employee of the department knew or	
21	should have known that the results of a test conducted under this section were false	
22	and took action that affected a person's eligibility for cash assistance based on the false	
23	test results, a person may not bring an action for damages against the department or an	
24	agent or employee of the department for	
25	(1) good faith actions taken to conduct, or as a result of, alcohol	
26	impairment or drug testing under this section;	
27	(2) failure to test for alcohol impairment or drugs or for a specific	
28	drug;	
29	(3) failure to test for or detect a specific drug or medical or	
30	psychological condition or disorder;	
31	(4) termination or suspension of an alcohol or drug prevention or	

1 testing program or policy.

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

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

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

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

11 **Sec. 47.27.420. Confidentiality; liability.** (a) The results of a test conducted
12 under AS 47.27.410 are confidential, except that the results may be revealed to the
13 recipient of cash assistance who was tested and to agents and employees of the
14 department as required to determine eligibility for cash assistance.

15 (b) A person may not bring an action for defamation of character or reputation
16 as a result of disclosure of the results of an alcohol impairment or drug test under the
17 alcohol impairment or drug testing program established under AS 47.27.410 unless

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

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

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

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

24 **Sec. 47.27.430. Testing policies and procedures.** (a) In administering the
25 program established under AS 14.27.410, the department shall

26 (1) adopt testing policies and procedures that include

27 (A) a list of substances tested;

28 (B) a description of the testing methods and collection
29 procedures, including on-site testing;

30 (C) a right to confirmatory testing and the procedures for
31 confirmatory testing;

1 (D) the consequences for refusal to test or retest that are
2 consistent with the provisions in AS 47.27.450;

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

7 (F) the right of an applicant and a recipient, on the applicant's
8 or recipient's request, to receive, within 72 hours of the test or before an
9 adverse action is taken, whichever occurs first, a confidential explanation of
10 the applicant's or recipient's test results;

11 (G) providing the department's confidentiality and testing
12 policies to applicants for and recipients of cash assistance not less than 30 days
13 before initiating testing on the applicant or recipient;

14 (2) pay the cost of testing and, if the testing is performed at a location
15 other than a location of the department, the cost of transportation to and from the
16 testing center; and

17 (3) enter into contracts to conduct testing and analysis of samples
18 consistent with the requirements in AS 47.27.400 - 47.27.499 and AS 36.30 (State
19 Procurement Code).

20 (b) Sample collection and testing must

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

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

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

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

28 (5) include relevant medical information.

29 (c) A positive drug test must be confirmed using a different analytical process
30 than was used in initial testing. A positive drug test must be reported as a negative
31 result if a licensed physician verifies that the test was affected by medication

1 prescribed for the applicant or recipient tested.

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

4 **Sec. 47.27.440. Training of test administrators.** (a) The department shall
5 ensure that at least one designated employee of the department receives not less than
6 one hour of training on alcohol abuse and an additional one hour of training on the use
7 of controlled substances for the purpose of finding reasonable suspicion for testing
8 under AS 47.27.400 - 47.27.499.

9 (b) If the department provides for on-site testing for alcohol impairment or
10 illegal drug use under AS 47.27.410, the department shall employ or contract for on-
11 site administrators who

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

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

18 **Sec. 47.27.450. Consequences of confirmatory positive testing.** (a) Except as
19 provided in (b) of this section, the department shall deny or suspend cash assistance to
20 an applicant for or recipient of the assistance who, under AS 47.27.400 - 47.27.499,

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

24 (2) has refused alcohol impairment or drug testing required by the
25 department.

26 (b) The department may provide cash assistance on behalf of an eligible
27 recipient who is subject to denial or suspension under (a) of this section if the
28 department has assigned a protective payee to manage the cash assistance for which
29 the recipient or the recipient's family is otherwise eligible and the third party provides
30 care, shelter, or food to the recipient or the recipient's dependent children.

31 **Sec. 47.27.499. Definition.** In AS 47.27.400 - 47.27.499, "cash assistance"

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means

(1) cash assistance as defined in AS 47.27.900; and

(2) benefits received under Alaska Native family assistance programs and grants under AS 47.27.200 and regional public assistance programs under AS 47.27.300.

* Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION. Notwithstanding the requirements for alcohol and drug testing under AS 47.27.400 - 47.27.499, added by sec. 3 of this Act, the Department of Health and Social Services may not, under the program established in those sections, test more than 100 persons a month during the first two fiscal years after the effective date of this Act.

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CS FOR HOUSE BILL NO. 16()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-EIGHTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES KELLER, Peggy Wilson

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to procedures and eligibility for specified cash assistance that require**
2 **citizenship or status as a legal alien and, under certain circumstances, submission of and**
3 **compliance with a sworn statement not to abuse alcohol or use illegally obtained drugs**
4 **while receiving assistance."**

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

6 *** Section 1. AS 47.25.120 is amended by adding a new subsection to read:**

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

10 *** Sec. 2. AS 47.25.150 is amended to read:**

11 **Sec. 47.25.150. Application for assistance.** A person requesting assistance
12 shall apply for it, either personally or through another person, on [UPON] forms
13 furnished and under regulations adopted by the department. Regulations adopted
14 under this section must

1 (1) require an applicant to sign a sworn statement that the
2 applicant

3 (A) is legally present in the state;

4 (B) does not and will not, while receiving assistance, abuse
5 alcohol or use illegally obtained drugs; and

6 (2) provide for denial, discontinuation, or modification of the
7 person's assistance, or assignment of an alternate payee for the person's
8 assistance, if the person makes a false statement or an intentional
9 misrepresentation to the department, knowing it was a false statement or an
10 intentional misrepresentation, to obtain benefits.

11 * Sec. 3. AS 47.25.160 is amended to read:

12 Sec. 47.25.160. Investigation of applicant and recipient. The department
13 shall promptly investigate each applicant and recipient to determine the applicant's
14 and recipient's eligibility. The investigation must include a request for reliable
15 testing for and other evidence of alcohol abuse or use of illegally obtained drugs if
16 the department reasonably suspects an applicant or recipient of alcohol abuse or
17 use of illegally obtained drugs.

18 * Sec. 4. AS 47.25.180 is amended to read:

19 Sec. 47.25.180. Appeal. An applicant whose application is not acted on
20 [UPON] or is denied, discontinued, or modified by the department shall be granted an
21 opportunity for fair hearing before the office of the administrative hearings
22 (AS 44.64.010). The hearing shall be held within a reasonable time after demand for
23 it. The conduct of the hearing shall be governed by the regulations adopted for that
24 purpose by the department. Refusal by an applicant for assistance or a recipient of
25 assistance to submit to reliable testing for alcohol abuse or use of illegally
26 obtained drugs, after the department has notified the applicant or recipient of a
27 reasonable suspicion of alcohol abuse or use of illegally obtained drugs, creates a
28 rebuttable presumption that the applicant or recipient made a false statement or
29 an intentional misrepresentation to the department to obtain benefits.

30 * Sec. 5. AS 47.25.440 is amended to read:

31 Sec. 47.25.440. Application for assistance. A person requesting assistance

1 shall apply for it, either personally or through another, on [UPON] forms furnished
2 and under regulations adopted by the department. Regulations adopted under this
3 section must

4 (1) require an applicant to sign a sworn statement that the
5 applicant

6 (A) is legally present in the state;

7 (B) does not and will not, while receiving assistance, abuse
8 alcohol or use illegally obtained drugs; and

9 (2) provide for denial, discontinuation, or modification of the
10 person's assistance, or assignment of an alternate payee for the person's
11 assistance if the person makes a false statement or an intentional
12 misrepresentation to the department, knowing it was a false statement or an
13 intentional misrepresentation, to obtain benefits.

14 * Sec. 6. AS 47.25.450 is amended to read:

15 Sec. 47.25.450. Investigation of applicant and recipient. After receiving an
16 [UPON] application, the department shall investigate promptly and record the
17 circumstances of each applicant and recipient to determine the facts supporting the
18 application and receipt of benefits and other information required by the department.
19 The investigation must include a request for reliable testing for and other
20 evidence of alcohol abuse or use of illegally obtained drugs if the department
21 reasonably suspects an applicant or recipient of alcohol abuse or use of illegally
22 obtained drugs.

23 * Sec. 7. AS 47.25.460(c) is amended to read:

24 (c) A recipient whose award is proposed to be modified or terminated, or an
25 applicant whose application is denied by the department, shall be granted an
26 opportunity for a hearing before the office of administrative hearings (AS 44.64.010).
27 The hearing shall be held promptly after a request for hearing is made. The hearing
28 shall be conducted in accordance with regulations adopted by the department. Refusal
29 by an applicant for assistance or a recipient of assistance to submit to reliable
30 testing for alcohol abuse or use of illegally obtained drugs, after the department
31 has notified the applicant or recipient of a reasonable suspicion of alcohol abuse

1 or use of illegally obtained drugs, creates a rebuttable presumption that the
2 applicant or recipient made a false statement or an intentional misrepresentation
3 to the department to obtain benefits.

4 * Sec. 8. AS 47.27.020(b) is amended to read:

5 (b) On the application, each applicant shall attest, in a sworn statement,

6 (1) to whether the family, at any time, has received cash assistance or
7 self-sufficiency services from another state program that was established with federal
8 money under the federal Temporary Assistance for Needy Families program;

9 (2) to [AND] whether the family has ever been disqualified from
10 receiving cash assistance or self-sufficiency services under the federal Temporary
11 Assistance for Needy Families program for the period for which the application has
12 been submitted;

13 (3) that the applicant is legally present in the state; and

14 (4) that the applicant does not and will not, while receiving
15 assistance, abuse alcohol or use illegally obtained drugs.

16 * Sec. 9. AS 47.27.030(a) is amended to read:

17 (a) A participant in the Alaska temporary assistance program shall cooperate
18 with the department, or its designee, to develop and sign a family self-sufficiency plan
19 that includes

20 (1) the steps the family will take towards the self-sufficiency of the
21 family;

22 (2) the self-sufficiency services the department will provide to assist
23 the family to attain self-sufficiency;

24 (3) specific benchmarks to indicate the steps toward successful
25 completion of the family plan;

26 (4) a statement that the family may be subject to reductions in cash
27 assistance or self-sufficiency services or other sanctions if the family fails to comply
28 with the family plan; [AND]

29 (5) a statement that describes the necessary conditions and the steps
30 that must be taken to renegotiate the terms of the family plan; and

31 (6) a sworn statement that the members of the family do not and

1 **will not, while receiving assistance, abuse alcohol or use illegally obtained drugs.**

2 * Sec. 10. AS 47.27.080 is amended by adding a new subsection to read:

3 (c) If the determination by the department that denies, limits, or modifies cash
4 assistance, diversion payments, or self-sufficiency services is based on a reasonable
5 suspicion of an applicant's or a recipient's alcohol abuse or use of illegally obtained
6 drugs, the department shall notify the applicant or recipient of the basis for the
7 suspicion and request the applicant or recipient to submit to reliable testing for alcohol
8 abuse or illegal drug use. Refusal by an applicant for assistance or a recipient of
9 assistance to submit to reliable testing for alcohol abuse or use of illegally obtained
10 drugs creates a rebuttable presumption that the applicant or recipient made a false
11 statement or an intentional misrepresentation to the department to obtain benefits.

12 * Sec. 11. AS 47.27.085(a) is amended to read:

13 (a) Except as provided in (b) of this section, the department shall **deny or**
14 **terminate benefits, assign a protective payee to manage cash assistance, or** reduce
15 the amount of cash assistance provided to the family of an Alaska temporary
16 assistance program applicant or participant who, without good cause, **provides false**
17 **information or misrepresents information, knowing that it was false, to the**
18 **department to obtain benefits,** fails to comply with a condition of the family self-
19 sufficiency plan, [WHO] fails to participate in work activities required as a part of the
20 Alaska temporary assistance program, or [WHO] fails to cooperate with the child
21 support services agency as required under AS 47.27.040. The reduction shall be,

22 (1) beginning on the date the department makes a finding that the
23 family is not in compliance under this subsection, 40 percent of the maximum cash
24 assistance that would be payable under AS 47.27.025 for a family of the same size,
25 assuming the family has no income counted for purposes of this chapter, until the date
26 the department determines that the family is in compliance under this subsection if the
27 family comes into compliance within the first four months after the date of the
28 department's finding of noncompliance under this subsection; on the date the
29 department determines that the family is in compliance, the department shall begin to
30 pay the family the full amount of cash assistance for which the family is eligible;

31 (2) beginning five months after the date the department made the

1 finding that the family was not in compliance under this subsection, 75 percent of the
2 maximum cash assistance that would be payable under AS 47.27.025 for a family of
3 the same size, assuming the family has no income counted for purposes of this
4 chapter, until the date the department determines that the family is in compliance
5 under this subsection if the family comes into compliance during the fifth, sixth,
6 seventh, or eighth month after the date the department initially determined that the
7 family was not in compliance under this subsection; on the date the department
8 determines that the family is in compliance, the department shall begin to pay the
9 family the full amount of cash assistance for which the family is eligible;

10 (3) beginning nine months after the date the department made the
11 finding that the family was not in compliance under this subsection, the full amount of
12 the family's cash assistance if the noncompliance under this subsection is not corrected
13 within eight months after the date of the department's initial finding of noncompliance
14 under this subsection; in order to again receive cash assistance under this chapter, the
15 family shall reapply under AS 47.27.020 and satisfy all requirements applicable to
16 applicants under that section.

17 * Sec. 12. AS 47.27.085(c) is amended to read:

18 (c) An Alaska temporary assistance program applicant or participant who
19 receives cash assistance, a diversion payment, or self-sufficiency services when not
20 entitled to them under this chapter because [THE] information provided by the
21 applicant or participant was false or a misrepresentation made by the applicant or
22 participant knowing the information to be false, or was otherwise inaccurate or
23 incomplete, is liable to the department for the value of the cash assistance, diversion
24 payment, and self-sufficiency services improperly provided to the applicant or
25 participant.

26 * Sec. 13. AS 47.27.200(e) is amended to read:

27 (e) An organization's plan for operation of the Alaska Native family assistance
28 grant must

29 (1) be designed to facilitate self-sufficiency of assistance recipients in
30 the region specified in the federally approved tribal family assistance plan by
31 addressing the conditions specific to that region;

1 (2) provide for a reasonable pattern of service delivery from all
2 providers serving that region;

3 (3) serve a specified region that consists of a geographically cohesive
4 group of communities that share similar interests, resources, and traditions;

5 (4) establish the same maximum number of months of benefits as is
6 established for the state program under AS 47.27.015(a)(1); [AND]

7 (5) provide for administration of the grant money received under this
8 section to establish a program in accordance with the plan accepted by the department
9 and in compliance with other requirements of this section; the program must include
10 the following standards for providing assistance to eligible families:

11 (A) only families with at least one dependent child or a woman
12 in the last trimester of pregnancy are eligible for assistance paid from an
13 Alaska Native family assistance grant;

14 (B) amounts for assistance provided from an Alaska Native
15 family assistance grant to eligible families may not exceed the amounts
16 specified under AS 47.27.025(b) when combined with assistance provided
17 under the federally approved tribal family assistance grant;

18 (C) to remain eligible for assistance paid from an Alaska
19 Native family assistance grant, a minor parent of a dependent child must meet
20 the requirements of AS 47.27.027;

21 (D) families receiving assistance paid from an Alaska Native
22 family assistance grant shall comply with the provisions of AS 47.27.035(a)
23 regarding participation in work activities;

24 (E) families receiving assistance paid from Alaska Native
25 family assistance grant money shall comply with the provisions of (l) - (n) of
26 this section regarding assignment of support rights and cooperation with the
27 child support services agency;

28 (F) the organization has an impartial appeals process to allow
29 affected families in the region of the state covered by the plan accepted by the
30 department to have a fair hearing;

31 (6) require a sworn statement on an application for benefits that

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the applicant does not and will not, while receiving assistance, abuse alcohol or use illegally obtained drugs and provide

(A) a procedure for denial, reduction, and termination of benefits and for assignment of an alternate payee;

(B) for an investigation of an applicant and recipient and, if the organization has a reasonable suspicion that an applicant or recipient submitted false information knowing that the information was false, or intentionally misrepresented information, a request for reliable testing and other relevant evidence, including drug or alcohol testing.

ALASKA STATE LEGISLATURE

Interim:

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Session:

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REPRESENTATIVE WES KELLER DISTRICT 7 MEMO

To: Members of the Alaska Legislature

Date: March 11, 2013

Re: Sectional for CS for House Bill 16 (28-LS0059\C)

Section 1: Requires a person applying for assistance to be a citizen of the United States or a legal alien to be eligible for specified cash assistance.

Section 2: Requires that an applicant for general relief assistance must sign a sworn statement that he or she is in the state legally and will not abuse alcohol or illegally obtained drugs will accepting assistance. It further provides that an individual may be denied assistance or the funds may be provided to an alternate payee if the person makes a false statement.

Section 3: Establishes that each applicant or recipient may be the subject of an investigation that could include suspicion based drug and alcohol abuse testing.

Section 4: Information of a refusal to submit to suspicion based testing may be used during an administrative hearing or appeal to a decision to cut a portion or all benefits.

Section 5: Requires that an applicant for adult assistance must sign a sworn statement that he or she is in the state legally and will not abuse alcohol or illegally obtained drugs will accepting assistance. It further provides that an individual may be denied assistance or the funds may be provided to an alternate payee if the person makes a false statement.

Section 6: Establishes that each applicant or recipient may be the subject of an investigation that could include suspicion based drug and alcohol abuse testing.

Section 7: Information of a refusal to submit to suspicion based testing may be used during an administrative hearing or appeal to a decision to cut a portion or all benefits.

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Section 8: Requires the applicant to verify in writing if they have been on assistance in another state and if they have ever been denied or disqualified.

Section 9: The applicant for temporary assistance shall work with the Department toward self-sufficiency and will sign a statement that the members of the family being supported do not abuse alcohol or illegally obtained drugs.

Section 10: If the department denies or limits assistance based on a suspicion of alcohol or illegally obtained drug abuse the department will contact the recipient and request a drug or alcohol abuse test. Refusal will allow the department to proceed as if the applicant made a false statement on the application.

Section 11: Inserts language for denial or reduction to a protective payee based on providing false information on the application.

Section 12: A temporary assistance participant may lose or be denied assistance based on knowingly providing false information on the application.

Section 13: adds the language of the sworn statement of illegally obtained drugs or alcohol to the Alaska Native Family assistance program

Please 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.

28-LS0059\U
Mischel
1/25/13

CS FOR HOUSE BILL NO. 16()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-EIGHTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES KELLER, Peggy Wilson

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 specified cash assistance."**

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

4 *** Section 1. AS 47.25.120 is amended by adding a new subsection to read:**

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

8 *** Sec. 2. AS 47.27.200(e) is amended to read:**

9 (e) An organization's plan for operation of the Alaska Native family assistance
10 grant must

11 (1) be designed to facilitate self-sufficiency of assistance recipients in
12 the region specified in the federally approved tribal family assistance plan by
13 addressing the conditions specific to that region;

14 (2) provide for a reasonable pattern of service delivery from all

1 providers serving that region;

2 (3) serve a specified region that consists of a geographically cohesive
3 group of communities that share similar interests, resources, and traditions;

4 (4) establish the same maximum number of months of benefits as is
5 established for the state program under AS 47.27.015(a)(1); [AND]

6 (5) provide for administration of the grant money received under this
7 section to establish a program in accordance with the plan accepted by the department
8 and in compliance with other requirements of this section; the program must include
9 the following standards for providing assistance to eligible families:

10 (A) only families with at least one dependent child or a woman
11 in the last trimester of pregnancy are eligible for assistance paid from an
12 Alaska Native family assistance grant;

13 (B) amounts for assistance provided from an Alaska Native
14 family assistance grant to eligible families may not exceed the amounts
15 specified under AS 47.27.025(b) when combined with assistance provided
16 under the federally approved tribal family assistance grant;

17 (C) to remain eligible for assistance paid from an Alaska
18 Native family assistance grant, a minor parent of a dependent child must meet
19 the requirements of AS 47.27.027;

20 (D) families receiving assistance paid from an Alaska Native
21 family assistance grant shall comply with the provisions of AS 47.27.035(a)
22 regarding participation in work activities;

23 (E) families receiving assistance paid from Alaska Native
24 family assistance grant money shall comply with the provisions of (l) - (n) of
25 this section regarding assignment of support rights and cooperation with the
26 child support services agency;

27 (F) the organization has an impartial appeals process to allow
28 affected families in the region of the state covered by the plan accepted by the
29 department to have a fair hearing;

30 (6) establish an alcohol and drug testing program as required
31 under AS 47.27.400 - 47.27.499.

* Sec. 3. AS 47.27 is amended by adding new sections to read:

Article 4A. Alcohol and Drug Testing.

Sec. 47.27.400. Alcohol impairment and drug testing; legislative findings and purpose. The legislature finds that a statewide threat to public safety exists with regard to excessive use of alcohol and illegal drugs. The purpose of the testing program established under AS 47.27.400 - 47.27.499 is to reduce that risk, to provide an opportunity for rehabilitation, and to protect the residents of the state.

Sec. 47.27.410. Alcohol impairment and drug testing for eligibility; regulations; immunity. (a) The department shall establish and administer a program consistent with AS 47.27.400 - 47.27.499 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 seek work and of applicants for and recipients of cash assistance for the use of illegal drugs. In this subsection, "recipient of cash assistance" does not include a dependent child, a caretaker of a dependent child who is not a recipient of public assistance based on the caretaker's financial need, or a protective payee, 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 47.27.430 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)
-----------	--

1	Marijuana metabolite	15
2	(Delta-9-tetrahydrocannabinol-9-carboxylic acid)	
3	Cocaine metabolite (Benzoyllecgonine)	150
4	Opiates	
5	Morphine	2,000
6	Codeine	2,000
7	6-Acetylmorphine	10
8	(when morphine concentration exceeds	
9	2,000 nanograms in each milliliter)	
10	Phencyclidine	25
11	Amphetamines	
12	Amphetamine	500
13	Methamphetamine	500
14	(when amphetamine concentration is	
15	greater than or equal to 200 nanograms	
16	in each milliliter)	
17	(3) for testing of alternative specimens that is consistent with the	
18	mandatory guidelines for the federal workplace drug testing program adopted by the	
19	United States Department of Health and Human Services.	
20	(c) Unless the department or an agent or employee of the department knew or	
21	should have known that the results of a test conducted under this section were false	
22	and took action that affected a person's eligibility for cash assistance based on the false	
23	test results, a person may not bring an action for damages against the department or an	
24	agent or employee of the department for	
25	(1) good faith actions taken to conduct, or as a result of, alcohol	
26	impairment or drug testing under this section;	
27	(2) failure to test for alcohol impairment or drugs or for a specific	
28	drug;	
29	(3) failure to test for or detect a specific drug or medical or	
30	psychological condition or disorder;	
31	(4) termination or suspension of an alcohol or drug prevention or	

1 testing program or policy.

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

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

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

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

11 **Sec. 47.27.420. Confidentiality; liability.** (a) The results of a test conducted
12 under AS 47.27.410 are confidential, except that the results may be revealed to the
13 recipient of cash assistance who was tested and to agents and employees of the
14 department as required to determine eligibility for cash assistance.

15 (b) A person may not bring an action for defamation of character or reputation
16 as a result of disclosure of the results of an alcohol impairment or drug test under the
17 alcohol impairment or drug testing program established under AS 47.27.410 unless

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

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

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

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

24 **Sec. 47.27.430. Testing policies and procedures.** (a) The department shall
25 adopt testing policies and procedures that include

26 (1) a list of substances tested;

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

29 (3) a right to confirmatory testing and the procedures for confirmatory
30 testing;

31 (4) the consequences for refusal to test or retest that are consistent with

1 the provisions in AS 47.27.450;

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

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

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

13 (b) The department shall pay the cost of testing and, if the testing is performed
14 at a location other than a location of the department, the cost of transportation to and
15 from the testing center. The department may enter into contracts to conduct testing
16 and analysis of samples consistent with the requirements in AS 47.27.400 - 47.27.499
17 and AS 36.30 (State Procurement Code).

18 (c) Sample collection and testing must

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

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

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

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

26 (5) include relevant medical information.

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

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

1 testing.

2 **Sec. 47.27.440. Training of test administrators.** (a) The department shall
3 ensure that at least one designated employee of the department receives not less than
4 one hour of training on alcohol abuse and an additional one hour of training on the use
5 of controlled substances for the purpose of finding reasonable suspicion for testing
6 under AS 47.27.400 - 47.27.499.

7 (b) If the department provides for on-site testing for alcohol impairment or
8 illegal drug use under AS 47.27.410, the department shall employ or contract for on-
9 site administrators who

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

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

16 **Sec. 47.27.450. Consequences of confirmatory positive testing.** (a) Except as
17 provided in (b) of this section, the department shall deny or suspend cash assistance to
18 an applicant for or recipient of the assistance who, under AS 47.27.400 - 47.27.499,

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

22 (2) has refused alcohol impairment or drug testing required by the
23 department.

24 (b) The department may provide cash assistance on behalf of an eligible
25 recipient who is subject to denial or suspension under (a) of this section if the
26 department has assigned a protective payee to manage the cash assistance for which
27 the recipient or the recipient's family is otherwise eligible and the third party provides
28 care, shelter, or food to the recipient or the recipient's dependent children.

29 **Sec. 47.27.499. Definition.** In AS 47.27.400 - 47.27.499, "cash assistance"
30 means

31 (1) cash assistance as defined in AS 47.27.900; and

1 (2) benefits received under Alaska Native family assistance programs
2 and grants under AS 47.27.200 and regional public assistance programs under
3 AS 47.27.300.

4 * Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 TRANSITION. Notwithstanding the requirements for alcohol and drug testing under
7 AS 47.27.400 - 47.27.499, added by sec. 3 of this Act, the Department of Health and Social
8 Services may not, under the program established in those sections, test more than 100 persons
9 a month during the first two fiscal years after the effective date of this Act.

HB 16 Q & A

Question: Is this bill constitutional and does it violate my Fourth Amendment Rights?

Answer: In examining the Constitutionality of random drug testing for public assistant recipients, it is important to remember that the U.S. Supreme Court has not addressed this issue directly. The Supreme Court has heard matters regarding suspicionless drug tests in other settings, but the test for determining the Constitutionality of such tests all falls on the reasons behind the testing, or more specifically, the “compelling state interest.” It would be premature and improper to extrapolate all previous rulings to the random drug testing system established in this bill.

Any time the government, or any agent thereof, conducts a search, such as a drug test, the search must be examined in the context of our Fourth Amendment privacy protections against unreasonable searches and seizures. Considering there are no criminal implications in this bill, the Supreme Court would most likely question the search’s reasonableness. A search is “reasonable” when supported by “special needs” beyond the normal need for law enforcement. In the most recent cases before the Supreme Court regarding suspicionless searches (i.e. random drug tests) the Court has held that public schools have the right to test athletes and participants of extracurricular activities because the public school’s custodial and educational duties, a finding of individual suspicion was not necessary. Arguably, the State has a compelling interest in curbing the drug use of citizens in general, maximizing the benefit of every dollar expended, and specifically, deterring drug use of persons receiving public assistance, because (a) the State cannot rationally justify the incompatible policies of criminally policing drug use while simultaneously providing money for persons to purchase drugs, and (b) the preeminent interest of protecting low-income families from the ravages of addiction and abuse.

Second comes the question of an “expectation of privacy.” The average citizen has the greatest expectation of privacy under the Fourth Amendment. Various activities or conditions affect this expectation; for example, prisoners, students and military personnel all have a diminished expectation of privacy. In the recent Supreme Court cases mentioned above, the Court held that students involved in athletics and extra-curricular activities have a diminished expectation of privacy because of the rules, procedures and activities inherent in participation. Similarly, a person accepting public assistance may have a diminished expectation of privacy due to the fact that as a condition precedent to receiving assistance a person must submit to the government private information such as name, address, social security number, income, number of dependents, etc., and this information is checked and rechecked to ensure the eligibility for public assistance. This bill provides no criminal recourse for anyone testing positive for illicit use of controlled substances and ensures the confidentiality of all test results. One could argue that it treads on the Fourth Amendment in the lightest way possible.

Lastly, the Supreme Court will probably require that a drug testing program be “tailored” (possibly narrowly) to fit the State’s “compelling interest.” This bill provides for random

testing, and prohibits the use of any other criteria, including but not limited to, suspicion of drug use, previous drug use or criminal conviction for drug use or possession. Again, the results are completely confidential and cannot be distributed to a public or private person or entity. Additionally, following a positive test, the recipient will not lose any benefits until failing a second drug test 30-60 days later. If a person twice fails a drug test and is determined ineligible, the person can reapply in two years. Both of these provisions are aimed at deterring drug use while allowing self-help and providing a remedy, and are less stringent than alternative policies the State could implement in dealing with the dilemma.

Again, the Supreme Court has yet to directly address the issue of drug testing of public assistance recipients which was actually provided for in the Welfare Reform Act of 1996, and the unique nature of the issue would require a specific analysis. The bill has been drafted in a way to navigate the constitutional waters and provide a limited solution to a definitive problem.

Question: Won't drug testing hurt the children of families on public assistance?

Answer: No. Drug addicted parents hurt the children. Drug addicted fathers do not provide a positive role model and squander precious financial resources on illicit drugs. Drug addicted mothers do the same, but with one additional problem -- in many instances they give birth to drug addicted babies. These children then must go through a painful withdrawal program immediately following birth. In some instances these children are permanently damaged by the mother's drug abuse and will never be a productive member of society. Effectively addressing a father or mother's drug problem will lead to treatment and a more productive future for the entire family.

Question: Isn't drug testing an invasion of my privacy and a violation of my civil rights?

Answer: No. Signing up for any kind of public assistance is voluntary in the first place. No one requires anyone to apply for these benefits. But those who do choose to sign up for welfare and food assistance are already required to prove need by providing the government access to their bank accounts and their sources of income. This information is then reviewed and sometimes investigated by the government agency providing the assistance. Applicants voluntarily agree to disclose such information as a condition of receiving assistance. Drug testing is simply another investigation that an applicant will voluntarily agree to in order to receive assistance. People have a choice -- if they do not want to be tested for drugs, they do not have to sign up for assistance.

Question: How much will the drug testing cost?

Answer: The cost of testing ranges from \$50-150 depending on the detail of the test. Here's the important thing to remember: What is the cost of not testing? Clearly there will be a cost on the front side, but hundreds of thousands of dollars will be saved by weeding out those who abuse the system.

Question: Receiving welfare, food assistance and unemployment is a right. Why are you trying to take my assistance away?

Answer: This bill does not violate your constitutional rights. Applying for assistance is a choice, not a requirement

TREASURY EMPLOYEES v. VON RAAB, 489 U.S. 656 (1989)

Emphasizing the "special needs" of the public school context, reflected in the "custodial and tutelary" power that schools exercise over students, and also noting schoolchildren's diminished expectation of privacy, the Court in *Vernonia School District v. Acton* Supp.7 upheld a school district's policy authorizing random urinalysis drug testing of students who participate in interscholastic athletics. The Court redefined the term "compelling" governmental interest. The phrase does not describe a "fixed, minimum quantum of governmental concern," the Court explained, but rather "describes an interest which appears important enough to justify the particular search at hand." Supp.8 Applying this standard, the Court concluded that "detering drug use by our Nation's schoolchildren is at least as important as enhancing efficient enforcement of the Nation's laws against the importation of drugs . . . or deterring drug use by engineers and trainmen." Supp.9 On the other hand, the interference with privacy interests was not great, the Court decided, since schoolchildren are routinely required to submit to various physical examinations and vaccinations. Moreover, "[l]egitimate privacy expectations are even less [for] student athletes, since they normally suit up, shower, and dress in locker rooms that afford no privacy, and since they voluntarily subject themselves to physical exams and other regulations above and beyond those imposed on non-athletes. The Court "caution[ed] against the assumption that suspicionless drug testing will readily pass muster in other contexts," identifying as "the most significant element" in *Vernonia* the fact that the policy was implemented under the government's responsibilities as guardian and tutor of schoolchildren. Supp.10

TREASURY EMPLOYEES v. VON RAAB, 489 U.S. 656 (1989)
489 U.S. 656

Moreover, the mere circumstance that all but a few of the employees tested are innocent does not impugn the program's [489 U.S. 656, 658] validity, since it is designed to prevent the substantial harm that could be caused by the promotion of drug users as much as it is designed to detect actual drug use. Pp. 673-675.

Addicts may be unable to abstain even for a limited period or may be unaware of the "fade-away effect" of certain drugs. More importantly, since a particular employee's pattern of elimination for a given drug cannot be predicted with perfect accuracy and may extend for as long as 22 days, and since this information is not likely to be known or available to the employee in any event, he cannot reasonably expect to deceive the test by abstaining.... Pp. 676-677.

We have recognized before that requiring the Government to procure a warrant for every work-related intrusion "would conflict with `the common-sense realization that government offices could not function if every employment decision became a constitutional matter.'" *O'Connor v. Ortega*, supra, at 722, quoting *Connick v. Myers*, 461 U.S. 138, 143 (1983). See also 480 U.S., at 732 (SCALIA, J., concurring in judgment); *New Jersey v. T. L. O.*, supra, at 340

**NATIONAL TREASURY EMPLOYEES UNION ET AL. v. VON RAAB,
COMMISSIONER, UNITED
STATES CUSTOMS SERVICE
CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH
CIRCUIT
No. 86-1879.**

**Argued November 2, 1988
Decided March 21, 1989**

The United States Customs Service, which has as its primary enforcement mission the interdiction and seizure of illegal drugs smuggled into the country, has implemented a drug-screening program requiring urinalysis tests of Service employees seeking transfer or promotion to positions having a direct involvement in drug interdiction or requiring the incumbent to carry firearms or to handle "classified" material. Among other things, the program requires that an applicant be notified that his selection is contingent upon successful completion of drug screening, sets forth procedures for collection and analysis of the requisite samples and procedures designed both to ensure against adulteration or substitution of specimens and to limit the intrusion on employee privacy, and provides that test results may not be turned over to any other agency, including criminal prosecutors, without the employee's written consent. Petitioners, a federal employees' union and one of its officials, filed suit on behalf of Service employees seeking covered positions, alleging that the drug-testing program violated, inter alia, the Fourth Amendment. The District Court agreed and enjoined the program. The Court of Appeals vacated the injunction, holding that, although the program effects a search within the meaning of the Fourth Amendment, such searches are reasonable in light of their limited scope and the Service's strong interest in detecting drug use among employees in covered positions.

Held:

1. Where the Government requires its employees to produce urine samples to be analyzed for evidence of illegal drug use, the collection and subsequent chemical analysis of such samples are searches that must meet the reasonableness requirement of the Fourth Amendment. Cf. *Skinner v. Railway Labor Executives' Assn.*, ante, at 616-618. However, because the Service's testing program is not designed to serve the ordinary needs of law enforcement - i. e., test results may not be used in a criminal prosecution without the employee's consent, and the purposes of the program are to deter drug use among those eligible for promotion to sensitive positions and to prevent the promotion of drug users to those positions - the public interest in the program must be balanced against [489 U.S. 656, 657] the individual's privacy concerns implicated by the tests to determine whether a warrant, probable cause, or some level of individualized suspicion is required in this particular context. *Railway Labor Executives*, ante, at 619-620. Pp. 665-666.
2. A warrant is not required by the balance of privacy and governmental interests in the context of this case. Such a requirement would serve only to divert valuable agency resources from the Service's primary mission, which would be compromised if warrants were necessary in connection with routine, yet sensitive, employment decisions. Furthermore, a warrant would provide little or no additional protection of personal

privacy, since the Service's program defines narrowly and specifically the circumstances justifying testing and the permissible limits of such intrusions; affected employees know that they must be tested, are aware of the testing procedures that the Service must follow, and are not subject to the discretion of officials in the field; and there are no special facts for a neutral magistrate to evaluate, in that implementation of the testing process becomes automatic when an employee pursues a covered position. Pp. 666-667.

3. The Service's testing of employees who apply for promotion to positions directly involving the interdiction of illegal drugs, or to positions that require the incumbent to carry firearms, is reasonable despite the absence of a requirement of probable cause or of some level of individualized suspicion. Pp. 667-677.

(a) In light of evidence demonstrating that there is a national crisis in law enforcement caused by the smuggling of illicit narcotics, the Government has a compelling interest in ensuring that front-line interdiction personnel are physically fit and have unimpeachable integrity and judgment. It also has a compelling interest in preventing the risk to the life of the citizenry posed by the potential use of deadly force by persons suffering from impaired perception and judgment. These governmental interests outweigh the privacy interests of those seeking promotion to such positions, who have a diminished expectation of privacy in respect to the intrusions occasioned by a urine test by virtue of the special, and obvious, physical and ethical demands of the positions. Pp. 668-672.

(b) Petitioners' contention that the testing program is unreasonable because it is not based on a belief that testing will reveal any drug use by covered employees evinces an unduly narrow view of the context in which the program was implemented. Although it was not motivated by any perceived drug problem among Service employees, the program is nevertheless justified by the extraordinary safety and national security hazards that would attend the promotion of drug users to the sensitive positions in question. Moreover, the mere circumstance that all but a few of the employees tested are innocent does not impugn the program's [489 U.S. 656, 658] validity, since it is designed to prevent the substantial harm that could be caused by the promotion of drug users as much as it is designed to detect actual drug use. Pp. 673-675.

(c) Also unpersuasive is petitioners' contention that the program is not a sufficiently productive mechanism to justify its intrusion on Fourth Amendment interests because illegal drug users can easily avoid detection by temporary abstinence or by surreptitious adulteration of their urine specimens. Addicts may be unable to abstain even for a limited period or may be unaware of the "fade-away effect" of certain drugs. More importantly, since a particular employee's pattern of elimination for a given drug cannot be predicted with perfect accuracy and may extend for as long as 22 days, and since this information is not likely to be known or available to the employee in any event, he cannot reasonably expect to deceive the test by abstaining after the test date is assigned. Nor can he expect attempts at adulteration to succeed, in view of the precautions built into the program to ensure the integrity of each sample. Pp. 676-677.

4. The record is inadequate for the purpose of determining whether the Service's testing of those who apply for promotion to positions where they would handle "classified" information is reasonable, since it is not clear whether persons occupying particular positions apparently subject to such testing are likely to gain access to sensitive information. On remand, the Court of Appeals should examine the criteria used by the Service in determining what materials are classified and in deciding whom to test under this rubric and should, in assessing the reasonableness of requiring tests of those employees, consider pertinent information bearing upon their privacy expectations and the supervision to which they are already subject. Pp. 677-678.

Illicit drug users, the court found, are susceptible to bribery and blackmail,....

As we note in *Railway Labor Executives*, our cases establish that where a Fourth Amendment intrusion serves special governmental needs, beyond the normal need for law enforcement, it is necessary to balance the individual's privacy expectations against the Government's interests to determine whether it is impractical to require a warrant or [489 U.S. 656, 666] some level of individualized suspicion in the particular context. *Ante*, at 619-620.

Petitioners do not contend that a warrant is required by the balance of privacy and governmental interests in this context, nor could any such contention withstand scrutiny. We have recognized before that requiring the Government to procure a warrant for every work-related intrusion "would conflict with `the common-sense realization that government offices could not function if every employment decision became a constitutional matter.'" *O'Connor v. Ortega*, *supra*, at 722, quoting *Connick v. Myers*, 461 U.S. 138, 143 (1983). See also 480 U.S., at 732 (SCALIA, J., concurring in judgment); *New Jersey v. T. L. O.*, *supra*, at 340 (noting that "[t]he warrant requirement . . . is unsuited to the school environment: requiring a teacher to obtain a warrant before searching a child suspected of an infraction of school rules (or of the criminal law) would unduly interfere with the maintenance of the swift and informal disciplinary procedures needed in the schools").

a warrant would provide little or nothing in the way of additional protection of personal privacy. A warrant serves primarily to advise the citizen that an intrusion is authorized by law and limited in its permissible scope and to interpose a neutral magistrate between the citizen and the law enforcement officer "engaged in the often competitive enterprise of ferreting out crime." *Johnson v. United States*, 333 U.S. 10, 14 (1948).

United States v. Martinez-Fuerte, 428 U.S., at 557

Our precedents have settled that, in certain limited circumstances, the Government's need to discover such latent or hidden conditions, or to prevent their development, is sufficiently compelling to justify the intrusion on privacy entailed by conducting such searches without any measure of individualized suspicion. E. g., *ante*, at 624.

United States v. Ramsey, 431 U.S. 606, 608 -609 (1977).

The record also indicates, and it is well known, that drug smugglers do not hesitate to use violence to protect their lucrative trade and avoid apprehension. *Id.*, at 109.

Without disparaging the importance of the governmental interests that support the suspicionless searches of these employees, petitioners nevertheless contend that the Service's drug-testing program is unreasonable in two particulars. First, petitioners argue that the program is unjustified because it is not based on a belief that testing will reveal any drug use by covered employees. In pressing this argument, petitioners point out that the Service's testing scheme was not implemented in response to any perceived drug problem among Customs employees, and that the program actually has not led to the discovery of a significant number of drug users. Brief for Petitioners 37, 44; Tr. of Oral Arg. 11-12, 20-21. Counsel for petitioners informed us at oral argument that no more than 5 employees out of 3,600 have tested positive for drugs. *Id.*, at 11. Second, petitioners contend that the Service's scheme is not a "sufficiently productive mechanism to justify [its] intrusion upon Fourth Amendment interests," *Delaware v. Prouse*, 440 U.S. 648, 658 -659 (1979), because illegal drug users can avoid detection with ease by temporary abstinence or by surreptitious adulteration of their urine specimens. Brief for Petitioners 46-47. These contentions are unpersuasive. [489 U.S. 656, 674]

Petitioners' first contention evinces an unduly narrow view of the context in which the Service's testing program was implemented. Petitioners do not dispute, nor can there be doubt, that drug abuse is one of the most serious problems confronting our society today. There is little reason to believe that American workplaces are immune from this pervasive social problem, as is amply illustrated by our decision in *Railway Labor Executives*. See also *Masino v. United States*, 589 F.2d 1048, 1050 (Ct. Cl. 1978) (describing marijuana use by two Customs inspectors). Detecting drug impairment on the part of employees can be a difficult task, especially where, as here, it is not feasible to subject employees and their work product to the kind of day-to-day scrutiny that is the norm in more traditional office environments. Indeed, the almost unique mission of the Service gives the Government a compelling interest in ensuring that many of these covered employees do not use drugs even off duty, for such use creates risks of bribery and blackmail against which the Government is entitled to guard. In light of the extraordinary safety and national security hazards that would attend the promotion of drug users to positions that require the carrying of firearms or the interdiction of controlled substances, the Service's policy of deterring drug users from seeking such promotions cannot be deemed unreasonable.

The mere circumstance that all but a few of the employees tested are entirely innocent of wrongdoing does not impugn the program's validity. The same is likely to be true of householders who are required to submit to suspicionless housing code inspections, see *Camara v. Municipal Court of San Francisco*, 387 U.S. 523 (1967),.... The Service's program is designed to prevent the promotion of drug users to sensitive positions as much as it is designed to detect those employees who use drugs.

We think petitioner's second argument - that the Service's testing program is ineffective because employees may attempt to deceive the test by a brief abstention before the test date, or by adulterating their urine specimens - overstates the case. As the Court of Appeals noted, addicts may be unable to abstain even for a limited period of time, or may be unaware of the "fade-away effect" of certain drugs. 816 F.2d, at 180.

We think petitioner's second argument - that the Service's testing program is ineffective because employees may attempt to deceive the test by a brief abstention before the test date, or by adulterating their urine specimens - overstates the case. As the Court of Appeals noted, addicts may be unable to abstain even for a limited period of time, or may be unaware of the "fade-away effect" of certain drugs. 816 F.2d, at 180. More importantly, the avoidance techniques suggested by petitioners are fraught with uncertainty and risks for those employees who venture to attempt them. A particular employee's pattern of elimination for a given drug cannot be predicted with perfect accuracy, and, in any event, this information is not likely to be known or available to the employee. Petitioners' own expert indicated below that the time it takes for particular drugs to become undetectable in urine can vary widely depending on the individual, and may extend for as long as 22 days. App. 66. See also ante, at 631 (noting Court of Appeals' reliance on certain academic literature that indicates that the testing of urine can discover drug use "for . . . weeks after the ingestion of the drug"). Thus, contrary to petitioners' suggestion, no employee reasonably can expect to deceive the test by the simple expedient of abstaining after the test date is assigned. Nor can he expect attempts at adulteration to succeed, in view of the precautions taken by the sample collector to ensure the integrity of the sample. In all the circumstances, we are persuaded that the program bears a close and substantial relation to the Service's goal of deterring drug users from seeking promotion to sensitive positions. 4 [489 U.S. 656, 677]

Jim Pound

Subject: FW: HB 16

From: Rep. Shelley Hughes
Sent: Thursday, February 07, 2013 6:26 PM
To: Rep. Wes Keller
Subject: FW: HB 16

Wes,

Here's some written testimony in support of HB 16 from one of my constituents – and he provided permission for you to have it. He might also be willing to provide oral testimony when you need it.

Hope this is helpfull

Best regards,

Shelley

Shelley Hughes

Representative
Alaska State Legislature
House District 8 - Greater Palmer
State Capitol Room 409
Juneau, Alaska 99801

From: David Marshall
Sent: Wednesday, February 06, 2013 8:09 AM
To: Rep. Shelley Hughes
Subject: HB 16

Dear Ms. Hughes,

I would like to take this opportunity to encourage you to support House Bill 16, sponsored by Wes Keller. My wife, daughter and I have lived in Palmer for over 8 years. My wife and I are both retired Air Force veterans and now working in the private sector. In order to obtain employment, we both had to pass alcohol and drug tests. We are also subject to random drug tests throughout the year. The paychecks we receive at our jobs that we spend 50-60 hours per week performing, have taxes taken out that support those individuals who receive government assistance (welfare, food stamps, etc...). So we think it is only logical that individuals who receive assistance from hard working taxpayers, should be subject to the same rules and requirements as those of us who fund these programs. I would hate to think that our hard earned tax dollars are enabling individuals drug and alcohol addictions.

Sincerely,

David Marshall

**International Union, United Auto., Aerospace and Agr. Implement Workers
of America v. Winters**
336 F.Supp.2d 686
W.D.Mich., 2003.
Apr 07, 2003

The Supreme Court has ruled that government has a special need to conduct drug testing in several different circumstances where no particularized suspicion is present: testing of employees of the Customs Service who apply for positions directly involving interdiction of illegal drugs or positions requiring the agen to carry firearms, Nat'l Treasury Employees Union v. Von Raab, 489 U.S. 656, 109 S.Ct.1384,103 L.Ed. 2d 685 (1989); testing of railroad employees involved in train accidents, Skinner v. Ry. Labor Executives' Ass'n, 489 U.S. 602, 109 S.Ct. 1402,103 L.Ed.2d 639(1989); testing of student athletes in an effort to prevent the spread of drugs among the student population, Vernonia Sch. Dist. 47J v. Acton, 515 U.S. 646, 115 S.Ct. 2386, 132 L.Ed.2d 564 (1995); and testing of students who participate in competitive extracurricular activities, Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls, 536 U.S. 82, 122 S.Ct. 2559, 153 L.Ed.2d 735 (2002) The circuit has held that a school district has a special need to test applicants for all safety-sensitive positions in a school district, Knox County Educ. Ass'n v. Knox County Bd. of Educ., 158 F.3d 361 (6th Cir.1998); that a city has a special need to test its municipal bus drivers, Tanks v. Greater Cleveland Reg'l Transit Auth., 930 F.2d 475 (6th Cir.1991); and that a city has a special need to test its firemen and policemen, Penny v. Kennedy, 915 F.2d 1065 (6th Cir. 1990)



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State

Alaska

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Year 2009 go

Rankings by Measure

--Select Measure-- go

Researchers estimate that the direct healthcare cost of obesity for the state of Alaska is \$157 million. If current obesity levels are maintained, in 10 years Alaska could save \$388 million off a projected \$2,936 million healthcare bill. That's \$735 for every adult in the state.

more

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Alaska (2009)
America's Health Rankings™

Ranking:
Alaska is 34th this year; it was 32nd in 2008.

Strengths:
Strengths include a low percentage of children in poverty at 9.6 percent of persons under age 18, low levels of air pollution at 6.9 micrograms of fine particulate per cubic meter, strong public health funding at \$171 per person and a low rate of deaths from cardiovascular disease at 235.8 deaths per 100,000 population.

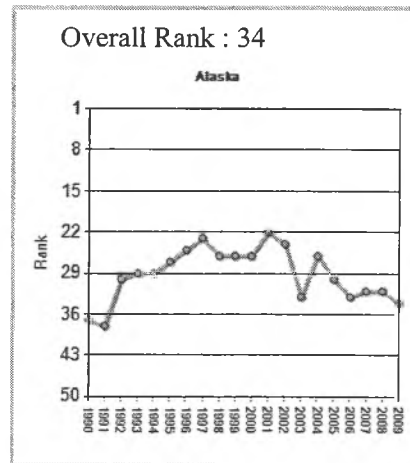
Challenges:
Challenges include a high rate of uninsured population at 19.0 percent, a low high school graduation rate with 66.5 percent of incoming ninth graders who graduate within four years, high geographic disparity within the state at 19.4 percent, a high violent crime rate at 652 offenses per 100,000 population and a high occupational fatalities rate at 13.0 deaths per 100,000 workers. Alaska ranks lower for determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:
↓ to 62.4 discharges per 1,000 Medicare enrollees. ↓ In the past five years, the rate of deaths from cardiovascular disease declined from 279.5 to 235.8 deaths per 100,000 population. ↓ In the past five years, the prevalence of smoking decreased from 26.2 percent to 21.5 percent of the population. ↑ In the past ten years, immunization coverage increased from 54.3 percent to 76.2 percent of children ages 19 to 35 months receiving complete immunizations.

Health Disparities:
In Alaska, smoking is more prevalent among non-Hispanic American Indians and Alaskan Natives at 39.9 percent than non-Hispanic whites at 19.0 percent. Mortality rates vary considerably by race and ethnicity in Alaska, with 1,054.4 deaths per 100,000 population among American Indians and Alaskan Natives compared to whites, who experience 735.2 deaths per 100,000 population.

State Health Department Web Site:
health.hss.state.ak.us

Download this state summary as a PDF file



New! Supplemental Measures
America's Health Rankings™ have been expanded to include 15 more state-specific measures of health, from Daily Vegetable and Fruit intake to Incidence of High Blood Pressure and Diabetes. [GO](#)

Behaviors	2009		2008		No. 1 State
	Value	Rank	Value	Rank	
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	28.2	35	19.1
Prevalence of Smoking (Percent of population)	21.5	40	22.2	38	9.3
Prevalence of Binge Drinking (Percent of population)	17.6	37	18.3	44	9.0
Community & Environment					
Occupational Fatalities (Deaths per 100,000 workers)	13.0	50	9.9	46	3.1
Infectious Disease (Cases per 100,000 population)	15.8	30	14.9	27	2.4
Air Pollution (Micrograms of fine particles per cubic meter)	6.9	5	7.2	5	4.8
Children in Poverty (Percent of persons under age 18)	9.6	3	8.5	2	8.6
Violent Crime (Offenses per 100,000 population)	651	44	661	43	117
Public & Health Policies					
Lack of Health Insurance (Percent of population)	19.0	46	17.4	39	5.4
Immunization Coverage (Percent of children ages 19 to 35 months)	76.2	32	78.6	35	85.0
Public Health Funding (Dollars per person)	\$170	3	\$175	2	\$220
Clinical Care					
Prenatal Care (Percent of pregnant women)	56.8	48	59.1	44	86.1

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 State
	Value	Rank	Value	Rank	
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 Disease					
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
Cardiac Heart Disease (Percent of adult population)	3.0	2	2.5	2	2.7
Diabetes (Percent of adult population)	6.6	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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Congress Considers Drug Testing Welfare Recipients

Four States Legally Prohibited from Drug Testing Could Lose Federal Funding

Public Health, Social Work, Drug Addiction Experts: Drug Testing Wasteful, Counterproductive, and Will Push Families into Poverty

For Immediate Release: Wednesday, March 16, 2005.

Contact: Tony Newman (212) 613-8026 or Elizabeth (212) 613-8036

Congress is debating legislation that could cut federal welfare funding to at least four states and undermine anti-poverty efforts nationally. The bill, the Personal Responsibility, Work, and Family Promotion Act (HR 240), would extend welfare legislation enacted by Congress and President Clinton in 1996. Earlier this week, however, a House subcommittee amended the bill to cut federal welfare funding to any state that does not drug test those applying for or receiving welfare benefits. No state currently drug tests welfare recipients. In fact, a 2003 ruling by a federal appeals court that covers the states of Kentucky, Michigan, Ohio, and Tennessee ruled that states cannot drug test welfare recipients because it's unconstitutional. Those states, and many others, could lose federal funding if the drug testing provision makes it into law.

"We expect to see a rebellion by members of Congress from states that would lose federal funding under this law," said Bill Piper, Director of National Affairs for the Drug Policy Alliance. "These states won't just be caught between a rock and a hard place, they'll be crushed under the rock."

In 2000 Michigan became the only state to adopt random and suspicionless drug testing of those applying for public assistance. Three years later, in *Marchwinski v. Howard*, the federal Court of Appeals for the Sixth Circuit upheld a lower court ruling striking down the program as a violation of the 4th amendment to the U.S. Constitution. To date no other state has established a program to drug test welfare applicants or recipients. In fact, experts on welfare and drug testing say states that have studied the issue have concluded that it would waste money that would be better used on anti-poverty programs.

An amicus brief in the Michigan case submitted by the Drug Policy Alliance in opposition to the drug testing program was supported by the American Public Health Association, the National Association of Social Workers, National Association of Alcoholism and Drug Abuse Counselors, National Council on Alcoholism and Drug Dependence, National Black Women's Health Project, and other legal and health groups. The brief, which was cited by the court, concluded that Michigan's drug testing program would do more harm than good and undermine the state's efforts to reduce poverty and keep families together.

"Congress is wading into an area that federal courts have already found constitutionally objectionable," said Daniel Abrahamson, Director of Legal Affairs for the Drug Policy Alliance and the author of the Alliance's legal brief in the Michigan case. "But even if the bill became law and somehow survived legal challenge, the legislation would likely wreak havoc on state anti-poverty programs across the country, further pushing working families into poverty."

The federal welfare bill was approved by the Ways and Means Committee's Human Resources Subcommittee on Tuesday, March 15th. It could be considered by the full committee as early as April.



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.

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. ^{2,4,8,11,18}

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.

Press Release

State of Alaska > Health & Social Services > Press



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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 accounts 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 of workers through physical or mental impairment, incarceration for a criminal offenses, or inpatient treatment or hospitalization. Of the productivity losses, nearly half were due to premature death from alcohol and other drug abuse. The economic loss for 1999 for this cause alone was \$172 million, based on an annual average number of deaths related to alcohol and other drug abuse. Between 1994 and 1998, this was an average 224 deaths a year.

The Economic Costs of Alcohol and Other Drug Abuse in Alaska, Phase Two report was prepared for ABADA by McDowell Group, a research-based consulting firm in Juneau and Anchorage, with a grant from the Alaska Mental Health Trust Authority. The ABADA is appointed by the Governor to advise the Administration and Legislature on substance abuse issues.



• State of Alaska
• Health & Social Services
• Public Notices
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Search

Public Health

State of Alaska > Health & Social Services > Public Health

Programs

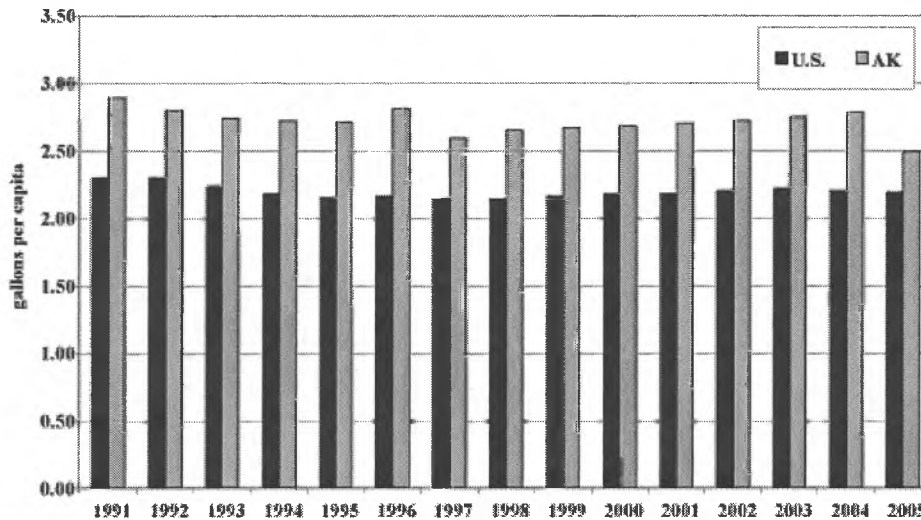
- Alaska Crash Outcomes Pilot Project
- Alaska Office of Rural Health
- Alaska Primary Care Office
 - Loan repayment programs
 - CHC
 - HPSA
 - MUA
- Certificate of Need
- Community Health Aide Training and Supervision (CHATS) Grants
- Comprehensive Integrated Mental Health Plan (Moving Forward)
- Frontier Extended Stay Clinics (FESC)
- Hospital Discharge Data System
- Rural Hospital Flexibility
- Small Hospital Improvement
- State Planning Grant
- Telehealth and Health Information Technology
- Links and Resources
- Publications

More Information

- Alaska health plans and special reports
- Community Data and Information
- Community Health Centers
- Comprehensive Integrated
- Mental Health Plan
- Critical Access Hospitals (CAH)
- Health insurance coverage
- Shortage designations (HPSAs and MUAs)
- Rural hospitals
- State Office of Rural Health
- Workforce



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 Alaskans 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 DHSS Division of Behavioral Health; compiled by NCADD

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.^{[17][22]} Alcohol abuse is also associated with increased risks of committing criminal offences including child abuse, domestic violence, rapes, burglaries and assaults.^[36] 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 caused 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 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.

National Institute on Drug Abuse

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.

Created September 2007

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 in 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 + (discount rate) by itself once (squared). Benefits delayed by 3 years are adjusted by dividing them by the result of multiplying the sum 1 + (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.

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 IOFC, 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 race sponsorship, the committee was able to get a contract for the tests at a reduced rate, he said.

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."

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

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Special thanks to the “Epi- Influences” subcommittee

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Report may be download at <http://hss.state.ak.us/dbh/prevention/publications/>
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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 ^{SCCS 2007}
Positive Connection to <i>Other Adults</i>	87% of students have a positive connection with at least <i>one other</i> adult outside of their home. ^{YRBS 2007}
Engagement in Meaningful Activities	51% of students are involved in volunteer and helping activities one or more times per week. ^{YRBS 2007}
Social, Emotional and Employability Skills	28.3% of students report they have social, emotional and employability skills. ^{SCCS 2007}
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. ^{DICS new database 2007} 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. ^{YRBS 2007}
Death by suicide of a family member	20.6 suicides were completed per 100,000 Alaskans ^{BVS 2007} 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 population-based; the data may not be available for individual communities. Indicators may be modified for prevention programs and services, as performance measures.	

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^{7,30} 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. ^{3,4,5,8,9,11}

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 increase risk, as does antisocial or delinquent behavior by siblings and peers. ^{1,6,11,17,20}

Child Abuse Indicator Rate of substantiated child abuse and neglect per 1,000 children ages 0-17.

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.^{14,16,19,21}

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 can assist in the development of stronger measures that may form the basis for future population-based and program-based indicators. **Recommendation:** The current indicators will require further analysis and represent only two elements of preservation or loss of cultural identity. The subcommittee urges the state to partner with interested organizations to further define cultural identity and develop indicators

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30. **Coe, M.** Suicide Attempts in Physically Abused Adolescents: Protective and Risk Factors *Prevention Science Seminar* 6.11.2003

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) - Calculated by the Alaska Bureau of Vital Statistics (BVS), February 2007.
- ◆ Youth Risk Behavior Survey 2007. Department of Education and Early Childhood and Development (DEED) and Department of Health and Social Services (DHSS).



February 22, 2013

Representative Pete Higgins
Chair of House Health & Social Services Committee
Juneau, AK

Dear Representative Higgins:

Per your request (through Tim Sullivan), I am providing you with information regarding the Alaska Railroad Corporation's (ARRC's) drug and alcohol testing program. The ARRC's program is conducted under the authority of the Federal Railway Administration (FRA), Federal Motor Carriers Safety Administration (FMCSA), and our own authority. All of our drug and alcohol tests are performed in accordance with the specimen collection and laboratory analysis procedures prescribed in 49 CFR Part 40. All drug tests are conducted with urine specimens and all alcohol tests are conducted with breath specimens.

During 2012, the ARRC spent \$60,000 for drug and alcohol testing for the following testing reasons:

Pre-employment: all newly hired employees must submit to pre-employment drug and alcohol tests. The FRA and FMCSA mandate these tests for employees in safety-sensitive positions (e.g. Conductor, Brakeman, Dispatcher, Locomotive Engineer, CDL driver). In addition, the ARRC requires it for employees hired into non-safety-sensitive positions.

Random: FRA and FMCSA mandate monthly random drug and alcohol testing for safety-sensitive positions.

Reasonable Cause: The ARRC requires drug and alcohol testing of employees involved in safety and operating rule violations and those involved in certain accidents and incidents.

Reasonable Suspicion: The FRA, FMCSA, and the ARRC require mandatory testing if an employee exhibits signs and symptoms of drug and/or alcohol use at work.

Fit-for-duty: The ARRC requires employees to do drug and alcohol tests when returning to work after a layoff or leave of absence of more than 90 days or if returning to work after an injury or surgery.

Our costs include the specimen collection, laboratory analysis, medical review officer services and third party administrative services (supplies, training and recordkeeping).

Let me know if I can be of further assistance. Thank you.

Sincerely,

Susan Lindemuth
Director, Human Resources Department



STATE of ALASKA

Bethel Legislative Information Office

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Written Testimony for the Record:

TCN: 4477

Committee: HHS

Date: 2/12/2013

Bill Number(s): HB16

Subject(s): _____

Please enter my testimony into the record.

Bing Santamora
Testifier's name (s):

Self
Representing (opt.)

PO Box 1573, Bethel, AK 99559
Address

543-2729
Phone

(Ms) BRIG SANTAMOUR
PO Box 1573
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(907) 543-2729 landline

HB16
Adult DPA

Greetings / Cama-i

I was disappointed when I found out about the last minute change of NOT having HB16 today.

For future consideration, please think of the Entire State and People who sent you to Juneau, for the important work that you undertake each year AND NOT JUST your own JUNEAU schedule(s).

The proposed changes / amendments to the bill are good. Many people, many of whom you will never hear from, will be pleased to know of the changes of adding drug testing to maintain or retain benefits. Those sections that keep minors and the innocent covered is an excellent protection for those affected.

Please think about inserting a section to cover those eligible individuals who have legal medical prescriptions for using medical marijuana. There are more and more people who cannot take ^{the} pills for pain control and must turn to medical marijuana for a better quality of life.



February 12, 2013

**AMERICAN CIVIL
LIBERTIES UNION OF
ALASKA**

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The Honorable Pete Higgins, Chair
The Honorable Wes Keller, Vice-Chair
House Health and Social Services Committee
Alaska State House of Representatives
Juneau, AK 99801

via email: Rep.Pete.Higgins@akleg.gov
Rep.Wes.Keller@akleg.gov

**Re: House Bill 16 – Alcohol and Drug Testing
Constitutional Review**

Chair Higgins, Vice-Chair Keller:

Thank you for the opportunity to submit written testimony regarding House Bill 16. As you know, the American Civil Liberties Union of Alaska (“ACLU) represents thousands of members and activists throughout the State of Alaska who seek to preserve and expand individual freedoms and civil liberties guaranteed under the United States and Alaska Constitutions. From that perspective, we have several concerns with the proposed legislation.

Receipt of Cash Assistance Does Not Allow Unreasonable Search

House Bill 16 improperly conditions the receipt of cash assistance upon submission to testing for use of alcohol or illegal drugs. The testing scheme proposed in the bill would constitute an impermissible search. *Anchorage Police Department Employees Ass'n v. Municipality of Anchorage*, 24 P.3d 547 (Alaska 2001), police department’s drug screening policy “unquestionably requires employees to submit to ‘searches.’”

As a search, the testing for alcohol or drugs must be “reasonable.” The touchstone for reasonableness is pre-approval by a court in the form of a

warrant. Alternatively, reasonableness may be based on “special needs,” balancing the government’s interest on the one hand versus the burden placed on the constitutional rights of the individual.

Here, the State’s need to prevent drug use among cash assistance recipients would not be more compelling than its interest in preventing drug abuse among the general population. Welfare recipients do not perform a special position of public trust, such as the customs agents in *National Treasury Employees Union v. Von Raab*, 489 U.S. 656 (1972), nor are they closely related to public safety, as the railway workers in *Skinner v. Railway Labor Executives’ Assn.*, 489 U.S. 602 (1989). Neither have welfare recipients knowingly sacrificed some of their privacy, nor does the state bear them a special *parens patriae* responsibility, as the schoolchildren in *Vernonia School Dist. 47J v. Acton*, 515 U.S. 646 (1995).

“The touchstone of a compelling state interest, then, is simply that ‘[the] right [to privacy] must yield when it interferes in a serious manner with the health, safety, rights and privileges of others or with the public welfare.’” *Anchorage Police Department Employees Association*, 24 P.3d at 555. Recipients of cash assistance are not uniquely positioned relative to the health, safety, rights, or privileges of others. They are largely undifferentiated from the general population in that respect, and their privacy interests cannot be infringed absent some clear and special relationship to such important interests.

Indeed, the only cases we have found relating to such a scheme have resulted in a federal injunction against its enforcement. In a recent case in Florida, a federal district court issued a preliminary injunction preventing the operation of the drug testing scheme. *Lebron v. Wilkins*, 820 F. Supp. 2d 1273, 1291 (M.D. Fla. 2011). A similar plan in Michigan was struck down by a federal court. *Marchwinski v. Howard*, 113 F. Supp. 2d 1134, 1140 (E.D. Mich. 2000) *aff’d by an equally divided en banc court*, 60 F. App’x 601 (6th Cir. 2003).

Testing Standards in Employment Context

Most drug testing cases take place against the background of employment. An employee who does not wish to participate in an employment-based drug testing program has the right to avoid the program by quitting his or her job. Drug testing is proposed in most of these cases as a “condition” of employment (or in *Vernonia*, of participation in school extracurricular activities). We know of no case, at the federal or state level, that has endorsed a program of compulsory drug testing for a category of citizens such as “those receiving cash assistance.”

Generally, regulations and statutes mandating drug testing of public employees have been approved by federal courts in unique circumstances, such as after traffic accidents, or for employees in tightly regulated industries or positions of great public trust. The federal courts have also approved drug testing requirements for public school students participating in extracurricular activities. However, the interest of the state must be “substantial” and must be

based in either an obvious risk or a pattern of substance abuse problems. *Chandler v. Miller*, 520 U.S. 305, 318 (U.S. 1997).

In Alaska, the courts have taken a narrower view of the constitutionality of testing. In *Anchorage Police Department Employees Association*, the court approved drug testing at particular times – for instance, prior to a promotion or after a traffic accident – but prohibited the use of random drug testing for officers. The Alaska decision in *Anchorage Police Department Employees Association* shows the manifest unconstitutionality of the proposed legislation. The Alaska Supreme Court found that police and firefighters in fact “undeniably hold safety-sensitive positions in extensively regulated fields of activity where they ‘discharge duties fraught with risks of injury to others that even a momentary lapse of attention can have disastrous consequences.’” *Id.* at 555.

Despite finding that the firefighters and police officer plaintiffs fit the heavily-regulated standard justifying the strongest special needs analysis, the court *still* found that random drug testing lacked sufficient justification, because of the added invasion of privacy of the randomness of the screenings, the subjective fear or disruption caused by an unplanned, unannounced drug test, and the diminished state interest in unprompted drug testing. *Id.* If the municipality of Anchorage had an insufficient state interest in invading the privacy of its employees who drive government vehicles, carry government-issued firearms, and are charged with protecting the safety of citizens of the municipality to justify a random drug testing regime, the state of Alaska likewise has an insufficient interest in invading the privacy of cash assistance recipients not engaged in any of these sensitive, safety related activities.

Alternatives to Testing

In addition to the consideration of the constitutional rights of cash assistance recipients, the constitutionality of the state’s proposed practice depends in part upon the alternatives available to vindicate its interest. Here, a simple alternative would be for the state to dedicate more resources to the treatment of substance abuse in the community. Under this alternative, cash assistance recipients who require treatment could obtain it whenever needed. This plan would better vindicate the state’s interests.

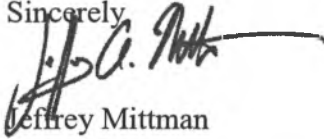
Under the scheme proposed in HB 16, recipients would be denied assistance but remain in the community, and remain addicted to drugs or alcohol. In all likelihood, the untreated addicts in our community would create more need for public services. Consider the serious problems around the state with homelessness. In Anchorage, the Municipality pays millions of dollars a year to address emergency medical and police calls for the homeless, many of whom must live in the parks and shelters and subsist by panhandling and through charities. More costs are imposed on the public in needed hospital services for these individuals. Similar problems are seen in Fairbanks, Juneau, and Nome. Denying assistance to those suffering from addiction problems will not increase sobriety nor create actual public savings.

Conclusion

While the ACLU of Alaska takes very seriously the issue of chemical dependency and supports public policy proposals to provide treatment, given that HB 16 would be found unconstitutional and that it would not be effective in reducing the burdens of substance abuse placed on the state, we urge the Committee to appropriately revise or vote against this Bill.

Thank you again for the opportunity to share our concerns. And please feel free to contact the undersigned should you require any additional information.

Sincerely,



Jeffrey Mittman
Executive Director
ACLU of Alaska

cc: Representative Benjamin Nageak, Rep.Benjamin.Nageak@akleg.gov
Representative Lance Pruitt, Rep.Lance.Pruitt@akleg.gov
Representative Lora Reinbold, Rep.Lora.Reinbold@akleg.gov
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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)

**ECONOMIC COSTS OF ALCOHOL
AND OTHER DRUG ABUSE IN ALASKA,
2005 UPDATE**

**PREPARED FOR:
THE ADVISORY BOARD ON
ALCOHOLISM AND DRUG ABUSE
DEPARTMENT OF HEALTH
& SOCIAL SERVICES**



Research-Based Consulting

Juneau
Anchorage

December 2005



Frank H. Murkowski, Governor, State of Alaska

**Karleen Jackson, Commissioner
Department of Health & Social Services**

**Kathy Craft, Interim Director
Advisory Board on Alcoholism & Drug Abuse**

December 28, 2005

www.hss.state.ak.us/abada

Acknowledgement

The Governor's Advisory Board on Alcoholism and Drug Abuse acknowledges the tireless efforts of Kaye Marie Taylor in securing and coordinating the funding that has made possible this update of Phase II of the Economic Costs of Alcohol and Other Drug Abuse in Alaska.

**ECONOMIC COSTS OF ALCOHOL
AND OTHER DRUG ABUSE IN ALASKA,
2005 UPDATE**

**PREPARED FOR:
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DEPARTMENT OF HEALTH
& SOCIAL SERVICES**

PREPARED BY:



JUNEAU • ANCHORAGE

DECEMBER 2005

TABLE OF CONTENTS

Executive Summary	1
Productivity Losses	6
Summary	6
Lost Production Due to Mortality	7
Lost Production Due to Diminished Productivity	10
Lost Production Due to Incarceration	12
Lost Production Due to Alcohol/Other Drug Treatment	15
Traffic Crashes	16
Criminal Justice and Protective Services	19
Criminal Justice	19
Protective Services.....	26
Health Care	28
Hospital Costs	29
Residential and Outpatient Alcohol and Other Drug Treatment Costs	31
Medical Outpatient Costs	32
Prescription Drugs and Nursing Home/Long-Term Care Costs	33
Fetal Alcohol Spectrum Disorders.....	34
AIDS and HIV Costs.....	37
Hepatitis B and C Costs	39
Co-Occurring Disorders	41
Co-Occurrence of Serious Mental Illness and Substance Dependence or Abuse	41
Bring the Kids Home Initiative	43
Public Assistance and Social Services	45
Cost of Underage Drinking in Alaska	46
Employment and Tax Impacts of Alcohol Sales	47
List of References	49

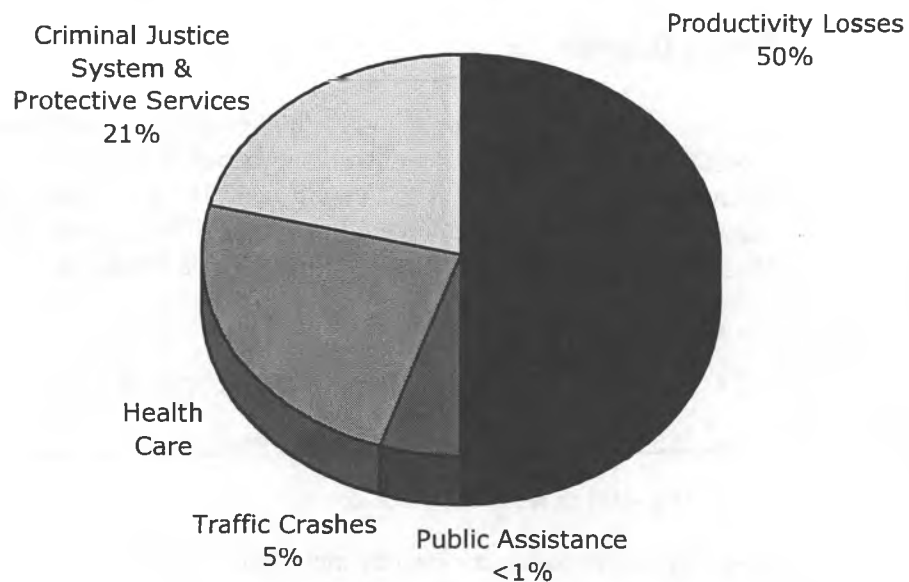
EXECUTIVE SUMMARY

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.

**Percentage of Costs by Category
Related to Alcohol and Other Drug Abuse in Alaska, 2003**



More detailed study results for each cost category are presented below. Some of the economic benefits related to the manufacturing and sale of alcohol are also included.

Productivity Losses

Lost productivity occurs when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for criminal offense, and inpatient treatment or hospitalization. The reduced efficiency of employees, or premature death of Alaska residents, results in less production of goods and services, and is thus a cost to society.

Alcohol and other drug abuse in Alaska cost an estimated \$367 million in lost productivity during 2003. Components of productivity losses and associated costs include:

- Premature death from alcohol and other drug abuse in Alaska resulted in an estimated \$183 million in lost productivity in 2003. The annual average number of deaths from alcohol and other drug abuse between 1999 and 2003 was 236.
- Workers impaired by alcohol and other drug abuse had an estimated reduced productivity in Alaska of \$136 million during 2003. This includes \$106 million in alcohol-related impairment and \$20 million in other drug-related impairment.
- Costs from alcohol and other drug-related incarcerations totaled an estimated \$39 million in lost productivity during 2003. During that period, 1,193 inmate incarcerations were directly related to alcohol and other drug abuse.
- Lost productivity from Alaska residents receiving inpatient treatment for alcohol and other drug abuse cost an estimated \$8.8 million in 2003.

Traffic Crashes

Alcohol and other drug abuse are a major cause of traffic crashes in Alaska. There were 1,109 traffic crashes in Alaska attributed to alcohol and other drug abuse during 2002. Of these crashes, 25 were fatal, 107 were major injury crashes, 370 were minor injury crashes, and 607 had property damage only. The estimated costs from these crashes were more than \$35 million. Costs included:

- \$16 million for legal costs.
- \$12 million for insurance administration costs.
- \$5 million for property damage costs.
- \$2 million for workplace costs.

Costs by traffic accident category included:

- \$26 million from major injuries.

- \$5 million from fatalities.
- \$2.5 million from minor injuries.
- \$1 million from property damage only.

Criminal Justice

Alcohol and other drug abuse contribute to crime and child abuse. In 2003, an estimated 17,400 arrests were attributed to alcohol and other drug abuse. During this same period, 15,800 Alaska residents were victims of alcohol and other drug abuse-related crimes. Costs attributed to crime-related alcohol and other drug abuse in the state were nearly \$154 million during this period. Crime costs in 2003 included:

- \$43 million for law enforcement.
- \$38 million for corrections.
- \$12 million for legal costs and court adjudication.
- \$636,000 for property damage.
- \$1.9 million in economic costs to victims.
- Adult and child protective services attributed to alcohol and other drug abuse cost an estimated \$59 million. These costs include foster care services, adoption care services, residential care services, and social worker services.

Health Care

Health care costs attributed to alcohol and other drug abuse result from illnesses or injuries. Examples of the kinds of health problems that can result from alcohol and drug abuse are cirrhosis of the liver, hypertension, diabetes, or stomach cancer. Health care costs related to alcohol and other drug abuse totaled an estimated \$178 million in 2003. Health care costs included:

- Hospital costs from illnesses and injuries were estimated at \$9.3 million. Alcohol abuse-related health care costs accounted for \$84.8 million, while other drug abuse-related costs were \$8.2 million.
- Alcohol and other drug residential and outpatient treatment costs were approximately \$26.8 million.
- Total medical outpatient costs from illnesses and injuries totaled an estimated \$25.7 million.
- Pharmaceutical costs were estimated at \$23.0 million, while nursing home costs were \$719,400.

- Medical care totaled \$3.9 million for patients with other drug-related HIV and HIV with AIDS. Approximately 78 HIV and HIV with AIDS cases were attributed to intravenous drug abuse.
- Costs for medical treatment of hepatitis B and C caused by intravenous drug abuse was \$5.1 million. Intravenous drug abuse contributed to 344 hepatitis B and C cases in Alaska in 2003.

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.

Employment Impacts of Alcohol Sales

Although the focus of this study is centered on the cost of alcohol and other drug abuse, there are some economic benefits associated with the sale of alcoholic beverages. These economic benefits include employment, income and tax revenues. In 2003, there were approximately 3,000 jobs in alcohol-related industries in Alaska, with earnings of approximately \$62 million. State excise tax revenue on alcoholic beverages, collected at the wholesale level, was approximately \$33 million in FY 2004.

Actual Costs

It is critical the reader recognize that the alcohol and other drug-related costs presented in this study are estimates only. Actual costs could be 25 percent higher or lower than the total presented in this report. Very little underlying data exists regarding the monetary impact of alcohol and other drug abuse in Alaska. There is a clear need for more comprehensive research.

For this report, the McDowell Group study team used national data to estimate Alaska's alcohol and other drug abuse costs and then adjusted these costs for Alaska's higher cost of living. The study team relied heavily on a 1998 publication from the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (NIDA/NIAAA, 1998), and a 1999 study for the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. As exhaustive and thorough as these studies are, they do not address Alaska's higher alcohol rates or its higher cost of providing services. Alaska's alcohol-dependent population is double the national average, according to results of the Alaska Adult Household Telephone Survey conducted by the Gallup Organization. In addition, cost-of-living indicators published by American Chamber of Commerce Researchers Association (ACCRA) show Anchorage health care costs were 65 percent higher than the national average during 2003.

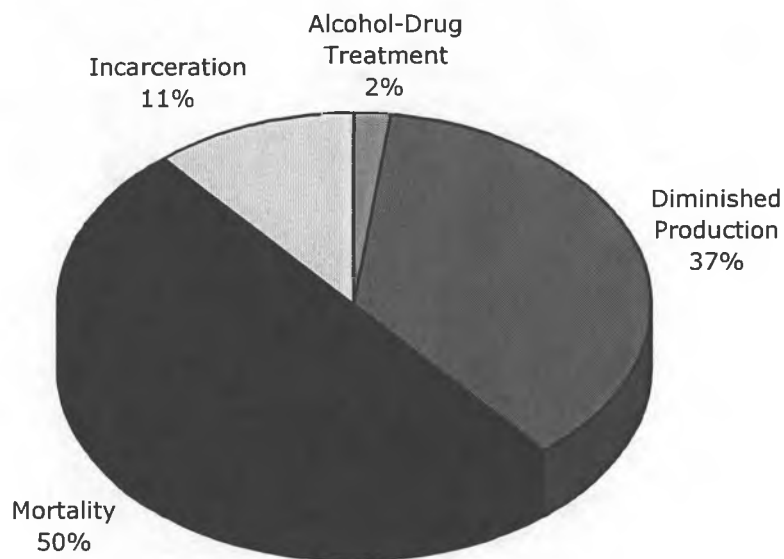
In nearly all cases, Alaska-specific data were not available on the amount of crime, health and medical costs, lost production, and public assistance that can be

attributed to alcohol and other drug abuse. Estimates rely on national norms based on tested methodologies. National norms are based on a lower prevalence of alcohol abuse and dependence than is the case in Alaska. Comprehensive development of Alaska-specific data is recommended.

Summary

Alcohol and other drug abuse cost Alaska an estimated \$367 million in lost productivity during 2003. Lost productivity occurs when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for criminal offense, and residents requiring inpatient treatment or hospitalization. Overall, the reduced efficiency of employees or premature death of Alaska residents results in less production of goods and services, and thus is a cost to society. Figure 1 illustrates the sources of lost productivity in the Alaska economy.

Figure 1
Percent of Lost Productivity for Alaska from
Alcohol and Other Drug Abuse in 2003



- Premature death from alcohol and other drug abuse in Alaska resulted in an estimated \$183 million in lost productivity in 2003. Males accounted for \$145 million in estimated losses and females, \$37.7 million. An average of 236 deaths annually can be attributed to alcohol and other drug abuse between 1999 and 2003. Alcohol and drug abuse accounted for approximately 8 percent of deaths in that period; the average annual number of deaths from all causes in Alaska was 2,964 between 1999 and 2003.
- Alcohol and other drug abuse can impair worker performance resulting in lost productivity. An estimated 39,596 Alaska residents are alcohol dependent, resulting in reduced productivity of \$106 million in 2003. Another

14,238 residents were drug dependent, resulting in \$30 million in diminished productivity. The male population accounted for the largest portion of lost productivity at \$111 million, while productivity losses for females were estimated at \$26 million.

- Of the 3,743 Alaska residents incarcerated in 2003, an estimated 1,193 incarcerations can be attributed to alcohol and other drug abuse. Lost productivity from alcohol and drug related incarcerations was estimated at \$39 million.
- Time spent by Alaska residents while receiving inpatient treatment for alcohol and other drug abuse resulted in approximately \$9 million in lost productivity in 2003. These figures do not include the actual cost of treatment.

Lost Production Due to Mortality

The largest cost to Alaska residents from alcohol and other drug abuse stems from productivity losses due to premature death. Death from alcohol and other drug abuse can result from suicide, motor vehicle crashes, homicide, cirrhosis, diabetes, or other medical causes. From an economic point of view, an Alaska resident provides two types of production benefits. The first is in the form of employment. By being employed, the resident is contributing to the overall benefit of Alaska society by producing goods and services. The second production benefit is from household services. An individual spends time caring for children, cleaning and maintaining a household like any wage and salary job, though that service is generally not compensated. Combined, these production losses contribute to the largest cost from alcohol and other drug abuse in Alaska.

Methodology

To estimate productivity losses from premature death, McDowell Group relied on the same methodology used in the "The Economic Costs of Alcohol and Drug Abuse in the United States - 1992" for the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (NIDA/NIAAA) published in 1998. The research team first applied attribution factors by diagnosis supplied in the NIDA/NIAAA study to annual deaths by diagnosis reported by Alaska Vital Statistics from 1999 to 2003. Second, 2000 estimates of the present value of life earnings by age and gender were obtained from a published report by University of California Professor Dorothy Rice. These values are a combination of earnings data and estimated value of household services, which originate from U.S. Bureau of Census data. Earnings were adjusted by 5.5 percent to reflect the change in annual per capita personal income from 2000 to 2003 reported by the Bureau of Economic Analysis. Finally, the number of deaths by age and gender attributed to alcohol and other drug abuse were multiplied by the appropriate present value of life earnings in 2003 dollars.

In summary, the value of an average person's lifetime productivity is estimated and, depending on their age at the time of premature death, lost productivity is

measured. It is important to note that this measure is not an estimate of "out-of-pocket" losses. Rather, it is a theoretical construct intended to reflect the fact that humans have the potential to be productive, and if life is cut short, society has suffered a loss of production potential.

Results

On average, there were 236 deaths in Alaska due to alcohol and other drug abuse between 1999 and 2003. Based on data from this period, alcohol and other drug abuse accounted for approximately 8 percent of all the deaths in the state (there was an annual average of 2,964 deaths from all causes between 1999 and 2003).

A breakdown of average annual deaths by age and gender is presented in Table 1. Of these deaths, 72 were females and 163 were males. From 1999 to 2003, the age group with the highest number of deaths for females was 40 and 44 (seven alcohol and other drug-related deaths) and 45 to 54 for males (36 alcohol and other drug-related deaths). Table 2 shows the number of alcohol and other drug-related deaths by cause during this period. Motor vehicle crashes (41 deaths) and suicide (33 deaths) were the major causes of premature death from alcohol and other drug abuse between 1999 and 2003.

Table 1
Average Annual Number of Deaths Attributed to Alcohol and Other Drug Abuse by Age and Gender, 1999-2003

Age	Males	Females
00-04	2.9	2.0
05-09	1.4	0.2
10-14	2.9	1.4
15-19	10.8	4.0
20-24	11.4	4.0
25-29	9.7	3.5
30-34	9.9	3.3
35-39	13.3	5.9
40-44	15.6	6.9
45-49	16.7	6.5
50-54	14.1	4.7
55-59	11.9	4.2
60-64	8.7	4.6
65-69	9.5	3.8
70-74	9.1	4.1
75-79	6.1	4.2
80-84	5.4	3.5
85+	4.0	5.2
Total	163.4	72.2

Source: Alaska Bureau of Vital Statistics.

Table 2
Average Annual Number of Deaths Attributed to Alcohol and
Other Drug Abuse by Diagnoses or Accident, 1999-2003

Illness or Accident	Average Deaths
Motor vehicle accidents	41.2
Intentional self-harm (suicide)	33.0
Mental and behavioral disorders due to use of alcohol	31.2
Assault (homicide)	20.0
Malignant neoplasm of esophagus	14.0
Cerebrovascular disease	11.8
Accidental drowning and submersion	9.1
Accidental poisoning by and exposure to alcohol	8.6
Fibrosis and cirrhosis of liver	8.2
Toxic liver disease	7.7
Malignant neoplasm of lip, oral cavity and pharynx	6.5
Accidental falls	5.4
Accidents caused by fire and flames	4.7
Psychoactive Substance (nondependent) abuse	4.4
Diabetes mellitus	4.2
Malignant neoplasm of stomach	4.0
Air and space transport accidents	3.3
Water transport accidents	3.1
Drug dependence	2.8
Pedal cyclist, motorcycle rider and ATV accidents	2.5
Alcoholic cardiomyopathy	2.4
Pneumonia and influenza	2.4
Acute pancreatitis	2.4
Other diseases of pancreas (including alcohol-induced and chronic)	0.9
Essential hypertension	0.8
Diseases of esophagus, stomach and duodenum	0.8
Respiratory tuberculosis	0.4
Alcoholic gastritis	0.2
Total	235.6

Source: Alaska Bureau of Vital Statistics.

Total economic loss from premature death of Alaska residents was \$183 million during 2003. Table 3 presents estimated loss of productivity by age and gender. Males accounted for almost \$145 million in lost productivity. Females accounted for approximately \$38 million. The most significant costs were associated with males in two age groups, those between the ages of 20 to 24 years and 40 to 44 years, which each accounted for \$18 million in lost productivity. Females age 35 to 39 years accounted for \$5 million, as did those age 40 to 44.

Table 3
Mortality Costs Attributed to Alcohol and Other Drug Abuse
By Age and Gender, 2003

Age	Males	Females
1-4	\$3,363,000	\$1,693,000
5-9	\$1,751,000	\$226,000
10-14	\$4,038,000	\$1,382,000
15-19	\$16,320,000	\$4,450,000
20-24	\$18,240,000	\$4,602,000
25-29	\$15,410,000	\$3,892,000
30-34	\$14,810,000	\$3,348,000
35-39	\$17,870,000	\$5,216,000
40-44	\$18,040,000	\$5,054,000
45-49	\$15,590,000	\$3,765,000
50-54	\$9,872,000	\$1,951,000
55-59	\$5,456,000	\$1,076,000
60-64	\$2,188,000	\$625,000
65-69	\$1,189,000	\$236,000
70-79	\$539,800	\$115,200
75-79	\$150,100	\$49,440
80-84	\$59,880	\$16,690
85 & over	\$12,000	\$4,255
Total	\$144,900,000	\$37,700,000

Source: Alaska Bureau of Vital Statistics and Dr. Dorothy Rice, University of California.

Lost Production Due to Diminished Productivity

Alcohol and other drug abuse by Alaska residents results in reduced productivity. This loss can come in the form of high absenteeism, reduced efficiency from diminished physical and mental abilities, or limited work history because of the individual's inability to hold a job. Abuses of alcohol and other drugs may also impact a person's ability to be productive in non-employment related activities like household or parenting services. In extremely severe cases, abusers of alcohol and other drugs can be hospitalized or even institutionalized, in essence removing the individual from productive society entirely. These productivity losses from alcohol and other drug abuse have a significant cost burden to the residents of Alaska.

Methodology

The primary method for estimating economic costs from diminished productivity was to measure lost earnings. The research team relied on estimates presented in the NIDA/NIAAA (1998) study that determined the percent of lost earnings from alcohol and other drug dependence. In the study, the authors estimated the loss of earnings from alcohol-dependent males at 9.4 percent of average earnings and lost earnings from other drug dependent males at 7.7 percent of average earnings. Estimates on lost earnings for the female alcohol and other drug-dependent population came from the 1990 Rice study on the economic impacts of alcohol and other drug abuse. These estimates were used because the authors of the NIDA/NIAAA (1998) study found no impacts to female earnings from alcohol or other drug dependence. The 1990 study reports a reduction in earnings from alcohol dependence of 6.9 percent and 5.4 percent from other drug dependence.

Estimates on the number of Alaskans who are alcohol and other drug dependent came from the 2003 National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration (SAMHSA). In the report, SAMHSA estimated that 10.4 percent of Alaska's population is classified with alcohol or drug dependence or abuse: 8.6 percent for alcohol and 3.1 percent for other drugs. Approximately 1.3 percent of the population is dependent or abusing both alcohol and drugs. SAMHSA reports that males are almost twice as likely to be classified with substance dependence or abuse as females.

Total costs from diminished productivity for male and females were calculated by multiplying diminished productivity by the number of Alaskans who were alcohol and other drug dependent in 2003. The research team collected data from the Alaska Department of Labor and Workforce Development (ADOL) on earnings for males and females during 2003. Alaska males earned an average of \$33,762 in 2003, while females earned \$23,056. The research team then estimated the annual loss in earnings by multiplying the percent decline in earnings for alcohol or other drug dependence for each gender by the appropriate annual Alaska earnings for 2003.

Results

In 2003, Alaska had approximately 39,596 adult residents classified with alcohol dependence or abuse and 14,238 residents classified with drug dependence or abuse. Of those alcohol-dependent residents, 27,355 were males and 12,240 were females. The drug-dependent population consists of 9,283 adult males and 4,956 adult females. Table 4 presents computation figures for estimating diminished productivity from alcohol and other drug dependence or abuse.

Table 4
Productivity Losses from Alcohol and
Other Drug Dependence or Abuse by Gender, 2003

	Alcohol		Other Drugs	
	Males	Females	Males	Females
Alaska population 18 years and over that is alcohol and other drug dependent	27,355	12,240	9,283	4,956
Annual average earnings for Alaska in 2003	\$33,762	\$23,056	\$33,762	\$23,056
Loss in productivity from alcohol and other drug dependence	9.4%	6.9%	7.7%	5.4%
Annual lost earnings from alcohol and other drug abuse	\$3,174	\$1,591	\$2,600	\$1,245
Estimated productivity loss from alcohol and other drug abuse	\$87 million	\$19 million	\$24 million	\$6 million

Sources: Alaska Department of Labor, Employment and Earnings report, 2003; SAMHSA 2003 National Survey on Drug Use and Health, and *The Economic Costs of Alcohol and Drug Abuse in the United States-1992* (NIDA/NIAAA, 1998).

The typical Alaska male alcohol abuser cost society \$3,174 annually in diminished productivity in 2003. The typical male drug abuser cost society \$2,600 in 2003. During that same period, the average female alcohol abuser cost society \$1,591 in lost production, while the typical female drug abuser cost society \$1,245. Total diminished productivity for Alaska from alcohol and other drug-dependent residents was an estimated \$137 million. Of those adults who abuse alcohol or are dependent, the largest portion was from the state's male population. An estimated \$87 million in diminished productivity was from males who abuse or are dependent on alcohol, and another \$19 million was from females. Diminished productivity from other drug dependence was estimated to cost the state economy \$30 million, \$24 million from males and \$6 million from females.

Lost Production Due to Incarceration

Another source of lost productivity for Alaska is from residents incarcerated because of alcohol and other drugs. Residents can be incarcerated for committing an alcohol or other drug related crime or from committing a crime while under the influence of alcohol or other drugs. An example of an alcohol or other drug-related crime would be distributing alcohol without a license or selling illegal drugs. Sexual assault is an example of a crime committed under the influence, where alcohol or other drug use was a contributing factor. Without alcohol or other drugs, incarcerated Alaskans could be productive members of society producing goods and services. While incarcerated, these individuals are generally not employed and thus are not productive members of society. This loss in productivity can be measured by estimating lost earnings.

Methodology

Estimates for lost productivity from incarcerations involved two steps. The first was to determine the number of Alaska residents incarcerated due to alcohol or other drug-related crimes. The research team relied on national attribution rates published in the NIDA/NIAAA (1998) study. These rates are presented in Table 5. These national attribution rates are thought to be lower than incarceration rates for Alaska from alcohol and other drug abuse. However, no Alaska-specific research has been completed to verify this premise. Currently, only anecdotal information is available. It is speculated that alcohol and other drug abuse plays a role in 85 percent to 95 percent of all incarcerations in Alaska.¹

Table 5
Attribution Rates for Alcohol and Other Drug-Related Incarcerations

	Alcohol	Other Drug
Homicide	30.0%	15.8%
Assault	30.0%	5.1%
Sexual assault	22.5%	5.1%
Robbery	3.4%	27.2%
Burglary	3.6%	30.0%
Larceny/theft	2.8%	29.6%
Auto theft	3.5%	6.8%
Drug laws	0.0%	100.0%
Driving under the influence	100.0%	0.0%
Liquor laws	100.0%	0.0%
Prostitution	0.0%	12.8%

Source: *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

The second step was to estimate potential loss of earnings from incarceration. The research team assumed that persons incarcerated because of alcohol and other drug abuse could be as productive as the general population. As shown above, ADOL indicates Alaska males earned \$33,762 in 2003 and females earned \$23,056. The earnings estimates were then applied to the alcohol and other drug-related incarcerated population for Alaska in 2003.

¹ Based on discussions with Sarah Williams, Coordinator of Substance Abuse Program, and Teri Carns, Staff Director for the Alaska Criminal Justice Assessment Commission.

Results

In 2003, there were 3,743 people incarcerated for crimes of all types (this is a count of the inmate population regardless of what year they were placed in a correctional facility, not the number of annual offenses). Of these, 1,193 incarcerations were attributed to abuse of alcohol and other drugs. Males accounted for most of the incarcerations attributed to abuse of alcohol and other drugs at 1,065 in 2003, while females accounted for 128 incarcerations.

Table 6 presents the number of people incarcerated for alcohol or drug related offenses in 2003 by offense and gender. These are not the number of incidences in a single year, but the cumulative total of those in prison as of December 31, 2003. Sexual assault, assault, and homicide were the primary offenses committed. Based on attribution rates shown in Table 5, an estimated 122 people were incarcerated for sexual assaults, 163 for assaults, and 122 for homicides attributed to alcohol abuse. Drug law violations were the primary offense associated with other drug abuse at 175 incarcerations.

Table 6
Alcohol and Other Drug-related Incarcerations in
Alaska by Offense and Gender, 2003

Offense	Alcohol		Other Drug	
	Females	Males	Females	Males
Homicide	7	115	4	61
Assault	11	152	2	26
Sexual Assault	1	121	0	27
Robbery	0	4	2	32
Burglary	0	2	0	21
Larceny-Theft	1	5	11	51
Auto Theft	0	1	0	3
Drug Laws	0	0	34	141
Driving under the influence	41	259	0	0
Liquor Laws	8	49	0	0
Prostitution	0	0	0	0
Total	70	708	54	360

Source: McDowell Group based on Alaska Department of Corrections 2003 Offender Profile data and attribution rates by offense from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998).

Total lost productivity from incarcerations from alcohol and other drug abuse in Alaska was \$39 million in 2003. Incarcerated males accounted for \$36 million, while females accounted for \$3 million in lost productivity.

Lost Production Due to Alcohol/Other Drug Treatment

The final source of lost productivity included in this study is from Alaska residents receiving inpatient alcohol and other drug treatment. Treatment includes long-term residential treatment, short-term hospitalization, and detoxification. While receiving treatment for alcohol and other drug abuse, patients are not productive residents in the Alaska economy, so society loses the benefit of their production of goods and services. This loss in productivity can be measured by estimating lost earnings.

Methodology

Total bed days for residential and detoxification treatment centers were used to estimate lost productivity in 2005 from time spent while undergoing alcohol and other drug treatment. Data for 2003 was not available, therefore 2005 is considered a reasonable proxy for 2003 bed days. Total bed days were then converted to work years. Work years were multiplied by average annual 2003 earnings of \$37,356 for all Alaskans, as reported by ADOL.

Results

DBH grantees reported 85,926 total bed days for alcohol and other drug abuse in 2005.² These total bed days was equivalent to 235 work years. Overall, total lost production from inpatient treatment for alcohol and other drug abuse was estimated at \$8.8 million. This figure does not include lost productivity from residents receiving substance abuse treatment outside the state. Although the exact number of these individuals is unknown, it is estimated that much of the private residential treatment received by Alaskans occurs outside of the state.³

² Source: Alaska Department of Health and Social Services, Mike Bellevue.

³ Source: Finding the Answers to Tough Questions About Substance Abuse in Alaska, 1999 Annual Report, State of Alaska Advisory Board on Alcoholism and Drug Abuse.

TRAFFIC CRASHES

Alcohol use is a major cause of traffic crashes in Alaska. In 2002, 1,109 traffic crashes were attributed to alcohol, costing an estimated \$35 million. Of these crashes, 25 were fatal injury crashes, 107 were major injury crashes, 370 were minor injury crashes, and 607 crashes had property damage only. According to the Alaska Department of Transportation and Public Facilities (ADOTPF), a traffic crash is alcohol-related under the following conditions:

- If the blood alcohol test given to the driver, pedestrian, pedal cyclists, or recreational vehicle operator was positive.
- If a police investigation indicated that alcohol consumption was a contributing factor.
- If a citation was issued for driving while under the influence of alcohol, driving with an open container of alcohol, or public drunkenness.

Methodology

To measure the cost of traffic crashes, the research team used two sources: State of Alaska 2002 alcohol-related traffic crash statistics from ADOTPF, and cost-per-accident data from the National Highway Traffic Safety Administration (NHTSA), adjusted for inflation to 2003 dollars.⁴ Crash data was divided into four categories: property damage only, minor injury, major injury, and deaths. These categories were matched to the national data, which shows unit costs from motor vehicle crashes in eight categories. McDowell Group matched minor injuries reported by ADOTPF with Maximum Abbreviated Injury Scale (MAIS) Level 1, classified as minimum injuries in the NHTSA report. Major injuries were matched to MAIS Level 5, classified as critical injuries by NHTSA. No extrapolation is needed for the remaining categories, property damage only and fatalities, which are in each study. Unit costs related to traffic crashes from the NHTSA report are presented in Table 7.

Table 7
Unit Costs of Traffic Crashes in the U.S., 2003

Type of Cost	Fatal	Major Injury (MAIS 5)	Minor Injury (MAIS 1)	Property Damage Only
Insurance administration	\$37,120	\$75,118	\$715	\$116
Workplace cost	\$8,702	\$8,191	\$252	\$51
Legal cost	\$102,138	\$88,753	\$172	\$0
Property damage	\$10,273	\$9,446	\$3,844	\$1,484
Total	\$158,233	\$181,508	\$4,983	\$1,651

Source: *The Economic Cost of Motor Vehicle Crashes, 2000*, NHTSA.

Other than knowing that other drugs are a contributing factor in traffic crashes, little is known about their significance, because only alcohol-related data is collected. In

⁴ *The Economic Cost of Motor Vehicle Crashes, 2000*, published by the National Highway Traffic Safety Administration (NHTSA).

the NHTSA study, costs from traffic crashes are divided into separate expense categories. This includes medical costs, loss in productivity from mortality and morbidity, insurance administration costs, workplace costs, legal costs, and property damage costs. To avoid double counting, the research team estimated insurance administration costs, workplace, legal and property costs. Losses in productivity and medical costs are accounted for in other sections of the report.

Cost estimates for alcohol-related traffic crashes were adjusted to reflect changes in the Alaska cost-of-living and in U.S. prices from 2000 to 2003. Inflation was estimated using the Anchorage consumer price index from the Bureau of Labor Statistics (BLS). Inflation over this period was approximately 8 percent. The source for the cost-of-living data was the American Chamber of Commerce Researchers Association (ACCRA). During 2003, Anchorage's cost-of-living was approximately 25 percent higher than the average participating city in the American Chamber of Commerce.

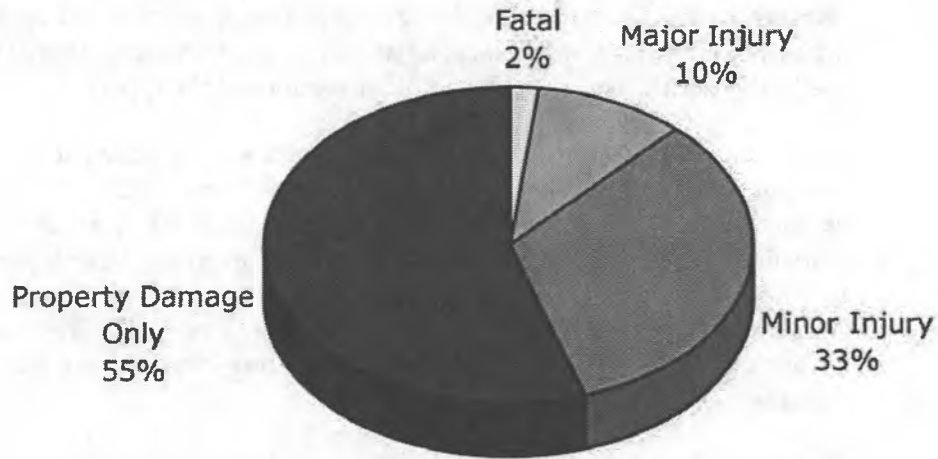
Traffic accident statistics include ATV and snowmobile crashes on roadways, but DOTPF does not collect ATV and snowmobile crashes off roadways, such as rivers, lakes, and in the backcountry. Lost productivity and health care costs associated with alcohol-related ATV and snowmobile deaths or injuries are included in the cost estimates. Property damage is not included.

Results

In 2002, 1,109 traffic crashes in Alaska were alcohol-related, about 8 percent of traffic crashes from all causes (13,325). However, the percentage of traffic fatalities caused by alcohol is much greater. About half of all U.S. fatal traffic crashes are caused by alcohol use (NHTSA, 1994). In Alaska, 32 percent of the 78 deaths from traffic crashes were attributed to alcohol in 2002. Figure 2 shows the number of alcohol-related crashes by category.

Adjusted to reflect 2003 dollars, alcohol-related traffic crashes in Alaska cost approximately \$35 million in 2003. Table 7 shows the cost of alcohol-related traffic crashes by severity and expense. Legal costs of \$16 million were the largest expense, followed by insurance administration costs at \$12 million. By crash category, major injuries accounted for the largest costs at \$26 million. Lost productivity associated with fatal crashes are not included in this estimate. (See chapter on Lost Productivity.) If these costs were included, the costs of alcohol-related traffic deaths would be far higher than other traffic crash categories.

Figure 2
Percent of Alcohol-Related Traffic Crashes by Type in Alaska, 2002



Source: Alaska Department of Transportation and Public Facilities.

Table 8
Number of Traffic Crashes and
Total Cost of Alcohol-Related Crashes in Alaska, 2003

Number of Traffic Crashes and Cost Type	Fatal	Major Injury	Minor Injury	Property Damage Only	Total Costs
Number of traffic crashes	25	107	370	607	1,109
Insurance administration cost (thousands of dollars)	\$1,245	\$10,787	\$355	\$94	\$12,482
Workplace cost (thousands of dollars)	\$292	\$1,176	\$125	\$42	\$1,635
Legal cost (thousands of dollars)	\$3,427	\$12,745	\$85	\$0	\$16,257
Property damage cost (thousands of dollars)	\$345	\$1,356	\$1,909	\$1,209	\$4,819
Total Costs (thousands of dollars)	\$5,309	\$26,064	\$2,474	\$1,345	\$35,192

Source: McDowell Group, Note: Number of accidents is based on 2002 data from Alaska Department of Transportation and Public Facilities report, *2002 Alaska Traffic Collisions*; and *The Economic Cost of Motor Vehicle Crashes, 2000*, NHTSA, adjusted for inflation and cost-of-living in Alaska.

CRIMINAL JUSTICE AND PROTECTIVE SERVICES

Alcohol and other drug abuse contribute to a majority of the criminal justice and protective services costs in Alaska. Combined, these costs totaled nearly \$154 million during 2003. Costs for police protection, legal and court services, and incarceration services totaled \$93.8 million in 2003. Child and adult protective services totaled nearly \$60 million in Alaska during 2003. Child protective services, the largest share of protective services, includes foster care, adoption care, residential care, and social worker services.

Criminal Justice

Like all states in the U.S., Alaska suffers from alcohol and other drug abuse-related crime. Nationwide, 49 percent of 14,000 inmates surveyed reported they were under the influence of alcohol and other drugs at the time of the offense (NIDA/NIAAA, 1998). In another study, it was reported that 2.5 million arrests were made in the U.S. for alcohol offenses, while another 1.5 million arrests were for other drug offenses (Schneider Institute for Health Policy, 2001).

In Alaska there were an estimated 17,000 arrests or offenses known to law enforcement in 2003 that were attributed to alcohol and other drug abuse. During the same period, approximately 57,000 Alaska residents were victims of alcohol and other drug abuse-related crimes. All combined, costs attributed to crime-related alcohol and other drug abuse in Alaska were \$93.8 million during this period.

The focus of this section is to provide estimates on the economic costs of crime-related alcohol and other drug abuse for Alaska during 2003.

Methodology

To estimate the economic costs of alcohol and other drug abuse-related crime, the research team relied on a methodology similar to that used in the NIDA/NIAAA (1998) report. Five cost measurements were used: law enforcement, legal and adjudication, corrections, victims' property damage, and victims' medical expenses. Within each category, crime-related attribution rates for alcohol and other drug abuse (NIDA/NIAAA, 1998) were applied to Alaska crime data.

To estimate enforcement and legal costs, estimates were based on data from the Alaska Department of Public Safety (DPS), and blended with attribution rates from the NIDA/NIAAA (1998) report. DPS prepares an annual report, "Crime Reported in Alaska," as part of the nationwide Unified Crime Reporting system. In 2003, law enforcement agencies reporting to DPS for the purposes of the UCR had jurisdiction over 97.5 percent of Alaska's population. The report presents data on offenses known to law enforcement for a proscribed group of offenses: murder, rape, aggravated assault, burglary, larceny-theft, and motor vehicle theft. This includes all offenses of which law enforcement is aware, whether or not an arrest was made. In addition, the report provides arrest data on a number of additional categories of

offense. For the purpose of this report, data on offenses known to law enforcement were used when available. When unavailable, straight arrest data was used. Variations between the two data types are noted when appropriate.

Though not used in this study, data from the Arrestee Drug Abuse Monitoring Program (ADAM) project provides an indication of the linkage between drug abuse and crime in Alaska. For example, a survey (including drug testing) of 718 male and female arrestees in Anchorage in 1999 found that 54 percent of males and 56 percent of females tested positive for one or more drugs (including cocaine, marijuana, opiates, Methamphetamine, and PCP).⁵ The ADAM project also collected arrestee data on alcohol use. The survey collected data on long-term and near-term drinking behavior prior to arrest for 1,178 males booked into Anchorage jails in 2000 and 2001. The authors of the summary report concluded that "among those that enter the criminal justice system through jails, problematic alcohol abuse is rampant."⁶

Inmate population by offense was used for correction cost estimates. Inmate counts were based on the Alaska Department of Corrections 2003 Offender Profile. The Offender Profile provides inmate counts by offense category as of December 31 of each year. Alcohol and drug abuse attribution rates from NIDA/NIAAA (1998) were applied to this data. Total expenditures by the Department of Corrections in 2003 were \$179 million.

Alaska population data from ADOL and victimization rates from the Bureau of Justice Statistics were used to estimate victim property damage and medical costs. In each case, Alaska-specific data by offense was multiplied by its associated attribute rate for alcohol and other drug abuse.

Attribution rates, arrests, and incarcerations related to alcohol and other drug abuse are presented in Tables 9 and 10.⁷ Victimization rates, victim numbers, and attribution rates related to alcohol and other drug abuse are shown in Table 11.

⁵ "Drug Abuse Among Arrestees in Anchorage", Alaska Justice Forum 17(1), Spring 2000.

⁶ "Alcohol Use Among Anchorage Arrestees", Alaska Justice Forum 19(4), Winter 2003.

⁷ Specific data on drug and alcohol arrests is available from the Alaska State Troopers Alaska Bureau of Alcohol and Drug Enforcement (ABADE). For example, ABADE alcohol-related arrest/charges included 43 for distribution/sales and 237 for transport in 2003. Cocaine related arrests/charges includes 53 for distribution/sales, 28 for transport and 24 for possession in 2003. Crack related arrests/charges includes 13 for distribution/sales and 11 for possession. Source: 2003 Annual Drug Report.

Table 9
Arrests Attributed to Alcohol and Other Drug Abuse in Alaska, 2003

Type of Offense	Total Number of Arrests	Alcohol Abuse	Drug Abuse	Arrests Attributed to Alcohol Abuse	Arrests Attributed to Drug Abuse	Total Substance Related Arrests
Murder	39	30%	16%	12	6	18
Aggravated Assault	2,638	30%	5%	791	135	926
Sexual Assault	575	23%	2%	129	14	143
Robbery	442	3%	27%	15	120	135
Burglary	3,809	4%	30%	137	1,143	1,280
Larceny-Theft	17,626	3%	30%	494	5,217	5,711
Auto Theft	2,411	4%	7%	84	164	248
Driving While Intoxicated*	4,987	100%	0%	4,987	0	4,987
Liquor Laws*	1,746	100%	0%	1,746	0	1,746
Stolen Property*	24	0%	15%	0	4	4
Prostitution*	59	0%	13%	0	8	8
Drug Laws*	2,187	0%	100%	0	2,187	2,187
Total	36,543			8,396	8,997	17,392

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998); and *Crime Reported in Alaska, 2003* from the Alaska Department of Public Safety.

Notes: Columns and rows may not total due to rounding.

* Categories marked with an asterisk (*) represent pure arrest data. Other categories are offenses known to law enforcement, which include arrests as well as offenses for which no arrest was made.

Table 10
Incarcerations Attributed to Alcohol and Other Drug Abuse in Alaska, 2003

Type of Offense	Alaska Inmates in 2003 by category	Percent Alcohol-related	Percent Other Drug Related	Incarcerations Attributed to Alcohol Abuse	Incarcerations Attributed to Other Drug Abuse	Total Incarcerations Related Alcohol and Other Drug Abuse
Murder	407	30.0%	15.8%	122	64	186
Aggravated assault	541	30.0%	5.1%	162	28	190
Sexual assault	543	22.5%	2.4%	122	28	150
Robbery	124	3.4%	27.2%	4	34	38
Burglary	70	3.6%	30.0%	3	21	24
Larceny/theft	209	2.8%	29.6%	6	62	68
Auto theft	40	3.5%	6.8%	1	3	4
Driving while intoxicated	300	100.0%	0.0%	300	0	300
Liquor laws	57	100.0%	0.0%	57	0	57
Prostitution	2	0.0%	12.8%	0	0	0
Drug laws	175	0.0%	100.0%	0	175	175
Total	2,468			778	414	1,192

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998); and incarceration data from Alaska Department of Corrections. Counts do not include entire inmate population; only those offenders in the specified categories are counted. Inmates whose offense was an "attempt" at any of the specified categories are included in the counts. For example, inmates imprisoned for "attempted murder" would be grouped in the "murder" category.

Notes: Columns and rows may not total due to rounding.

Table 11
Victimizations Attributed to Alcohol and Other Drug Abuse in Alaska, 2003

Type of Crime	Victimizations per 1,000 persons age 12 or older or per 1,000 households	Total Number of Victims	Percent Alcohol-related	Percent Other Drug Related	Number of Victims Attributed to Alcohol Abuse	Number of Victims Attributed to Other Drug Abuse	Total Number of Victims Attributed to Substance Abuse
Robbery	2.5	1,309	3.4%	27.2%	45	356	401
Assault	19.3	10,107	30.0	5.1	3,032	515	3,548
Personal larceny	124.4	28,506	2.8	29.6	798	8,438	9,236
Burglary	29.8	6,829	3.6	30.0	246	2,049	2,294
Motor vehicle theft	9	2,062	3.5	6.8	72	140	212
Sexual Assault	0.8	419	22.5	2.4	94	10	104
Murder	-	39	30.0	16.0	12	6	18
Total		49,232			4,299	11,514	15,813

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); population data from Alaska Department of Labor, and victimization rates from Bureau of Justice Statistics.

As reported under Productivity Losses, crime rates attributed to alcohol and other drug abuse are thought to be higher in Alaska than the rest of the nation. Attribution rates from the NIDA/NIAAA (1998) study were used to estimate Alaska crime rates related to substance abuse, because no Alaska-specific data is currently available to support this premise.

To measure criminal costs attributed to alcohol and other drug abuse, the research team used NIDA/NIAAA (1998) data to estimate the economic implications of criminal activity. After adjusting for inflation and the Alaska cost-of-living differential, law enforcement costs per arrest ranged from \$60 to \$4,100, depending on the offense, while the average legal costs for most offenses were \$1,100 per arrest. Legal costs for driving while intoxicated, liquor laws, and public drunkenness were approximately \$60 per arrest. Average incarceration costs per inmate were approximately \$33,500. Property damage and medical costs per victim by crime type are presented in Table 12. These unit costs were used to estimate the costs of arrests, incarcerations, and victimizations related to alcohol and other drug abuse.

Table 12
Property Damage and Medical Expenses per Victim, 2003

Type of Crime	Property Damage Expenses per Victim	Medical Expenses per Victim
Robbery	\$27	\$10
Assault	46	540
Rape	-	72
Murder**	-	23,816
Larceny	31	-
Burglary	58	-
Motor vehicle theft	207	-

Source: McDowell Group estimates based on NIDA, NIAAA 1992 and the Bureau of Justice Statistics.
** Medical costs for homicides include long-term costs. See NIDA/NIAAA (1998), Appendix C, Table C.6.

As noted above, costs were adjusted to reflect changes in U.S. prices from 1992 to 2003, as well as the cost-of-living in Alaska. Bureau of Labor Statistics inflation rates specific to health care were used to inflate health care and medical expenses (a 56 percent inflation rate). To adjust for Alaska's higher medical costs relative to the rest of the country, medical expenses for victims were increased by a 65 percent health care-specific cost-of-living differential. This differential was drawn from American Chamber of Commerce Research Association data for fourth quarter 2003.

Additional costs from lost productivity due to incarceration are presented in the Productivity Losses chapter to avoid double counting. Inmates are generally not employed while incarcerated, so society loses the benefit of their production of goods and services.

Drug traffic control costs were not included in this report. The U.S. budget in fiscal year 2003 for drug traffic control was \$11 billion.⁸ Some portion of this money was spent in Alaska for drug interdiction, international intelligence, research, and a number of other drug-related activities. However, specific information on Alaska's portion of this budget is not available.

Results

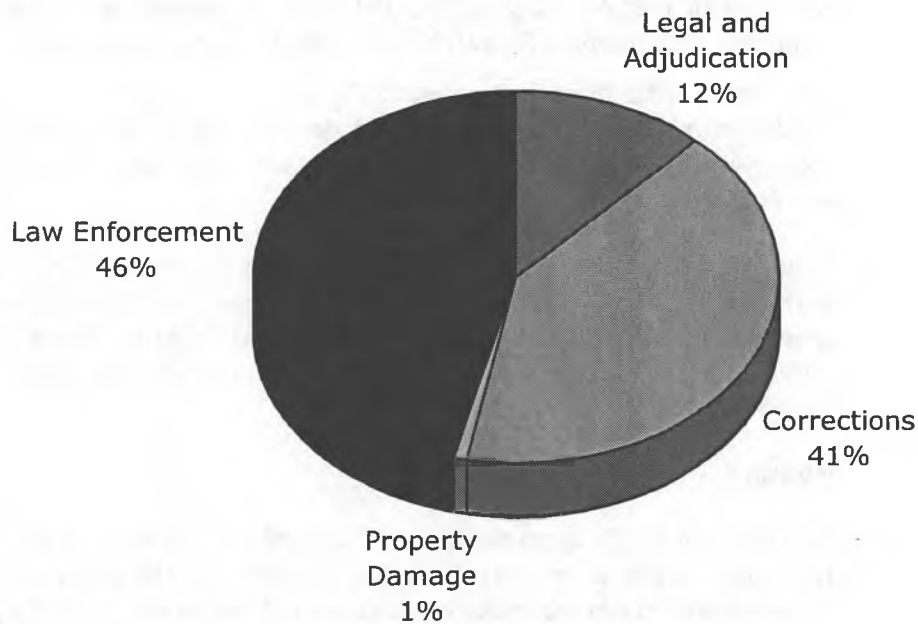
In Alaska in 2003, approximately 17,400 offenses known to law enforcement and 1,190 incarcerations were attributed to alcohol and other drug abuse. Of the 17,400 arrests, 8,400 crimes were related to alcohol abuse, while other drug abuse accounted for 9,000 crimes. Among incarcerations, 780 were alcohol-related and 410 were other drug-related.

Alaska also had an estimated 15,800 residents who were victims of alcohol or other drug abuse-related crimes. The number of victims who had property damage was 11,700, while 4,100 of the victimizations were against a person.

Figure 3 shows the distribution of alcohol and other drug-related crime by cost. Total costs for Alaska substance abuse-related crime were \$93.8 million in 2003. The largest expense was law enforcement at \$43.4 million, followed by correction costs at \$38.2 million and legal and adjudication costs at \$11.6 million. Property damage costs totaled more than \$636,000 and medical costs to victims totaled \$1.9 million. Medical costs are reported in this chapter for reference, but were not added to total crime-related costs to avoid double counting. Medical costs are included in the Health Care chapter.

⁸ Bureau of Justice Statistics, <http://www.ojp.usdoj.gov/bjs/dcf/dcb.htm>, retrieved 8/17/05.

Figure 3
Distribution of Criminal Justice Costs Attributed to Alcohol and Other Drug Abuse in Alaska, 2003



Note: Figures may not add to 100% due to rounding.

Table 13 presents law enforcement costs from alcohol and other drug-related crime for Alaska during 2003. Larceny and theft accounted for the largest expense at \$23 million. Burglary accounted for \$5.2 million and assault for \$3.7 million.

Legal costs from alcohol and other drug-related crimes for Alaska during 2003 are presented in Table 14. Larceny and theft were the largest expense at \$6 million. Costs for burglary were \$1.3 million, and for assault were \$972,000.

Among Alaska incarceration costs in 2003, costs for inmates imprisoned for driving while intoxicated were greatest, at \$10 million. This is a substantial increase from 1999, due largely to a more than doubling of the inmate population for DWI crimes. This was followed by costs for aggravated assault, at \$6.4 million and homicide at \$6.2 million. Drug laws were fourth, at \$5.9 million, and sexual assault followed, at \$4.5 million. Table 15 presents incarceration costs for Alaska during 2003 by offense.

Table 13
Law Enforcement Costs Attributed to
Alcohol and Other Drug Abuse by Offense in Alaska, 2003

Type of Offense	Alcohol	Drug	Total
Homicide*	\$47,000	\$25,000	\$71,000
Aggravated Assault*	3,196,000	544,000	3,740,000
Sexual Assault*	512,000	47,000	559,000
Robbery*	61,0600	485,000	545,000
Burglary*	555,000	4,610,000	5,165,000
Larceny-Theft*	1,986,000	21,066,000	23,051,000
Auto Theft*	348,000	657,000	1,005,000
Driving while intoxicated	311,000	-	311,000
Liquor Laws	107,000	-	107,000
Stolen Property	-	15,000	15,000
Prostitution	-	30,000	30,000
Drug Laws	-	8,831,000	8,831,000
Total	\$7,122,000	\$36,307,000	\$43,430,000

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998); and offense data from Alaska Department of Public Safety, *Crime in Alaska, 2003*.

* Categories marked with an asterisk (*) represent pure arrest data. Other categories are offenses known to law enforcement, which include arrests as well as offenses for which no arrest was made.

Note: Columns and rows may not total due to rounding.

Table 14
Legal and Adjudication Costs Attributed to
Alcohol and Other Drug Abuse by Offense in Alaska, 2003

Type of Offense	Alcohol-Related	Drug-Related	Total
Homicide	\$11,000	\$5,000	\$16,000
Aggravated assault	832,000	140,000	972,000
Sexual assault	140,000	23,000	163,000
Robbery	16,000	125,000	141,000
Burglary	142,000	1,195,000	1,337,000
Larceny-theft	520,000	5,494,000	6,013,000
Auto theft	97,000	174,000	271,000
Driving while intoxicated	311,000	-	311,000
Liquor laws	107,000	-	107,000
Stolen property	-	4,000	4,000
Prostitution	-	8,000	8,000
Drug laws	-	2,299,000	2,299,000
Total	\$2,176,000	\$9,468,000	\$11,644,000

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998); and offense data from Alaska Department of Public Safety, *Crime in Alaska, 2003*.

Note: Columns and rows may not total due to rounding.

Table 15
Incarceration Costs Attributed to
Alcohol and Other Drug Abuse by Offense in Alaska, 2003

Type of Offense	Alcohol-Related	Other Drug-Related	Total
Homicide	\$ 4,163,000	\$2,195,000	\$6,358,000
Aggravated assault	5,540,000	936,000	6,477,000
Sexual assault	4,122,000	444,000	4,566,000
Robbery	152,000	1,216,000	1,368,000
Burglary	85,000	708,000	792,000
Larceny/theft	202,000	2,110,000	2,312,000
Auto theft	47,000	93,000	140,000
Driving while intoxicated	10,074,000	-	10,074,000
Liquor laws	-	-	-
Prostitution	-	-	-
Drug laws	-	6,097,000	6,097,000
Total	\$24,384,000	\$13,800,000	\$38,184,000

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); and incarceration data from Alaska Department of Corrections.

Note: Columns and rows may not total due to rounding.

This incarceration data does not include Alaska Statute Title 47 Protective Holds in Department of Corrections Facilities. Department of Corrections data does not specify the reason for each protective hold, but DOC staff indicate that the “vast majority [of protective holds] are the result of incapacitation due to alcohol use.” For the years 2000-2002, there were a total of 7,920 protective holds for 3,243 individuals.⁹ Estimates of the annual cost of these protective holds are not available.

Protective Services

Alcohol and other drug abuse is a primary contributor to child abuse and neglect cases in Alaska. In a study completed by the National Center on Addiction and Substance Abuse at Columbia University in 1999, it was found that parents were three times more likely to abuse their children and four times more likely to neglect their children if the parents were substance abusers. In that same study, approximately seven out of ten abused or neglected children nationwide are linked to parents who abuse alcohol and other drugs. In a study completed by the Alaska, Department of Health and Social Services, Division of Alcohol and Drug Abuse (DADA) (now part of the Division of Behavioral Health), approximately 81 percent of all Division of Family and Youth Services (DFYS) (now the Office of Children’s Services) reports of child abuse involved alcohol and drug abuse.^{10,11}

⁹ “Analysis of Title 47 Protective Holds in Department of Corrections Facilities, CY 00-02.” Undated document.

¹⁰ *Final Report of the Alaska Criminal Justice Assessment Commission*, May 2000, published by the Alaska Judicial Council.

Methodology

Currently, there is no accurate measure of the cost to Alaska from child abuse and neglect caused by alcohol and other drug abuse. To overcome this shortfall, the research team relied on the 1999 DADA child abuse estimate and assumed that 81 percent of child protective services were attributable to alcohol and other drug abuse. These services include foster care, adoption care, residential care, and social work care through the Office of Children's Services (OCS). In addition, the Office of Public Advocacy (OPA) provides child protective services. Their services include advocacy within the legal system for children under state custody. Their total FY2003 expenditure was \$13.8 million. Unfortunately, OPA was not able to provide the portion of their budget that is attributed to child protective services.

Adult protective service costs during 2003 were provided by Division of Senior and Disability Services, in the Department of Health and Social Services. The division provides assistance to adults who are unable to care for themselves, either because of physical, emotional, or mental impairment. Total expenditures on adult protective services in 2003 were \$733,000. Department personnel estimate that 20 percent of all protective services cases are related to substance abuse or dependence by the care recipient. Another 20 percent of the cases the department handles are linked to substance abuse or dependence by primary caregivers or other family members.

Results

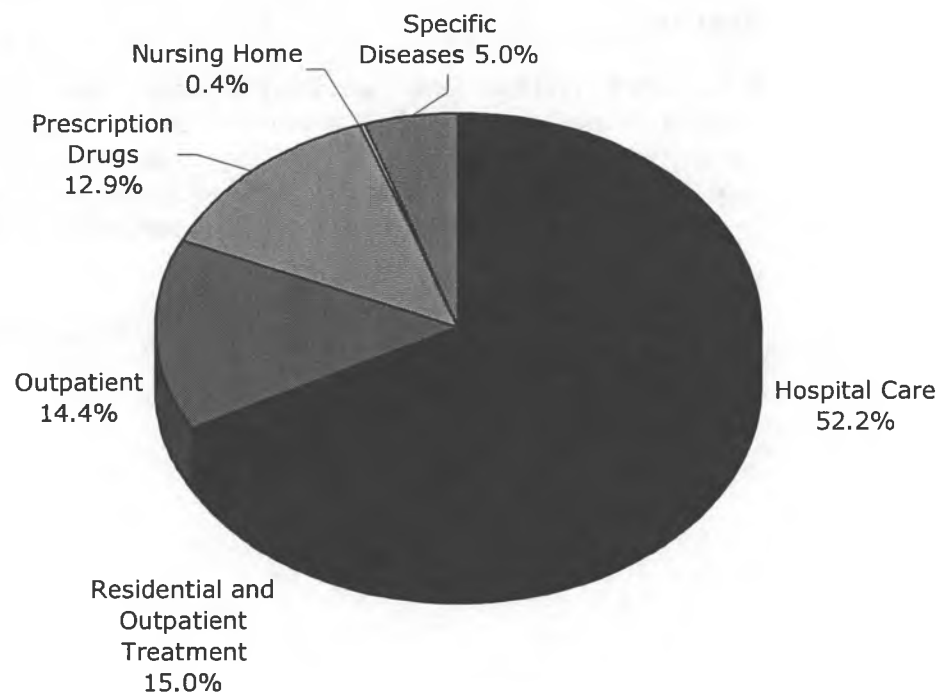
Total costs for child protective services provided by the Office of Children's Services in Alaska during fiscal year 2003 were nearly \$60 million. Social work accounted for the largest expense at \$18.4 million. Other expenses include \$13 million for foster care services, \$14 million for residential services, and \$13.7 million for adoption and guardianship services. Additional program funding for child abuse prevention programs was \$1.6 million.

Adult protective care services were estimated at \$293,000 during 2003.

Illness and injuries stemming from alcohol and other drug abuse have significant health costs. In Alaska, health care costs related to alcohol and other drug abuse are estimated at \$178 million. Alcohol and other drug-related illnesses or injuries range from acute to chronic. Acute illness includes alcohol poisoning, while chronic illness could be cirrhosis of the liver. In addition, prolonged alcohol and other drug abuse could increase the chance of other illnesses such as hypertension, diabetes, or stomach cancer.

This chapter estimates health care costs related to alcohol and other drug abuse in Alaska during 2003. Health care costs are presented for the following categories: hospital, outpatient, prescription drugs, nursing home and long term care facilities, fetal alcohol syndrome (FAS), HIV, and hepatitis B and C.

Figure 4
Distribution of Health Care Costs Related to Alcohol and Other Drug Abuse in Alaska, 2003



- Based on estimates made in this study, hospital costs from alcohol and other drug abuse-related injuries and illnesses in Alaska total \$93 million in 2003. Alcohol abuse-related hospital care for medical illnesses and injuries costs accounted for \$84.8 million, while other drug abuse-related costs were \$8.2 million.

- Alcohol and other drug in-resident and outpatient drug and alcohol treatment costs paid through state funding were approximately \$26.8 million,
- In 2003 there were and estimated 60,100 medical outpatient visits from alcohol and other drug abuse-related illness or injuries. The total cost of those outpatient visits is \$25.7 million in 2003.
- Pharmaceutical and long term care costs from alcohol abuse are estimated at \$23.0 million and \$719,400, respectively.
- Approximately 78 HIV and HIV with AIDS cases were attributed to intravenous drug use during 2003. Total medical costs for treating these patients were \$3.9 million.
- Intravenous drug abuse contributed to 344 hepatitis B and C cases in Alaska during 2003, with medical care costs of \$5.1 million.

Excluded from the total values are the costs of care for individuals with Fetal Alcohol Syndrome and other Fetal Alcohol Spectrum Disorders. Data on the number of individuals living with FASD in Alaska is unavailable. However, information on the number of children born with FAS in a given year is available, as are estimates for lifetime costs of care. Estimated lifetime health care costs for the 15 FAS births in 2003 are \$47.0 million.

Hospital Costs

Hospital costs from illness and injuries are a significant portion of alcohol and other drug-related health care costs. In 2003, hospital costs from illness and injuries accounted for 52 percent of total health care costs related to alcohol and other drug abuse (which totaled \$178 million). Hospital costs are composed of three sources:

- Illness or injuries directly related to alcohol and other drug abuse, which might include alcohol cirrhosis or gastritis.
- Illness indirectly related to alcohol and other drug abuse, which could include cancer of the esophagus, burns, or poisoning.
- Treatment or injuries complicated by alcohol and other drug abuse resulting in lengthy hospital stays.

Methodology

To estimate injury and illness-related hospital costs from alcohol and other drug abuse, the research team relied on results of two studies: the *National Survey on Drug Use and Health*, conducted annually by the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Social Services; and *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992*, NIDA/NIAAA (1998).

The NSDUH showed that 10.4 percent of Alaska's population age 12 and older was dependent upon or had abused illicit drugs or alcohol in 2003, while the U.S. national average was 4.5 percent. Alaska's portion of the U.S. substance dependent or abusing population was 0.5 percent.

No Alaska-specific data exists on the number of hospital inpatient days related to drug and alcohol abuse; to estimate this number, the research team adjusted NIDA/NIAAA (1998) estimates to reflect growth in the U.S. population, and used the factor for Alaska's alcohol and drug-dependent population (0.5 percent) to determine the number of hospital care days in the state. The NIDA/NIAAA study reported costs for non-federal and federal/veteran inpatient care, as well as costs for alcohol and other drug-related hospital and outside physician services. Cost estimates were adjusted to reflect U.S. price inflation for health care from 1992 to 2003 and Alaska health care costs. Inflation in nationwide health care costs over the time period was approximately 56 percent according to the Bureau of Labor Statistics. During fourth quarter 2003, health care costs in Fairbanks (the largest Alaska city included in 2003 American Chamber of Commerce Research Associates – ACCRA cost-of-living data) were approximately 65 percent higher than a national average. After adjusting for inflation and Alaska health care costs, estimated average cost per day for hospital care in 2003 was \$2,099. The daily cost for physician care averaged \$504.

Total Alaska non-federal hospital costs from illness and injury-related substance abuse were estimated by applying daily hospital costs to the estimated number of hospital care days related to alcohol and other drug abuse. Hospital costs were divided into three categories for alcohol: alcohol-specific illness, alcohol-related illness, and additional costs from co-occurring alcohol disorders. Other drug categories include other drug-specific illness, other drug-related illness, and additional days from other drug disorders.

Substance abuse-related hospital stay costs for illnesses and injuries in a veterans' or federal facility were estimated using the methodology from the NIDA/NIAAA (1998) study. In that study, veterans' and federal hospital revenues accounted for 9.5 percent of total U.S. hospital revenues. By applying this proportion to non-federal hospital costs for substance abuse, the research team estimated hospital costs for the federal facilities for Alaska during 2003.

Results

The estimated total number of hospital care days related to alcohol and other drug abuse illnesses and injuries were 32,900 in Alaska during 2003. Alcohol abuse accounted for an estimated 30,000 care days, while 2,900 were from other drug abuse. Among alcohol abusers, total hospital care days were estimated as follows: specific illnesses at 2,300, related illnesses at 22,700, and co-occurring alcohol disorders at 5,000. Estimated number of hospital care days for other drug abuse-specific illnesses was fewer than 10, while hospital care days for other drug abuse-related illnesses are not included in hospital costs to avoid double counting. These costs are presented later in this chapter. Additional days from other drug disorders were estimated at 2,900 hospital care days. Table 16 presents results on the number of care days by category for Alaska in 2003.

Table 16
Hospital Costs for Illness and Injuries
Related to Substance Abuse in Alaska, 2003

	Total Care Days	Non-Federal Hospital Costs	Veteran and Federal Hospital Costs	Total Hospital Costs
Alcohol-specific illness	2,300	\$6,072,400	\$514,000	\$6,586,300
Alcohol-related illness	22,700	59,164,600	5,007,800	64,172,400
Additional days from co-occurring alcohol disorders	5,000	12,931,600	1,094,600	14,026,100
Subtotal, alcohol abuse	30,000	78,168,600	6,616,300	84,784,900
Other Drug abuse-specific illness	<10	14,800	1,300	16,100
Other Drug abuse-related illness	*	*	*	*
Additional days from other drug disorders	2,900	7,586,700	642,200	8,228,900
Subtotal, other drug abuse	2,900	7,601,600	643,400	8,245,000
Total alcohol and other drug abuse	32,900	\$85,770,100	\$7,259,700	\$93,029,900

Source: McDowell Group, based on alcohol and drug dependent population estimates from the 2003 National Survey on Drug Use and Health, from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; and U.S. hospital care days and costs per day related to alcohol and other drug abuse from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

*These costs include HIV, and Hepatitis A and B, which are presented later in the chapter.

Alaska hospital costs from alcohol and other drug abuse-related medical injuries and illness in 2003 were estimated at \$93 million (Table 16). Non-federal hospitals accounted for \$85.8 million, while veterans and federal hospitals were \$7.3 million. Estimated hospital costs injuries and illness related to alcohol and other drug abuse were \$84.8 million and \$8.2 million, respectively. Alcohol-related illnesses resulted in the highest hospital costs at \$64 million.

Data maintained in the Alaska Department of Health and Social Services Alaska Trauma Registry, for the years 1997 through 2001, provides an indication of the number of accidents where alcohol and/or illegal drug use, at the time of the accident, was suspected or proven. Of approximately 22,700 trauma incidents recorded in the registry, alcohol use was suspected or proven in 24 percent of the cases and illegal drug use was suspected or proven in 10 percent of the cases.

Residential and Outpatient Alcohol and Other Drug Treatment Costs

In 2003, there were 4,006 substance abuse treatment admissions in Alaska. Just over 80 percent of these admissions were for alcohol or alcohol with secondary drug issues.

There are several categories of costs related to the treatment of alcohol and drug abuse and dependence in resident and outpatient facilities. The Alaska Department of Health and Social Services, Division of Behavioral Health, provides grant funds to organizations and agencies throughout the state in support of drug and alcohol treatment services. Specific services include rehabilitation, counseling, case management, and other types of treatment services for individuals and families. In addition, Medicaid pays for treatment in facilities within and outside of Alaska for qualifying Alaskans. Treatment can also be paid through private insurers or private parties.

Data pertaining to the state-funded treatment, both through DBH and through Medicaid, is readily available. Data on costs borne by private insurers or private parties is not available. As a result, cost estimates presented underestimate the total cost of drug and alcohol treatment.

Funding appropriated by the DBH to support alcohol and drug abuse treatment in 2003 totaled approximately \$23.3 million. Payments from Medicaid for substance abuse services in 2003 totaled \$3.5 million. These payments account for treatment received in substance abuse-specific treatment facilities. Not included in these treatment costs are any services for co-occurring disorders that may have been billed by mental health or other providers. Costs for lab tests for drug and alcohol screening are also excluded from this number. Because Health and Social Services provided the data on both DBH and Medicaid directly, no estimate procedures were needed.

Data from the National Survey of Substance Abuse Treatment Services (N-SSATS) provides data on the number of treatment facilities and clients in substance abuse treatment. As of March 2004, there were 2,503 clients in substance abuse treatment in 69 facilities in Alaska. Just over half of those clients (53 percent) were in private non-profit treatment facilities, 8 percent were in private for-profit facilities, 9 percent were in local government facilities, 14 percent were in federal government facilities, and 16 percent were in tribal government facilities.¹²

Medical Outpatient Costs

Another health expense related to alcohol and other drug abuse is outpatient medical treatment for a specific disorder or illness related to alcohol and other drug abuse. Examples of specific disorders could include alcohol gastritis or cirrhosis, while a related illness could be chronic pancreatitis or cancer of the esophagus.

Methodology

Like hospital costs, specific data on alcohol and other drug abuse-related medical outpatient visits was not available for Alaska. To estimate these costs, the research team applied Alaska prevalence figures to U.S. estimates for alcohol abuse-related medical outpatient visits reported in the NIDA/NIAAA (1998) study. The NIDA/NIAAA study did not report any medical outpatient visits for other drug

¹² N-SSATS State Profile - Alaska 2004.

abuse-specific disorders because of the lack of data and causal relationships needed to estimate the medical outpatient visits. Other drug abuse medical outpatient visits related to HIV and Hepatitis B and C are presented later in the chapter.

Estimated medical outpatient visits were multiplied by the average medical outpatient cost for alcohol and other drug abuse-related illnesses and injuries. Cost estimates were adjusted to reflect changes in U.S. prices from 1992 to 2003, and Alaska health care costs. Inflation was estimated at 56 percent using U.S. consumer price index for health care expenditures from the U.S. Bureau of Labor Statistics. Alaska health care cost data came from ACCRA. During fourth quarter 2003, health care costs in Fairbanks (the largest Alaska city for which data were available) were approximately 65 percent higher than the average participating city. After adjusting for inflation and cost-of-health care in Alaska, the estimated average cost for an alcohol and other drug abuse-related medical outpatient visit was \$504.

Results

Alcohol abuse-related medical outpatient visits in Alaska during 2003 were estimated at \$25.7 million. Alcohol-related disorders accounted for 52,200 estimated visits, while alcohol-specific illnesses had an estimated 7,900 visits. Table 17 presents estimated medical outpatient visits and costs for alcohol abuse-related disorders.

Of the total \$25.7 million in alcohol abuse-related outpatient medical costs in 2003, alcohol abuse-related illness and injury contributed an estimated at \$22.3 million, while alcohol abuse-specific illness and injury contributed \$3.4 million.

Table 17
Medical Outpatient Visits and Costs Related to Alcohol Abuse in Alaska, 2003

	Outpatient Visits	Outpatient Costs (thousands of dollars)
Alcohol-specific	7,900	\$3,373,000
Alcohol-related	52,200	22,286,000
Total, Alcohol Abuse	60,100	\$25,659,000

Source: McDowell Group, based on alcohol and other drug-dependent population estimates from *National Survey on Drug Abuse and Health, 2003*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; and U.S. medical outpatient and costs related to alcohol abuse from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998).

Prescription Drugs and Nursing Home/Long-Term Care Costs

Although not as high as hospital and medical outpatient costs, alcohol and other drug abuse also have prescription drug and nursing home costs. Prescription drugs are prescribed for alcohol abuse-specific illnesses such as cirrhosis or alcohol-related cancer. Long-term care and nursing home costs estimates are for residents who have a primary alcohol abuse-specific diagnosis.

Methodology

Alcohol-related prescription drug costs were estimated using Alaska prevalence data on substance abuse. Prevalence estimates were applied to the total U.S. prescription drug costs related to alcohol abuse, as published in the NIDA/NIAAA (1998) study. These totals were adjusted to reflect population growth, inflation, and the cost of health care in Alaska. In the study, 2.2 percent of U.S. prescription drug costs for all illnesses were attributed to alcohol abuse. Prescription drug costs related to other drug abuse were not estimated due to the lack of national data.

Nursing home costs related to alcohol abuse were estimated using data from the Alaska Department of Health and Social Services and the NIDA/NIAAA (1998) study. HSS collects data on the number of long-term care days per care facility in Alaska, as well as the daily rate information for each facility. There were an estimated 219,400 total nursing home and long-term treatment care bed days in Alaska for all during 2003, while cost per day of care averaged \$328 per day, with a range of \$213 to \$625 per day. The cost of Alaska nursing home care for all illnesses and injuries during 2003 was approximately \$71.9 million. Based on estimates published in the NIDA/NIAAA (1998) study, approximately 1 percent of the nation's nursing home care costs can be attributed to alcohol abuse-specific illnesses. The research team applied 1 percent to total nursing home and long term care costs in Alaska during 2003.

Results

Estimated pharmaceutical costs related to alcohol abuse in Alaska during 2003 were approximately \$23.0 million. Alcohol abuse-related nursing home care days totaled 2,194 in Alaska during 2003. Costs from these visits amounted to approximately \$719,000.

Fetal Alcohol Spectrum Disorders

Prenatal exposure to alcohol can cause specific birth defects which may include physical, mental, behavioral, and learning disabilities. Many children with fetal alcohol disorders are not identified until they reach school age or later. Individuals with alcohol-related effects may have difficulties with attention, memory, and problem solving. Heart, liver, and kidney defects are also common, as well as vision and hearing problems.¹³ Alcohol-related effects that fall within the broad category of fetal alcohol spectrum disorders (FASD) include:

- fetal alcohol syndrome (FAS),
- partial FAS (PFAS),
- fetal alcohol effects (FAE),
- alcohol-related neurodevelopmental disorder (ARND),
- and other alcohol-related birth defects (ARBD).¹⁴

¹³ National Organization on Fetal Alcohol Syndrome, *What is FAS/FASD?*, www.nofas.org/faqs.aspx?id=9

¹⁴ US Department of Health and Human Services, SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence. *The Language of Fetal Alcohol Spectrum Disorders*.

During the past ten years, a number of FAS prevalence rates have been established. Studies by the Centers for Disease Control and Prevention indicate a national rate from 0.2 to 1.5 cases per 1,000 births across various populations.¹⁵ Other studies, including those focusing on specific high-risk populations such as Native Americans, other minorities and families living in poverty have indicated rates from 0.5 to 5.0 per 1,000 live births. Clearly, the data is varied and limited.

In establishing a clear number of infants born each year in the United States with Fetal Alcohol Syndrome, the CDC estimates between 1,000 and 6,000 children will be born with FAS each year – a preventable birth defect and disability.

Beginning in 1997, Alaska was one of five states comprising the CDC's Fetal Alcohol Syndrome Surveillance Network (FASSNet), a program established to provide consistent and comparable FAS prevalence rates. Participating states included Arizona, Colorado, New York, Wisconsin and Alaska (however, FAS rates for Wisconsin are not available). At 1.5 per 1,000 live births, Alaska has a significantly higher rate of children born with FAS than other states in the FASSNet program. In addition, Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives. CDC data indicates FAS prevalence rates ranging from 0.3 per 1,000 in Arizona and Colorado to 0.4 in New York.

CDC estimates that other prenatal alcohol-related conditions, such as ARND and ARBD, occur approximately three times as often as FAS.¹⁶ Within the wider category of FASD (which would include individuals with FAS), the US is estimated to have about 10 cases per 1,000 live births.¹⁷

Alaska's estimated rate of all births impacted by prenatal alcohol exposure is 16.3 cases per 1,000 births, based on the 1995 to 1999 birth years. While these alcohol-related effects are closely associated with FASD, these rates are not directly comparable to national FASD rates of 10 per 1,000 live births due to differences in diagnoses and reporting at the state and national levels. Based on 16.3 cases per 1,000 and the number of live births from 1995 to 1999, approximately 160 infants are born each year in Alaska with FAS and other effects from maternal alcohol use during pregnancy. Of those, approximately 15 are born with Fetal Alcohol Syndrome (FAS).

FAS vs. FASD

It is important to remember that the information being used to determine the economic costs of care and service delivery to individuals with Fetal Alcohol Syndrome is only a small portion of the overall impact of prenatal exposure to alcohol and the resulting birth defects and disabilities. Beginning in 2000, the State of Alaska began extensive efforts to improve and expand the ability to appropriately diagnose individuals prenatally exposed to alcohol. In 2005, Alaska has a broad and regionally diverse network of diagnostic teams across the state.¹⁸ Data collected from these teams indicate that from July 2000 through March 2005 teams have conducted

¹⁵ FAS: *Guidelines for Referral and Diagnosis*, CDC, 2004.

¹⁶ CDC, *Tracking Fetal Alcohol Syndrome*, www.cdc.gov/ncbddd/fas/fassurv.htm

¹⁷ National Organization on Fetal Alcohol Syndrome, *What are the Statistics and Facts about FAS and FASD?*, www.nofas.org/faqs.aspx?id=12

¹⁸ For information on available services go to <http://health.hss.state.ak.us/fas/teams/default.htm>.

755 FASD diagnostic assessments. Of this number, 76 (10.0 percent) were diagnosed with FAS or atypical FAS; 378 (49.9 percent) were diagnosed with Static Encephalopathy; 251 (32.2 percent) were diagnosed with Neurobehavioral Disorder; and 50 (6.6 percent) were found to have no evidence of organic brain damage.

What this data indicates is that the costs associated with all alcohol-related births are much higher than those estimated just for individuals with FAS. And, as noted in the break-through research of Dr. Ann Streissguth in 1996 (Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome [FAS] and Fetal Alcohol Effects [FAE]), individuals with FAE (what is now referred to as FASD) are more likely to develop secondary disabilities and need more services than those with Fetal Alcohol Syndrome and the associated facial dysmorphism. For Alaska and the economic costs associated with all fetal alcohol spectrum disorders, the costs could be as much as 80 percent higher than indicated for FAS alone.

Economic Cost of Fetal Alcohol Syndrome

The cost of caring for and providing appropriate services to a person with FAS can be significant. These costs may include neonatal care for low birth weight to special speech therapy, behavioral management, or residential care for adults with FAS. Lifetime costs for care for children born in 2003 with FAS are estimated below. However, these costs are excluded from the total health care costs for 2003, as the component of that expenditure in 2003 alone cannot be determined.

Methodology

To estimate the economic costs from FAS, the research team first determined the number of live births with FAS in Alaska. The Alaska Department of Health and Social Services has closely monitored incidence of FAS in the state since 1998, as part of a U.S. Centers for Disease Control (CDC) monitoring program called the Fetal Alcohol Syndrome Surveillance Network (FASSNet), the ongoing Alaska FAS Surveillance Project and the Alaska Birth Defects Registry. The development of 13 community-based FASD diagnostic teams across Alaska has also assisted in the collection of data related to both FAS and other alcohol-related disabilities included in the FASD umbrella definition.

The Alaska FAS Surveillance Project data collection system is based on reports to the Alaska Birth Defects Registry, and uses medical chart data points to identify children with FAS or other prenatal alcohol-related conditions. DHSS staff consider the surveillance program to be highly rigorous. Alaska clinicians and case workers use a diagnostic process developed by researchers at the University of Washington Fetal Alcohol Syndrome Diagnostic and Prevention Network. Reporting of birth defects to the state registry is mandated by Alaska law. While Alaska's FAS surveillance system is believed to capture the majority of prenatal alcohol-related cases, it is possible that underreporting could make the incidence rate even higher.

For birth years 1995 to 1999, the incidence rate of FAS in Alaska is 1.5 per 1,000 live births.¹⁹ This was the highest rate of the five states that were involved in developing

¹⁹ Susan Merrick, FAS Surveillance Project Manager, Alaska Department of Health and Social Services, personal communication, July 2005.

the CDC FASSNet system. (The lowest rate was 0.3 FAS cases per 1,000 births.) However, the incidence of all prenatal alcohol-related conditions, including such conditions as alcohol-related birth defects (ARBD) and alcohol-related neurodevelopmental disorder (ARND), as well as FAS, is 16.3 per 1,000 live births. This incidence rate is assumed to be consistent in birth year 2003.

To estimate FAS costs in Alaska, the research team relied on data published in Health Professions Education Partnership Act of 1998 (Senate Bill 1754). The cost of treating an individual with FAS over his or her lifetime was estimated to be at least \$1.4 million in 1995. These costs could include neonatal intensive care, medical and surgical services (not related to neonatal care), special speech therapy, behavioral management, and residential care. Medical and surgical service might include rectifying or monitoring hearing loss or cleft palate surgery. Residential services include special education, home care, speech therapy or institutional care. The 1995 data was adjusted for inflation using the Bureau of Labor Statistics Consumer Price Index for medical care. Additionally, costs of providing care were adjusted by the Alaska differential for cost of living (65 percent in 2003). The resulting total lifetime costs (in 2003 dollars) for providing services to an individual with FAS are estimated at \$3.1 million.

The total cost for providing services to an individual with FAS born in Alaska during 2003 was estimated by multiplying the lifetime costs by the number of FAS births during that period.

Results

Table 18 presents estimated costs for FAS births in Alaska during 2003. During that period, Alaska had about 15 FAS births. Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately \$47.0 million.

Table 18
Lifetime Costs of Medical and Residential Services
for Children Born with FAS in 2003

	Incidence and Costs
Alaska births in 2003	10,084
FAS incidence per 1,000 live births	1.5
FAS births	15
Lifetime FAS cost	\$47,037,000

Source: Birth data from the Alaska Bureau of Vital Statistics. McDowell Group, based on FAS data from Alaska Department of Health and Social Services; and Health Professions Education Partnership Act of 1998, S. 1754, 108d Congress (1998).

AIDS and HIV Costs

Intravenous drug abuse among individuals who share unhygienic needles is a significant cause of AIDS and HIV. Although AIDS and HIV no longer require extensive inpatient medical care, both result in high medical expenses worth

measuring separately from the hospital and outpatient costs presented above (NIDA/NIAAA, 1998).

Methodology

The State of Alaska Department of Health and Social Services Epidemiology Section compiles data on HIV and AIDS diagnoses in the state. While the section does not track individuals with HIV and/or AIDS diagnoses, it does compile cumulative counts of the number of diagnoses in the state since the first known HIV diagnosis. Of the known cases of HIV and/or AIDS, 13 percent are associated with intravenous drug use. In addition, the Epidemiology Section tracks known deaths. The section does not track the whereabouts of diagnosed individuals, and as a result no data exists regarding the number of HIV/AIDS patients who may have moved away from Alaska. For the purposes of these estimates the research team assumes that 100 percent of diagnosed individuals remain in the state, though it is recognized that this may not be the case. Additionally, we assume that 100 percent of the known deaths occurred among individuals who had been diagnosed with AIDS, although data is not available on specific cause of death.

Two steps were used to calculate other drug-related AIDS and HIV medical costs. First, AIDS and HIV costs were estimated by applying annual medical expenses from the NIDA/NIAAA (1998) study to the number of known Alaska AIDS and HIV patients in 2003. Cost data was adjusted for inflation and the cost of health care in Alaska using the same sources and methods previously reported. Annual medical expenses for each Alaska HIV patient were estimated at \$30,600, while medical expenses for each AIDS patient were \$68,200.

The second step was to determine the percent of AIDS and HIV medical expenses that can be attributed to other drug abuse. The Epidemiology Section reported that approximately 13 percent of AIDS and HIV cases were attributed to intravenous drug abuse. This attribution rate was then applied to medical costs for AIDS and HIV patients.

Based on the data from the Alaska Division of Public Health, a total of 597 individuals with HIV or HIV/AIDS lived in Alaska in 2003. Of those, an estimated 295 had HIV without AIDS and 302 had HIV with AIDS. An estimated 13 percent of these individuals contracted HIV through intravenous drug use.

Although the following cost estimates are limited only to those caused by intravenous drug abuse, alcohol abuse is a risk factor in contracting AIDS and HIV from unprotected sex.

Results

An estimated 78 HIV and HIV with AIDS cases in Alaska are attributable to intravenous drug use. Medical costs for treating these patients in 2003 were approximately \$3.8 million. Table 19 presents the number of HIV and HIV with AIDS cases and annual medical expenses for these cases.

Table 19
Annual Medical Expenses per AIDS and HIV Case
Due to Other Drug Abuse in Alaska, 2003

	Annual Medical Expenses per Patient	Number of AIDS and HIV Patients	Total Costs due to Drug Abuse
HIV Positive	\$30,600	38	\$1,172,000
AIDS	\$68,200	39	\$2,678,000
Total	n/a	78	\$3,850,000

Source: McDowell Group, based on AIDS and HIV case numbers from Alaska Department of Health and Social Services, Division of Public Health; and annual medical expense data from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

Hepatitis B and C Costs

Intravenous drug abuse and sharing unhygienic needles are leading contributors to hepatitis B and C in Alaska. In fact, intravenous drug use is the largest contributor to hepatitis C. Hepatitis B and C have been linked to cirrhosis and primary hepatic cancer.

Methodology

Approximately 12 percent of hepatitis B cases and 36 percent of hepatitis C cases can be attributed to intravenous drug abuse (NIDA/NIAAA, 1998). According to the Alaska Department of Health and Social Services, there were 8 cases of hepatitis B and 952 cases of hepatitis C reported in the state in 2003. Hepatitis B infection is accompanied by acute illness, and reported cases in 2003 likely accurately represent the number of people seeking care for hepatitis B in that year. However, hepatitis C is not necessarily accompanied by acute symptoms, though long-term costs of care are generally far more significant. Due to limited data on the disease stage²⁰ and how many patients were cured, the report estimates the cost of treating only those hepatitis C cases reported by the Alaska Division of Public Health in 2003.

Medical expenses for hepatitis B and C were presented in the NIDA/NIAAA (1998) study by stage. Since data is limited for hepatitis B and C in Alaska, medical expenses from the NIDA/NIAAA study were averaged. Adjusting for inflation and Alaska health costs, the annual average medical expense is \$3,400 for treating hepatitis B and \$14,900 for hepatitis C. These costs were applied to all other drug abuse-related hepatitis B and C cases reported in 2003 by the Division of Public Health. However, it should be pointed out that most hepatitis B and C cases required only monitoring of the disease, which is relatively inexpensive. Hepatitis B cases generally require intensive treatment but limited long-term care, while hepatitis C cases may require low levels of treatment over an extended time, leading toward intensive treatment in later stages of the disease. The study provides an approximate cost of treating hepatitis B and C cases that were newly reported during 2003.

²⁰ Incubation, acute, and persistent are the three stages of hepatitis.

Results

In Alaska, intravenous drug abuse attributed to one hepatitis B case and 343 hepatitis C cases during 2003. Total annual medical costs for intravenous drug abuse-related hepatitis B were \$3,000. Costs associated with the treatment of hepatitis C attributed to intravenous drug abuse were an estimated \$5.1 million. Table 20 presents total medical costs and number of cases for hepatitis C in Alaska during 2003.

Table 20
Annual Medical Expenses per Hepatitis C Case
Due to Drug Abuse in Alaska, 2003

	Annual Medical Expenses per Patient	Number of Patients	Total Costs due to Drug Abuse
Hepatitis C	\$14,900	343	\$5,114,000

Source: McDowell Group, based on hepatitis B and C case numbers from the Alaska Department of Health and Social Services; and annual medical expense data from *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (NIDA/NIAAA, 1998).

Hepatitis B costs were not included in the table because costs were insignificant compared to Hepatitis C (\$3,000).

A significant percentage of individuals with serious mental illness also are users of or dependent upon drugs and/or alcohol. Similarly, rates of serious mental illness among individuals who experience drug and/or alcohol dependence or abuse are significantly higher than among the general population. Research also indicates that adults with co-occurring serious mental illness (SMI) and substance abuse disorders are more likely to receive treatment for their mental illness than for their substance dependence.

The State of Alaska is currently undergoing a process to integrate substance abuse treatment and mental health services in the state so that individuals in need of care can receive coordinated treatment for any co-occurring disorders. In addition, the state introduced an initiative in 2004 called Bring the Kids Home. The purpose of BTKH is to support the development of in-state residential psychiatric treatment capacity for Alaskan children and youths.

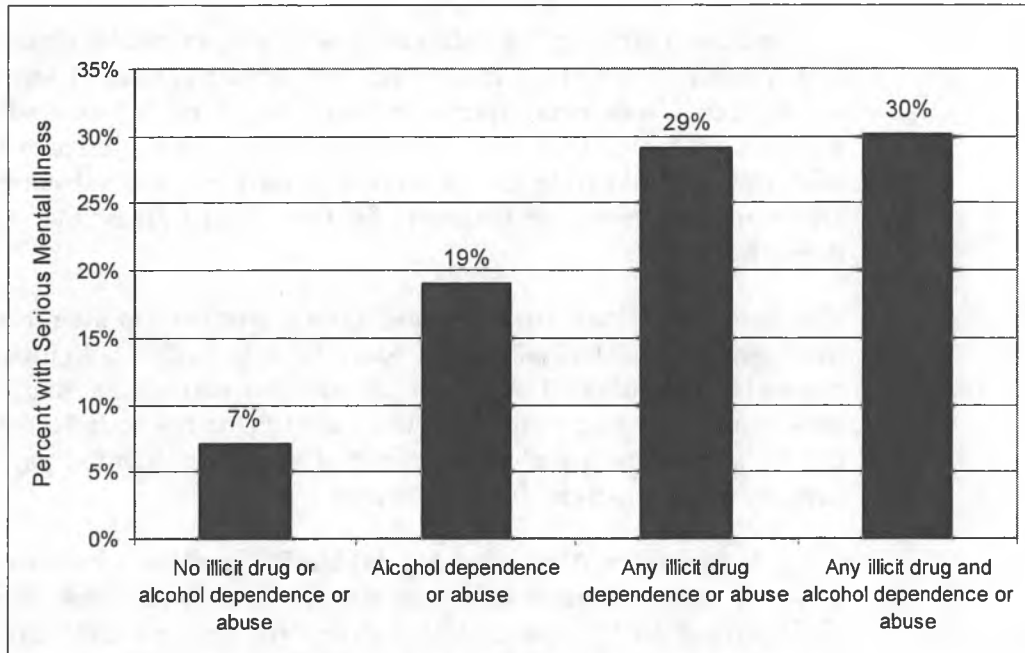
The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies published a report in 2004 on *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders* for the year 2002. The report provides data on co-occurrence of mental illness and substance dependence or abuse, as well as comparative data on the rates of treatment for individuals with these conditions, alone or in combination.

Co-Occurrence of Serious Mental Illness and Substance Dependence or Abuse

The prevalence of serious mental illness (SMI) among adults who have a substance use disorder is significantly higher than among adults who do not. Nineteen percent of adults who are dependent upon or who abuse alcohol had SMI in 2002, as did 29 percent of those with illicit drug dependence or abuse, and 30 percent of those with both drug and alcohol abuse or dependence. By contrast, only 7 percent of adults who have no substance use disorder experienced SMI (see Figure 5).

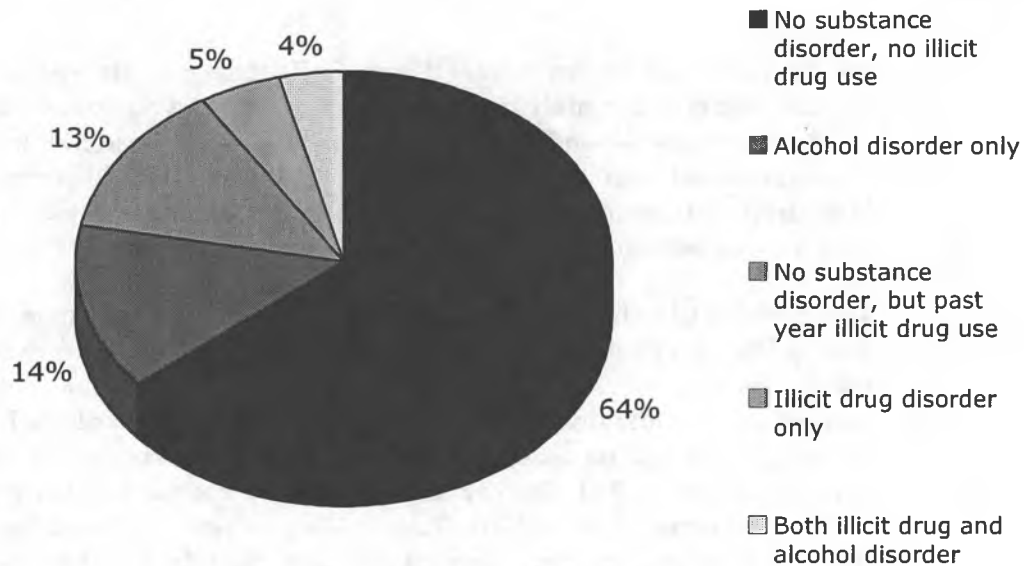
This data clearly shows that serious mental illness is much more likely to occur among the drug and/or alcohol dependent population. Likewise, among the population of adult Americans who experience serious mental illness, significant percentages of individuals are likely to have a drug and/or alcohol dependency or abuse. Of 17.5 million adults aged 18 or older who experienced SMI in 2002, 14 percent had an alcohol disorder only, 13 percent had no substance abuse disorder but had nevertheless used illicit drugs in the past year, 5 percent had an illicit drug disorder only, and another 5 percent had both illicit drug and alcohol disorders. In total, 46 percent of the population with SMI had drug or alcohol disorders or abuse, alone or in combination (see Figure 6.)

Figure 5
Serious Mental Illness among Adults Aged 18 or Older,
by Substance Dependence or Abuse, 2002



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002.

Figure 6
Substance Use Disorder Among Adults With Serious Mental Illness, 2002



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002.

These data clearly show that there is a strong correlation between alcohol and or substance dependence and serious mental illness.

The analysis of the use of treatment services for either SMI or for substance dependence in the SAMHSA report revealed interesting trends in the treatment services accessed by affected individuals. Individuals with SMI only, and no substance abuse disorder, were most likely (48 percent) to receive mental health treatment. Among those individuals with SMI and substance dependence, 46 percent received only mental health treatment, while 14 percent received only specialty substance use treatment. Only 12 percent received treatment for both SMI and a substance abuse disorder. In addition, adults with SMI co-occurring with illicit drug dependence or abuse were more likely to receive mental health treatment (54 percent) than those adults who had SMI co-occurring with alcohol dependence or abuse (43 percent).

Adults who had co-occurring SMI and substance dependence or abuse were more likely to receive specialty substance use treatment than adults with substance disorders but no SMI (14 versus 5 percent).

In 1999, the Gallup Organization conducted a household telephone survey in Alaska and determined that 9.7 percent of the population aged 18 and over abused or was dependent on alcohol. Applying this percentage to the 2002 adult population in Alaska of 448,000 would result in an estimated 43,500 alcohol dependent adults in that year. Based on the co-occurrence rates presented in the SAMHSA (2002) study, this means an estimated 8,300 Alaskans had co-occurring alcohol dependence or abuse and serious mental illness in 2002. However, the Gallup survey did not assess the percentage of Alaskans whose alcohol dependence was accompanied by illicit drug dependence or abuse. It is reasonable to assume that some of the 8,300 alcohol dependent Alaskans also had illicit drug dependence or abuse. The prevalence of SMI among adults with both alcohol dependence and illicit drug use is significantly higher (30 percent versus 19 percent for alcohol only), so it is likely that the number of Alaskan adults with co-occurring SMI and alcohol and/or illicit drug dependence or abuse is even higher.

Bring the Kids Home Initiative

Like adults, children and youth experience co-occurring mental and substance abuse disorders. According to the SAMHSA Report to Congress, 2002, researchers have found a link between substance abuse disorders and behavioral and mental/emotional disorders in youth. The 2001 National Household Survey on Drug Abuse found that 26 percent of 12 to 17-year-olds who had used illicit drugs in the past year had also received treatment or counseling for behavioral or mental health issues. This compared to only 16 percent of youths who had not used illicit drugs (SAMHSA, 2002).

In Alaska, there are a limited number of residential mental health treatment facilities for children and youth. When children and youth need intensive mental health treatment they often must travel to facilities outside of the state. However, according to the Alaska Division of Behavioral Health and the Mental Health Trust Authority, out-of-state treatment may not be as beneficial as services delivered close to home.

Possible disadvantages of out-of-state services may include less therapeutic benefit for children and their families, longer lengths of stay and higher risk of readmission, and transitional difficulties.

To address the high rates of out-of-state institutionalization, the State of Alaska launched the "Bring the Kids Home Initiative" to support the development of in-state infrastructure and treatment opportunities for youth and children. Since the program inception in late 2004, several steps have been taken to position the state to achieve these goals. Three workgroups have been established, including one that is working to identify means to support the establishment of services and service providers in Alaska and one that is identifying ways to support the development of a treatment professional workforce. A third work group, made up of three mental health clinicians, reviews the cases of children who are under consideration for out-of-state treatment, and tries to redirect cases within the state whenever clinically possible and appropriate.

Prior to the launch of the BTKH initiative, Alaska had seen a stark increase in the number of children in out-of-state residential psychiatric treatment centers (RPTCs). There was a 200 percent increase in the number of children covered by Medicaid who received treatment in an out-of-state RPTC from 2000 to 2004. This was accompanied by a 280 percent increase in the cost of those services, from \$9.9 million in 2000 to \$37.8 million in 2004.

Preliminary fiscal year 2005 data, however, shows that more children were able to receive treatment in Alaska facilities. The number of children receiving services in out-of-state treatment facilities through Medicaid decreased from the previous year, and the percentage of Alaskan children receiving treatment services in-state rose to 29 percent from 22 percent the previous year. In addition, 71 children who were in out-of-state facilities have been transferred to treatment facilities within Alaska since the program inception. Additionally, there was a drop in out-of-state spending on RPTC care.

Table 21
Medicaid Residential Treatment Care Expenditures,
State Fiscal Years 2001 to 2005

	SFY01	SFY02	SFY03	SFY04	SFY05 preliminary
In-State	8,243,000	9,230,000	10,093,000	11,532,000	12,659,000
Out-of-State	17,609,000	21,752,000	30,915,000	37,794,000	34,044,000
Total	\$25,852,000	\$30,982,000	\$41,008,000	\$49,326,000	\$46,703,000

Source: Division of Behavioral Health, "Bring the Kids Home Indicators: Baseline Data State Fiscal Years 1998-2004," May 2005; and "Bring the Kids Home Indicators: SFY05 Supplemental Data—Preliminary," August 2005. Note: Claims for state fiscal year 2005 are still being processed; final numbers will likely be higher.

While the state continues to process insurance claims for FY05 treatment services, HSS staff indicated that the trends reflected in the preliminary data are likely representative of overall change. While expenditures for the program were modest in FY05 (\$100,000), HSS staff said awareness of the BTKH initiative in the treatment community likely drove some of the shift toward Alaska-based treatment. The BTKH initiative has a budget of \$2.4 million for FY06.

PUBLIC ASSISTANCE AND SOCIAL SERVICES

Needy Alaskans who qualify for public assistance receive cash and food stamps and other social services from the state. A portion of the public assistance expenditures can be attributed to alcohol and other drug abuse. As noted earlier in the report, alcohol and other drug dependence can result in reduced income, trouble finding and holding a job, or even a disability, all of which may qualify the individual for public assistance. This chapter looks briefly at the economic costs of alcohol and other drug abuse-related public assistance.

Methodology

Different methods were used to estimate the costs of alcohol and drug abuse-related public assistance at the state and federal levels. At both levels, only administrative costs of programs were considered as public assistance payments are a redistribution of income and not an actual cost to society.

At the federal level, there are two sources of public assistance costs. The first is former Supplemental Security Income (SSI) and Old Age, Survivors, and Disability Insurance (OASDI) recipients. National administrative cost figures were used to estimate the Alaska-specific portion of the federal programs, using the assumption that costs were proportional to the number of recipients. NIDA/NIAAA (1998) attribution rates were used to estimate the proportion of total costs that are attributable to drug and alcohol abuse. For SSI and OASDI recipients, 1.7 percent of the cases were related to alcohol and other drug abuse.

At the state level, public assistance programs include the Alaska Temporary Assistance Program (ATAP) and food stamp programs, and other programs such as energy assistance and child care assistance. Again, NIDA/NIAAA (1998) attribution rates were used to estimate the cost attributable to substance abuse.

For ATAP and other state programs, 4.1 percent of the cases were related. Because Alaska's dependency rates are more than twice national rates, attribution rates published in the NIDA/NIAAA (1998) study likely provide a conservative estimate of Alaska's true administration costs from public assistance. However, the lack of Alaska attribution rates for alcohol and other drug abuse-related public assistance necessitates the use of these national attribution rates published in the NIDA/NIAAA study.

Results

Administration costs from alcohol and other drug abuse-related public assistance was approximately \$4.1 million in Alaska during 2003. The largest contributor was administration of payments for Alaska Temporary Assistance Program, food stamps and other state-administered assistance programs at \$4.0 million, while administrative costs from former OASDI and SSI recipients totaled \$170,000.

COST OF UNDERAGE DRINKING IN ALASKA

The cost of underage drinking in Alaska is a component of many of the alcohol and drug abuse-related costs already identified in this study. However, it is informative to examine specifically underage drinking costs, to place such costs in perspective relative to overall costs associated with alcohol and other drug abuse in Alaska.

This study did not include research focused on underage drinking costs. However, data from other sources is available. The Pacific Institute for Research and Evaluation (PIRE) has produced national and state-level estimates of the cost of underage drinking. PIRE data indicates that medical care costs and loss of work costs in Alaska totaled \$128 million in 2001. PIRE also placed "pain and suffering" costs at \$353 million. The following table provides more detail on specific sources of underage drinking costs in Alaska.

Table 22
Costs of Underage Drinking in Alaska, by Problem, 2001

	Total Costs (in millions)
Youth Violence	\$329.7
Youth Traffic Crashes	77.7
High-Risk Sex, Ages 14-20	13.9
Youth Property Crime	7.6
Youth Injury	26.9
Poisonings and Psychoses	2.6
FAS Among Mothers Age 15-20	3.3
Youth Alcohol Treatment	18.9
TOTAL	\$480.7

Source: Pacific Institute for Research and Evaluation (PIRE), March 2004.
Posted at <http://www.udetc.org/UnderageDrinkingCosts.asp>

As indicated above, many of these costs have been captured in other sections of this report. The largest component of underage drinking costs, as measured by PIRE, are pain and suffering-related costs, which are not addressed at all (for adults or youth) in this report. While it is likely that some of the direct medical and work loss costs identified in the PIRE study are not reflected in this report, the potential for double-counting is high, therefore none of the costs reported in Table 22 are added to the grand total costs related to alcohol and drug abuse in Alaska, as measured in this study. Research beyond the scope of this study would be required to identify specific components of costs reported in the PIRE report that are not captured in the McDowell Group report.

EMPLOYMENT AND TAX IMPACTS OF ALCOHOL SALES

Although this report concentrates on quantifying the costs of alcohol and other drug abuse, there are some measurable economic benefits associated with the sale of alcohol. The most obvious benefit is employment. Jobs related to alcohol sales include manufacturing, wholesale trade and retail trade. Alcohol excise tax revenues go into Alaska's unrestricted general-fund budget. Other benefits, including indirect employment impacts from alcohol manufacturing and sales, are more difficult to measure and beyond the scope of this study. Earnings from these jobs help employ other residents who are not directly linked to the alcohol industry.

This chapter looks briefly at the direct employment benefits from the alcohol industry and discusses the excise tax collected from the sale of alcohol beverages.

Methodology

To measure the employment and earnings related to manufacturing and sales of alcohol, the research team relied on data published in the 2003 Employment and Earnings Report by Alaska Department of Labor and Workforce Development, Research and Analysis Division. Employment and earnings data was collected for the following industries:

- Breweries & Wineries (NAICS 31212, 31213)
- Wholesale trade for beer, wine, and distilled beverages (NAICS 4248)
- Beer, Wine, Liquor stores (NAICS 4453)
- Drinking places, Alcoholic (NAICS 7224)

Total tax revenue collected in FY2004 from the sale of alcohol beverages was published in the Tax Division Annual Report of Division Operations, by the Alaska Department of Revenue. Per gallon tax rates on alcoholic beverages were increased, on October 1, 2002, from \$0.35 to \$1.07 for beer, \$0.85 to \$2.50 for wine and \$5.60 to \$12.80 for liquor. As of that same date, 50 percent of the revenue is deposited in the Alcohol and Other Drug Abuse Treatment and Prevention Fund.

Results

Table 22 presents employment and earnings for alcohol-related commerce and manufacturing industries in Alaska during 2003. Total employment related to the sale of alcoholic beverages in Alaska was approximately 3,000 jobs with earnings of \$62 million. Drinking establishments accounted for the most employment at approximately 1,800 jobs with \$26 million in payroll.

**Table 23
Employment and Earnings for Alcohol-Related Industries in Alaska, 2003**

Industry	Employment	Earnings (millions)
Breweries and Wineries	90	\$3.0
Wholesale trade	413	17.1
Retail trade: Liquor stores	672	15.9
Retail trade: Drinking places	1,815	25.8
Total	2,990	\$61.8

Source: 2003 *Employment and Earnings Report*, Alaska Department of Labor and Workforce Development, Research and Analysis Division.

Total tax revenue collected from the sale of alcohol beverages in Alaska was \$32.7 million during FY 2004. This includes \$14.1 million collected on sales of 1.1 million gallons of liquor, \$4.3 million collected on sales of 1.7 million gallons of wine, and \$14.3 million collected on sales of 14.7 million gallons of beer. Contributions of unrestricted revenue to the General Fund totaled \$16.4 million, with an equal amount contributed to the fund for alcohol and drug abuse treatment programs.

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