ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672
9137 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

HB

434

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: February 18, 1998 **FURTHER REFERRALS:** **Judiciary**

Date of Committee Action: 4/30/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 434**

HOUSE BILL NO. 434 **DRUG TESTING OF WELFARE RECIPIENTS**

"An Act requiring drug testing for applicants for and recipients of assistance under the Alaska temporary assistance program; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB 434 (HES) [ ] the same title [X] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[X] fiscal note(s) (2) HSS [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM

CHAIR'S SIGNATURE Con Bunde

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CSHB434

Revision Date:
Title: Relating to assessment of ATAP recipients for the use of drugs and alcohol
Sponsor: Rokeberg
Requestor: House(HFS)

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: ATAP
COMPONENT SERIAL NO. 220
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(106.3)	(106.3)	(88.8)	(88.8)	(88.8)	(88.8)
MISCELLANEOUS						
TOTAL OPERATING	(106.3)	(106.3)	(88.8)	(88.8)	(88.8)	(88.8)
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(53.2)	(53.2)	(44.4)	(44.4)	(44.4)	(44.4)
1003 GF Match						
1004 GF	(53.1)	(53.1)	(44.4)	(44.4)	(44.4)	(44.4)
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	(106.3)	(106.3)	(88.8)	(88.8)	(88.8)	(88.8)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: 80.0

ANALYSIS: (Attach a separate page if necessary)

CSHB434 authorizes the Division of Public Assistance (DPA) to conduct screening of all ATAP applicants and recipients for substance and alcohol dependency. If the screening protocol indicates the applicant or recipient has a chemical or alcohol dependency the DPA may, as a condition of the family self-sufficiency plan (FSSP), refer the client for assessment and require the participant to comply with the conditions of the assessment as a part of the FSSP.

The effects of this legislation on DPA relate primarily to the additional time necessary to screen clients and to provide follow-up case management services for ATAP participants who are referred to assessment and treatment. There will be some program savings generated by reductions in benefits for non-compliance.

Prepared by: Jim Nordlund
Division: Division of Public Assistance
Phone: 465-2680
Date: 05/01/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 5/1/98

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ANALYSIS (cont.):

Because the proposed legislation implies universal screening it is very likely that as a result of referrals there will be increased pressure on the existing infrastructure for providing assessments and treatment. In FY97, the Medicaid program spent approximately $2.6 million dollars to for assessment, in-patient and out-patient services to approximately 1200 individuals with chemical or alcohol dependencies. DPA estimates that approximately 400 ATAP participants may be referred each month for assessment.

Assumptions:

Approximately 1200 applicants and recipients will be screened each month.
By FY00 all on-going program participants will have been screened and only new applicants will be subject to screening.
Each month, approximately 40% of individuals (N=480 for FY99 and 00 and N=400 for FY01-04) will be referred to assessment.
Each month, approximately 5% of those referred to assessment (N=15) will fail to comply with this provision of the FSSP.
For the purposes of this fiscal note it is assumed that the average duration of a sanction is 1 month.
Caseloads will remain level from FY99 - FY04

Calculation:

FY99-00 Penalties
480 X .05 = 24 x $369 = $8.9 x 12 = $106.3

FY01-04 Penalties
400 x .05 = 20 x $7.4 = $7.4 x 12 = $88.8

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CSHB434

Revision Date:
Dept. Affected: Health and Social Services
Title: Relating to assessment of ATAP recipients for the use of drugs and alcohol
BRU: Public Assistance Admin
Component: PA Field Services
Sponsor: Rokeberg
COMPONENT SERIAL NO. 236
Requestor: House(HES)
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES	91.4	91.4	91.4	91.4	91.4	91.4
TRAVEL						
CONTRACTUAL	9.6					
SUPPLIES						
EQUIPMENT	9.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	110.0	91.4	91.4	91.4	91.4	91.4
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	55.0	45.7	45.7	45.7	45.7	45.7
1003 GF Match						
1004 GF	55.0	45.7	45.7	45.7	45.7	45.7
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	110.0	91.4	91.4	91.4	91.4	91.4

POSITIONS:

FULL-TIME	2	2	2	2	2	2
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: 80.0

ANALYSIS: (Attach a separate page if necessary)

CSHB434 authorizes the Division of Public Assistance (DPA) to conduct screening of all ATAP applicants and recipients for substance and alcohol dependency. If the screening protocol indicates the applicant or recipient has a chemical or alcohol dependency the DPA may, as a condition of the family self-sufficiency plan (FSSP), refer the client for assessment and require the participant to comply with the conditions of the assessment as a part of the FSSP.

The effects of this legislation on DPA relate primarily to the additional time necessary to screen clients and to provide follow-up case management services for ATAP participants who are referred to assessment and treatment. There will be some program savings generated by reductions in benefits for non-compliance.

5/1/98

Prepared by: Jim Nordlund
Division: Public Assistance
Phone: 465-2680
Date: 05/01/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 5/1/98

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ANALYSIS (cont.):

Because the proposed legislation implies universal screening it is very likely that as a result of referrals there will be increased pressure on the existing infrastructure for providing assessments and treatment. In FY97, the Medicaid program spent approximately $2.6 million dollars to for assessment, in-patient and out-patient services to approximately 1200 individuals with chemical or alcohol dependencies. DPA estimates that approximately 400 ATAP participants may be referred each month for assessment.

Assumptions:

Approximately 1200 applicants and recipients will be screened each month.
Screening for substance abuse will add 15 minutes to the interview process for each client.
By FY00 all on-going program participants will have been screened and only new applicants will be subject to screening.
Caseloads will remain level from FY99 - FY04
Increased level of effort required for screening amounts to two FTE.

Position Title			No. of Position	Range/Step	Bargaining Unit	Bill No. CSHB434
Eligibility Technician II			2	14A	GGU	
Time Status	Staff Months		Location			Election District
PFT	12.0		Anchorage			

TYPE of EXPENDITURE		AMOUNT
Salary		65.4
Benefits		26.0
Premium Pay		
Other		
Total Personal Services (100)		91.4
100 Travel		
200 Contractual		9.6
300 Supplies		
500 Equipment		9.0
Other		
Total Cost		110.0
FUNDING SOURCE for TOTAL COST		
1002 Federal Receipts		55.0
1003 GF Match		
1004 General Fund		55.0
1005 GF/Program Receipts		
1037 GF/Mental Health		
1007 I/A Receipts		
1061 CIP Receipts		
Other ( )		

Justification

REQUEST for NEW POSITION

AGENCY: Health and Social Services

BRU: Public Assistance Admin

COMPONENT: 236

Page:

Revision Date:

FY99

CS FOR HOUSE BILL NO. 434(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG

A BILL

FOR AN ACT ENTITLED

"An Act relating to the assessment of recipients of assistance under the Alaska temporary assistance program for the use of alcohol and controlled substances and compliance with recommendations of the assessment as a condition of the recipient's family self-sufficiency plan; and providing for an effective date."

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

• **Section 1.** AS 47.27.030 is amended by adding a new subsection to read:

(d) The department shall screen adult participants to identify barriers to family self-sufficiency related to the use of alcohol or controlled substances. As a condition of the plan, the department may refer the participant for assessment and require the participant to comply with the recommendations of the assessment as a condition of the family self-sufficiency plan. Assessments shall be conducted at a facility approved under AS 47.37.140.

• **Sec. 2.** This Act takes effect July 1, 1999.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM April 29, 1998

SUBJECT: CSHB 434(HES) (Draft version "L")

TO: Representative Con Bunde, Chair HES
Attn: Lynne

FROM: Terri Lauterbach
Legislative Counsel

Enclosed is a draft CS for HB 434.

Amendment #1, adopted by the HES committee, removed all amendments from AS 47.27.030(a) and restored its current language, so sec. 1 of the K version has been deleted for this CS.

The bill title has been modified to accurately describe the contents of the bill. The recommendations of an assessment may, or may not, involve assignment to a treatment program.

Please let me know if I can be of further assistance.

TML:pl
98-091.plm

Enclosure

0-LS0495\L
Lauterbach
4/29/98

CS FOR HOUSE BILL NO. 434(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG

A BILL

FOR AN ACT ENTITLED

"An Act relating to the assessment of recipients of assistance under the Alaska temporary assistance program for the use of alcohol and controlled substances and compliance with recommendations of the assessment as a condition of the recipient's family self-sufficiency plan; relating to family self-sufficiency plans; and providing for an effective date."

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

* **Section 1.** AS 47.27.030 is amended by adding new subsections to read:

(d) The department shall screen adult participants to identify barriers to family self-sufficiency related to the use of alcohol or controlled substances. As a condition of the plan, the department may refer the participant for assessment and require the participant to comply with the recommendations of the assessment as a condition of the family self-sufficiency plan. Assessments shall be conducted at a facility approved under AS 47.37.140.

(c) The family self-sufficiency plan for a family that includes a person who is unmarried and pregnant must include provisions that require the department to provide, and the person to accept, parenting classes, appropriate prenatal care, and family planning education, as available.

* Sec. 2. This Act takes effect July 1, 1999.

3-1-98

4/28/98

AMENDMENT #1

OFFERED IN THE HOUSE BY Representative Bunde
CSHB434(HES)

Page 2 Lines 2-3 Following "to" delete "reduction or elimination of benefits"

Insert "benefit reductions"

w/D

0-LS0495\K.3
Lauterbach
4/28/98

AMENDMENT #2 by Rep Bunde

OFFERED IN THE HOUSE

TO: CSHB 434( ), Draft Version "K"

Page 2, line 13, following ".":

Insert "If a blood test administered during an assessment conducted under this subsection indicates the presence of alcohol or a controlled substance, the person tested is liable for the cost of the blood test."

3-1 YD

0-LS0495\K.1
Lauterbach
4/28/98

AMENDMENT #3 by Rep Burns

OFFERED IN THE HOUSE

TO: CSHB 434( ), Draft Version "K"

Page 1, line 4, following ",":

Insert "relating to family self-sufficiency plans;"

Page 2, line 7:

Delete "a new subsection"

Insert "new subsections"

Page 2, following line 13:

Insert a new subsection to read:

"(e) The family self-sufficiency plan for a family that includes a person who is unmarried and pregnant must include provisions that require the department to provide, and the person to accept, parenting classes, appropriate prenatal care, and family planning education."

4/30 recind - time

1-3 MD

0-LS0495\K.2
Lauterbach
4/28/98

AMENDMENT #4 by Rep Brenda

OFFERED IN THE HOUSE

TO: CSHB 434( ), Draft Version "K"

Page 2, line 8:

Delete "adult participants"

Insert "family members who are 16 years of age or older"

Page 2, line 10:

Delete "the participant"

Insert "a family member"

Page 2, line 11:

Delete "participant"

Insert "family member"

AMENDMENT #5 W/D

OFFERED IN THE HOUSE HESS COMMITTEE

BY: REPRESENTATIVE KEMPLEN

TO: CSHB 434

DATE: APRIL 28, 1998

PAGE 1, Line 13,

After, "self-sufficiency"

Insert, "including child care, transportation to and from job interviews and work related activities, and transistional health care coverage."

AMENDMENT #6 W/D

OFFERED IN THE HOUSE HESS COMMITTEE

BY: REPRESENTATIVE KEMPLEN

TO: CSHB 434

DATE: APRIL 28, 1998

PAGE 2, Line 4,

Before, "fails"

Insert, "substantially"

AMENDMENT #1 1-3 no

OFFERED IN THE HOUSE HESS COMMITTEE

BY: REPRESENTATIVE KEMPLEN

TO: CSHB 434

DATE: APRIL 28, 1998

PAGE 2, Line 10,

After, "assessment"

Delete, "and require the participant to comply with the recommendations of the assessment as a condition of the family self-sufficiency plan."

0-LS0495\K
Lauterbach
3/30/98

CS FOR HOUSE BILL NO. 434( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG

A BILL

FOR AN ACT ENTITLED

"An Act relating to the assessment of recipients of assistance under the Alaska temporary assistance program for the use of alcohol and controlled substances and assignment to a treatment program as a condition of the recipient's family self-sufficiency plan; and providing for an effective date."

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

* Section 1. AS 47.27.030(a) is amended to read:

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

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

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

(3) specific benchmarks to indicate the steps toward successful

completion of the family plan;

(4) a statement that the family may be subject to **reduction or elimination of benefits** [BENEFIT REDUCTIONS] or other sanctions if the family fails to comply with the family plan; and

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

* Sec. 2. AS 47.27.030 is amended by adding a new subsection to read:

(d) The department shall screen adult participants to identify barriers to family self-sufficiency related to the use of alcohol or controlled substances. As a condition of the plan, the department may refer the participant for assessment and require the participant to comply with the recommendations of the assessment as a condition of the family self-sufficiency plan. Assessments must be conducted by a facility approved under AS 47.37.140.

* Sec. 3. This Act takes effect July 1, 1999.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

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SPECIAL COMMITTEE ON OIL & GAS, MEMBER
JUDICIARY COMMITTEE, MEMBER
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HESS BUDGET SUBCOMMITTEE, MEMBER

INTERIM:
716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 258-8191
FAX: (907) 258-2816

SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4964
FAX: (907) 465-2040

Representative Norman Rokeberg

MEMORANDUM

TO: Representative Con Bunde, Chairman
Health, Education & Social Services Committee

FROM: Representative Norman Rokeberg

DATE: April 21, 1998

SUBJECT: CS HB 434, changes to HB 434

HB 434
0-LS0495/F
2/18/98

The original bill has been deleted and completely revised.

CS HB 434
0-LS0495\K
3/30/98

Section 1 — Amends AS 47.27.030 (a) (4) by changing benefit reductions to reduction or elimination of benefits if the family fails to comply with the family self-sufficiency plan.

Section 2 — New Language

Page 2
Line 8 — Requires the Department of Public Assistance to screen adult Alaska Temporary Assistance Program (ATAP) participants for alcohol or controlled substance abuse.

Page 2
Line 10-13 — If alcohol or controlled substances abuse is suspected the participant is required further assessment (review) by a substance abuse counselor at an approved facility as part of the family self-sufficiency plan.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

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SPECIAL COMMITTEE ON OIL & GAS, MEMBER
JUDICIARY COMMITTEE, MEMBER
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INTERIM:
716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 258-8191
FAX: (907) 258-2916

SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4958
FAX: (907) 465-2040

Representative Norman Rokeberg

SPONSOR STATEMENT
CSHB 434 ( )

An Act relating to the assessment of recipients of assistance under the Alaska temporary assistance program for the use of alcohol and controlled substances and assignment to a treatment program as a condition of the recipient's family self-sufficiency plan; and providing for an effective date.

CSHB 434 ( ) requires a person eligible for assistance under the Alaska temporary assistance program (ATAP) to be assessed for alcohol and controlled substance abuse under AS 47.27.030 family self-sufficiency plan.

Under Section 902 of HR 3734 (Public Law 104-93) a state is not prohibited by the federal government from testing welfare recipients for use of controlled substances nor from sanctioning welfare recipients who test posi ive for the u.e of controlled substances.

Giving an Alaskan a hand in a time of need is a good ideal. However, we need to insure tha' the Alaskans we help make a effort to achieve self-sufficiency. Alcohol and substance abuse is a barrier to, finding a job, nurturing children, and is one of the primary factors in domestic violence.

The American Medical Association Classifies chemical dependency as a treatable disease. An individual should not be held accountable for having a disease. However, an individual who refuses treatment should be held accountable.

The Department of Public Assistance lacks the ability to levy penalties against an alcoholic or substance abuser who refuses treatment. This bill encourages treatment by denying benefits to individuals who refuse treatment.

I would urge your support of this legislation.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR & COMMERCE COMMITTEE, CHAIRMAN
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
JUDICIARY COMMITTEE, MEMBER
CORRECTIONS BUDGET SUBCOMMITTEE, MEMBER
ADMINISTRATION BUDGET SUBCOMMITTEE, MEMBER
HESS BUDGET SUBCOMMITTEE, MEMBER

INTERIM:
716 WEST 4TH AVENUE, SUITE 360
ANCHORAGE, AK 99501
PHONE: (907) 258-8191
FAX: (907) 258-2916

SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4958
FAX: (907) 465-2040

Representative Norman Rokeberg

SECTIONAL ANALYSIS
COMMITTEE SUBSTITUTE
HOUSE BILL 443
Representative Norman Rokeberg

Title: An Act relating to the assessment of recipients of assistance under the Alaska temporary assistance program for the use of alcohol and/or controlled substances and assignment to a treatment program as a condition of the recipient's family self sufficiency plan; and providing for an effective date.

Section 1: Adds a new subsection to AS 47.27.030 to require the department to screen adult participants to identify barriers to family self-sufficiency related to the use of alcohol or controlled substances. As a condition of the family self-sufficiency plan an adult that is believed to have an alcohol or controlled substance abuse problem is required to complete an assessment through an approved treatment facility. Furthermore that individual will be required to comply with the recommendations of the assessment as a condition of the family self-sufficiency plan in order to continue receiving ATAP benefits. Assessments of the adult participant must be conducted by a program approved under AS 47.37.140.

Section 2: Effective date: January 1, 1999.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR & COMMERCE COMMITTEE, CHAIRMAN
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
JUDICIARY COMMITTEE, MEMBER
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PHONE: (907) 258-8191
FAX: (907) 258-2916

SESSION:
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JUNEAU, AK 99801-1182
PHONE: (907) 465-4948
FAX: (907) 465-2040

Representative Norman Rokeberg

SPONSOR STATEMENT
HOUSE BILL 434

An Act requiring drug testing for applicants for and recipients of assistance under the Alaska temporary assistance program
By Representative Norman Rokeberg

House Bill 434 would require that a person eligible for assistance under the Alaska temporary assistance program would not be eligible for that program if the person unlawfully uses a controlled substance or refuses to be tested for drug use by the department.

Under Section 902 of HR 3734 (which became Public Law 104-93) a state is not prohibited by the federal government from testing welfare recipients for use of controlled substances nor from sanctioning welfare recipients who test positive for the use of controlled substances.

Giving an Alaskan a hand in a time of need is indeed a good idea. However, we need to be sure that the Alaskans we are helping are making an effort to help themselves. Illegal use of controlled substances is, frankly, illegal and Alaskan and Federal funds should not be used to prop up individuals who cannot stay clean long enough to take care of themselves, find a job, hold down a job, and provide a safe and nurturing atmosphere for their children.

In a recent House District 11 survey, 325 individuals believed that random alcohol and drug tests should be required of welfare recipients as a condition for receiving benefits while 106 did not.

I would urge your positive support of this legislation.

ED1:3/6/98

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

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JUNEAU, AK 99801-1182
PHONE: (907) 465-4958
FAX: (907) 465-2040

Representative Norman Rokeberg

SECTIONAL ANALYSIS
HOUSE BILL 434
By Representative Norman Rokeberg

Title: An Act requiring drug testing for applicants for and recipients of assistance under the Alaska temporary assistance program; and providing for an effective date.

Section 1: Adds a new subsection to AS 47.27.015 to require that a person is not eligible for assistance under the Alaska temporary assistance program if the person unlawfully used a controlled substance (see AS 11.71.900) or refuses to be tested for drug use.

Section 2: Effective date: January 1, 1999.

ED1:3/6/98

Second Opinion

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of the Ohio State Medical Journal or the Ohio State Medical Association.

Chemical Dependency: A Treatable Disease

By William J. Kennedy, MD

As a full-time addictionologist, I have many concerns about the role of organized medicine in the field of chemical dependency. A number of us working in this new field also have concerns for what we perceive to be vital areas: appropriateness of therapy, recognizable authorities in the field for consultations with courts, legislators and third-party carriers, recognized teaching resources for medical schools, etc.

Those of us working in the field have great concern for the continued inappropriate care offered by otherwise qualified medical practitioners. A recent American Medical Association (AMA) poll indicates that only 21% of physicians recognize alcoholism as a primary disease; 17% continue to see it as a psychiatric problem, while 57% see it as some kind of behavioral problem. Only 27% felt competent to treat alcoholism; 45% did not feel competent, and 26% had very mixed feelings.

This poll unfortunately demonstrates where we are in treating the nation's number one health problem.

Our experience with third-party carriers continues to be equally distressing. In the past, their staff and consultants have had little expertise in this field, and yet make significant decisions about treatment settings, modalities and length of treatment — all of which are decisions critically affecting treatment outcome in this very treatable disease.

One might assume that nothing of a constructive nature is underway to address these concerns. In addition, competition in the field is clouding the issue of who in the health care profession is taking the lead in this important and critical area. It might be well to review what is happening in the field of chemical dependency and how physicians, like myself, are involved in this effort.

A recent poll indicates that only 21% of physicians recognize alcoholism as a primary disease . . . and only 27% felt competent to treat it.

In the last few years, largely due to the stimulus generated by a group of recovering physicians, some significant steps have been made. In 1982, the State of California passed a law requiring medical directors of alcohol and drug programs be certified as specialists in the field of chemical dependency. In 1982, a group of us from around the nation, field tested an examination for the California Society for the Treatment of Alcoholism and other Drug Dependencies. In November, 1984, 115 physicians were examined and 101 were passed and certified as specialists in the field of chemical dependency.

Also, in October, 1982, the American Academy of Addictionology was founded, largely due to the leadership of Dr. G. Douglas Talbott. Under its sponsorship and with the support of the AMA, the two historic KROC Ranch Conferences came about. The first conference brought together all the diverse medical groups interested in the field of chemical dependency: the AMA, the California Society for the Treatment of Alcoholism and Other Chemical Dependencies, the American Medical Society on Alcoholism, the Association of

continued on page 79

Second Opinion

continued

Medical Educators and Researchers in Substance Abuse, the American Psychiatric Association, the National Institute of Drug Abuse, the National Institute of Alcohol and Alcohol Abuse, the National Institute of Health and others.

Out of these meetings, a consensus report was formulated, recognizing that there is a special body of knowledge applicable to the field of chemical dependency, and those who are familiar with this body of knowledge should be identified as specialists in this new and distinct discipline.

The second KROC Ranch Conference delegated to the American Medical Society on Alcoholism and Other Drugs the responsibility of implementing a credentialing and certification process, as well as developing fellowship or residency training programs.

Following the second conference, the American Medical Society on Alcoholism and Other Drugs accepted this charge and implemented this by appointing a number of us to a committee to continue developing a certification process, as well as fellowship training programs. Many of the members of these committees come from the medical teaching field, as well as having practical experience in the treatment of chemical dependency.

In addition, I was recently appointed to an AMA committee to review the terminology used in the chemical dependency field, and also hopefully remove chemical dependency from the psychiatric category in the DSM 3 as well as the current international classification. This issue is already being tested in the courts.

We are receiving strong support in our efforts from the AMA, and hopefully within a few years medicine will have a new recognized specialty in the field of Addictionology. This new field is obviously long overdue, when 85% of all chemically dependent people receive no treatment at all for their disease.

Organized medicine has a vital role to play — first, in assisting this new field to obtain the credibility that it so desperately needs and that it has strived so hard to obtain; second, in bringing chemical dependency into the mainstream of medicine. We need to rid it of the remaining vestiges of stigma as a moral issue, rather than a disease, to document its treatability and to recognize the successful methodology which is already in place. In short, chemical dependency should be viewed as any other life-threatening, treatable disease.

Dr. Kennedy is program director for the Alcohol Rehabilitation Unit of Licking Memorial Hospital in Newark and is a member of the OSMA Committee on Impaired Physicians.

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IN THE SPOTLIGHT

Adapting the Chronic Disease Model in the Treatment of Dually Diagnosed Patients

FORT WASHINGTON, PENNSYLVANIA

Abstract—*This article suggests that while the focal point of inpatient treatment in the field of addiction should continue to be abstinence and 12-step programs, there should be considerable modification of the process of treatment. Many of the present inpatient psychiatric hospitals that treat addiction seem to be largely unaware of the biochemistry and physiology of early recovery. A model of treatment is proposed that takes into account the neurocognitive impairment and emotional augmentation that is present in early recovery. The focus of active treatment in this program is the treatment of the addictive process. The psychiatric diagnosis is managed through supportive psychotherapy and/or education if appropriate. Active treatment of the psychiatric diagnosis is deferred to outpatient treatment.*

MODELS OF TREATMENT IN THE DUAL-DIAGNOSES SETTING

MALVERN INSTITUTE is a 35-bed residential treatment center in Malvern, Pennsylvania. The staff of the Malvern Institute has been treating chemically dependent patients since 1946 and dually diagnosed patients since 1981. In the Delaware Valley, dual diagnosis treatment is usually done in psychiatric hospitals. In that respect, Malvern Institute occupies a unique treatment niche. Patients who are floridly psychotic or suicidal are treated at Malvern Institute after their psychiatric conditions have stabilized.

Until recently, Malvern Institute has used the multidisciplinary treatment team model as the predominant treatment mode. This is a common approach in facilities that treat dually diagnosed patients. In these facilities, addiction is seen as the end result of multiple etiologies. In this model, it is important to expeditiously treat any condition that may have contributed to the evolution of this disease in the first 30 days of treatment.

Psychiatrists, psychologists, nurses, counselors, social workers, recreation, art, and movement therapists are employed, when available, by the facility. Each discipline views the addicted individual from a slightly different professional perspective. The input of these disciplines is then woven together into a patchwork program. These programs frequently recommend sobriety, 12-step programs, and mental health. Although this approach has been somewhat successful, there are inconsistencies in the treatment based on the training and talent of the members of the team.

A significant drawback in this approach is the lack

Requests for reprints should be addressed to Raymond A. Johnson, MD, 1201 Greentree Lane, Penn Valley, PA 19072.

of any built-in mechanism to define and enforce role and task boundaries with the staff. Our observations of the actual day-to-day working of this model indicated that there were great discrepancies between the actual work done by the disciplines and the work that was reported by them in case conference. For example, although counselors reported that they were working on first step issues, direct observation indicated that they were working on issues of personality development and attitude. Psychiatrists strongly asserted that they were reinforcing the program, when they were frequently using insight therapy. Nursing staff would confront and interpret behavior, believing themselves to be ego supportive.

As this kind of disjointed treatment continues, the patient community will begin to perceive such treatment as poor and inconsistent. If they confront the staff, they are told that they are acting like addicts. If the patients accept an interpretation of this nature and surrender to the treatment program, they have the approval of the staff. If they do not, they are continually told that they are an addictive community and approval is withheld.

It is also not unusual to see this model hybridized within the therapeutic treatment community model. Staff and patients are seen as equal participants in the treatment community. In this case, the staff may be in a position that is equally as perilous as that of the patients. They may both be subjected to a nonvoluntary group process. This process usually tends to be neither therapeutic nor supportive, but frequently seeks to influence thought and attitude. By the very nature of a therapeutic community, it runs, day-to-day, on the basis of a belief system. This system may have very little to do with the treatment of addiction. The long-term effect of this approach may push the staff into behaving like an alcoholic family. The staff behavior then shapes the community behavior.

Admittedly, this is worst-case scenario. These problems do not always occur. The success of these styles of treatment depend on the experience and quality of a core membership of the staff. Although a facility may enjoy tremendous initial success, these systems tend to deteriorate as members of this core elite move on to other places and positions.

The difficulty of maintaining a therapeutic environment with dually diagnosed patients is further compounded by the regressive pull that these patients exert on the staff. This pull comes from their tremendous needs and endless issues. Staff may frequently feel overwhelmed when using a style of counseling that is issue-oriented in its approach. In addition, this treatment approach suggests that if addiction is a disease, it is a disease of personality disorder. Recent research suggests strongly that addiction is a genetic, biochemical, and physiologic event, making the latter approach inaccurate, somewhat judgmental, and moralistic.

Wishing to avoid some of these pitfalls, the clinical administrative staff at Malvern Institute sought a treatment model that would do the following:

1. Keep both staff and patients on the primary task, that is, treatment of addiction, and help to prevent the inevitable regressions that seem to accompany many other models.
2. Keep the wisdom and structural support of AA and NA while using treatment methods and information based on the most up-to-date research on addiction.
3. Set realistic treatment goals that take into consideration the weakened and debilitated condition of the patients early in sobriety and not expect more of them than they can do. Studies show that as many as two thirds of patients entering a residential treatment center may have a significant level of neuropsychological impairment, with clinical presentation running the gamut from inability to set priorities to difficulty in learning new information. Frequently, patients remain in a state of prolonged withdrawal. As a result, they may be emotionally augmented for the length of their inpatient stay. *Augmentation* refers to a clinical state of increased emotional arousal secondary to withdrawal. Any treatment method used should be extremely simple (cognitively concrete), highly logical, and nonprovocative.
4. Give patients a clear message of personal responsibility for the treatment of their illness.

THE DUAL-DIAGNOSIS MODEL

The dual diagnosis model as used here refers to a model that sees addiction as a disease, but allows for the existence and treatment of a concurrent psychiatric illness. There are several advantages to this model.

1. Both disease processes are considered primary.
2. Both require treatment.
3. They coexist without attributing etiology to each other.
4. Substance abuse must stop in order to diagnose and treat the psychiatric illness.
5. If the patient is proven not to have a psychiatric illness, this exclusion permits a shift of focus to the disease model of treatment.
6. Allowing for two separate etiologies decreases denial and splitting within the staff.

The most important feature of this model is that it does not compel the treatment team to attribute etiology of the addiction to the psychiatric illness. This permits patients and staff to continue to view addiction as a primary disease requiring abstinence. The accurate diagnosis and subsequent treatment of the psychiatric illness also requires abstinence. This clear separation of both diseases suggests that we should not combine substance abuse treatment with psychodynamic therapy in the context of the same program. When we do

this, the spoken or unspoken message to the patient is that the two illnesses are somehow magically woven together. We are left with the embarrassingly impossible task of explaining how a genetic and physiologically distinct disease has been caused by a psychiatric disorder.

Once having committed to this model, however, it became obvious that while it permits clarity it does not suggest a method or mode of treatment. The advantage of combining the dual diagnosis model with the chronic disease model is that it gives us a methodology by which we can treat two separate chronic illnesses within the context of the same program.

THE CHRONIC DISEASE MODEL

The chronic disease model of treatment was developed and written about extensively by Ron Rogers and Scot McMillin. They have produced books describing the treatment philosophy, group process, and family involvement inherently implied in this model. The model is based on the seminal work, *Under the Influence*, written by Milam. It is distinguished from other therapies by several key features. Its most important accomplishment is the direct and focused treatment of the disease of addiction. Most multidisciplinary treatment team models and therapeutic treatment community models attempt to treat the issues that emanate from the addiction, that is, negative attitude, intergenerational family conflict, grief issues, sexual abuse, and so on. These matters certainly are important and may even have a direct bearing on an individual's recovery. They are better dealt with when the individual is less neuropsychologically impaired and is less emotionally augmented, in other words, when they are less toxic from the effects of drugs and alcohol.

Alcoholism and drug addiction are marked by two distinct phases of symptomatology. The first phase includes symptoms of intoxication that range from slurred speech, to explosive behavior, to delusion and hallucination. Less well known are the symptoms of withdrawal. There are those symptoms that occur immediately after cessation of alcohol and drug use and those that occur after prolonged abstinence. Acute withdrawal can last up to 7 days. It can result in loss of reality testing, convulsions, and death. It can certainly mimic almost any of the common axis-1 disorders.

The second and less well-known phase is the protracted withdrawal syndrome. This makes its appearance after the cessation of acute withdrawal and can last up to 2 years. In the past, it has been most frequently described within the context of the social sciences and has been mistaken for the emergence of preexisting psychiatric and emotional disorders. Data gathered by computerized axial tomography and electroencephalography strongly suggest cortical damage from long-term alcohol ingestion. In alcohol treatment centers using the Luria-Nebraska Neuropsychological Battery, as many as two-thirds of alcoholics entering treatment have been shown to have significant cognitive impairment (see Figure 1). This impairment begins to show improvement by the time of discharge in many of the patients. Vaillant's comprehensive review of large numbers of alcoholics revealed that many of the alcoholics who were studied demonstrated a wide variety of psychological and behavioral disturbances

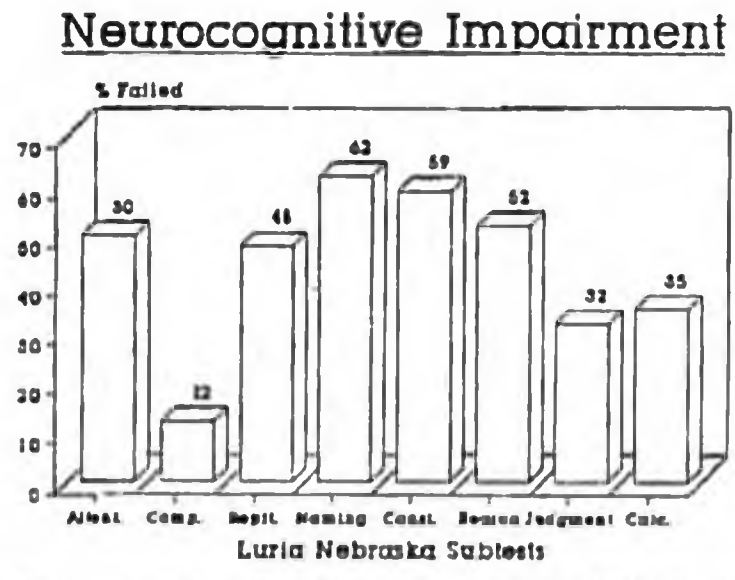

FIGURE 1. Study by Meek, Clark, and Solana demonstrates the percentage of alcoholics who failed specific subtests of the Luria-Nebraska Neuropsychological Battery given in the first 10 days of treatment.

that were not present before the onset of their disease. This strongly suggests that there is great physiologic disturbance that occurs as a direct result of the substance abuse and extends well past the period of acute withdrawal.

Obviously then, patients in early recovery are going to suffer from the effects of this protracted withdrawal. They will be easily confused, show disturbances of memory, and over-react to stress. They may be unable to attend, concentrate, conceptualize, and prioritize. All too often, these difficulties are interpreted as having Axis I or Axis II significance. They are then either medicated or confronted inappropriately. This knowledge should have far-reaching implications for the rehabilitation centers and intensive outpatient clinics that treat these patients.

The chronic disease model treats addictions in a direct and focused manner that assumes a disease with central nervous system sequelae. Program material repeats every 21 days so that patients repeat their first work. The program uses task groups that occur in appropriate sequence with the lectures. All of the work is then related to one of the four primary goals of treatment. Information deemed to be strategic and important for treatment is cycled to repeat in various lectures and at appropriate times.

GOALS OF TREATMENT

Once the patient's physical and emotional conditions are stabilized, programmatic goals of treatment can be met.

1. *Education:* The education of the patient and the staff is one of the most important functions of the program. Therefore, it becomes important that the information meet the following criteria:
   a. Everyone must be the recipient of the information; no secrets should be kept from the patients.
   b. The information used is endorsed by the scientific community as the most accurate and up to date.
   c. A significant part of the information should be a clear-cut explanation of the chronic disease model program. Patients are able to gauge their progress and hold the staff accountable to deliver their promise of treatment.
   d. Because the major form of treatment of chemical dependence is still 12-step programs, the information should be heavily weighted on the practical use of these programs.
   e. There should be a predictable and verifiable quantity of knowledge passed from the staff to the patients. Lectures entitled "The Disease of Addiction" must include information on tolerance, dependence, loss of control, and so on. Staff should not lapse into stories such as "My Personal Recovery." When patients are halfway through treatment, they should be able to understand their treatment and recovery program well enough to begin to teach it to the newcomers.
2. *Self-diagnosis:* The next most important goal of treatment is that the patients must self-diagnose. In other words, all the material given to them is worthless if they cannot apply it to themselves. However, this is the work of the patient and his peers, not of the treatment staff. The primary treater in this model is the patient. The goal of the counselor is to educate and facilitate the patient's self-diagnosis, not to push him into self-recrimination or to provoke him into sobriety. It becomes very difficult for the staff members to project their issues onto the patient, partially because treatment is not issue-oriented and partially because there is little opportunity to do it. Therefore, patients are asked only to personalize the material that they have learned.
3. *Learn how to treat their illness:* Just as diabetics must learn to count calories, weigh food, and adjust dosages of insulin, addicts must learn to maintain their health and sobriety. Recovering addicts must learn to make lifestyle changes. They must learn what to avoid, new ways of dealing with stress, how to obtain a sponsor, how to fire a sponsor, and so on.
4. *Assumption of personal responsibility:* Compliance is not punished in this program. Compliance is simply the act of doing what you are told to do. In other treatment models, it is thought of as a deceptive maneuver on the part of the patient. In the chronic disease model, it is considered an important step in the patient's progress. Progress is measured by whether or not the patient meets certain behavioral learning objectives in the program. The staff does not engage in mind reading or accusing patients of impure thoughts and motives. It becomes the goal of the staff to remove all such impediments to the patient's progress. In this respect, the chronic disease model has been compared to the Montessori method. Patients are also expected to learn about their psychiatric diagnosis and to take personal responsibility for it. The patient's psychiatrist might then educate the patient about manic-depressive illness, for example, and how to do the self-care necessary for continued stabilization.

ROLES

Role boundaries are very important in this model, and staff members are expected not to stray from their defined positions and delineated tasks. The patients also know the task and role expectations. The patients have

the right to remind staff members about program boundaries and to exercise that right with healthy exuberance. This encourages patients to begin to take charge of their lives while they are still in treatment, and this promotes skill building.

1. *Counselors* educate the patients, facilitate groups and community meetings. They set up back-to-work conferences. They also educate families and lead multiple family discussion groups. They counsel! They do not do interpersonal group therapy or individual therapy in a group setting.
2. The *addictionist* develops individual detoxification protocols and oversees the medical care of the patient. His primary goal is to stabilize the patient medically and apprise the patient of his condition. He will explain laboratory tests to the patients and relate results to their disease. He may also do individual counseling. In addition, the addictionist may help develop drug-free programs for the maintenance of chronic pain syndromes when appropriate.
3. It is the *psychiatrist's* job to diagnose and treat mental and emotional instabilities in a manner that is responsible and consistent with the goals of a chemical dependence treatment center.
   a. Before psychiatric medications are given, the patient must demonstrate *DSM-III-R* criteria for that illness before the onset of the addiction, or they must have maintained their symptoms for a period of 3 weeks after detoxification.
   b. Diagnoses such as borderline personality disorder are not medicated. We strongly believe that personality disorders cannot usually be accurately diagnosed in the first 4 weeks of treatment because of the complications of protracted withdrawal.
   c. The psychiatrist should continually assess the level of cognitive impairment of the patient and help to ease his adjustment to the program.
   d. Supportive therapy is provided when indicated. The goal of this therapy approach is to reinforce the patient's participation in the program and to help reduce the use of primitive ego defenses and acting out behavior.
   e. The psychiatrist must also educate the patient about the psychiatric illness and the responsible care of that illness.
4. *Nursing staff* help to maintain the program boundaries 24 hours a day and are extremely important to the ongoing integrity of the program. They take part in patient education through lectures and the explanation of laboratory tests. They also help the dietitian and the kitchen staff in educating the patients in the proper nutrition of recovery.
5. *Recreational staff* consult with the physician to help the patients develop a realistic and healthy exercise regiment that they will be more likely to continue after treatment. The focus is on the restoration of physical health through gradual increase in the level of physical activity. Self-care is taught along with the constructive use of leisure time.

THERAPEUTIC ACTIVITIES

Because the most important goal is to teach addicts to be responsible for their own care, it makes sense to approximate the individual's aftercare environment as closely as possible within the treatment setting. They would then be better able to use this environment after treatment because they would have some experience negotiating it. One might think of the clinical milieu as attempting to replicate the successful and unique attributes of a 12-step program.

These attributes are:

1. Alcoholics are not treated by professionals in 12-step programs. They are treated by each other. This is an experience that should then be replicated in group, community, and milieu therapy.
2. The basic character of 12-step programs is that they are homogeneous. They are made up of individuals who are addicted and have similar life experiences. No one goes to an AA meeting for therapy for an emotional disorder. People may go, however, to stay sober in the face of many emotional problems. They are then likely to see their therapist to deal with their emotional issues. Meetings are also positive in tenor, supportive in nature, and task oriented.
3. There are traditions that are passed on that are unchangeable. Some are written, and some are passed on by word of mouth from the older members to the newcomers. They prevent the group from being subverted by circumstance and individuals. This ensures that the primary task of the maintenance of sobriety continues within the 12-step program.
4. In addition to the following 12 traditions, each group develops its own character and mores.
5. Leadership is passed on so that no one individual becomes more important than the fellowship or the group.

The style of group process most often used in rehabilitation settings is the short-term Yalom group, which does not meet the aforementioned criteria. In these groups, patient's issues, many of which vary from patient to patient, are worked on one at a time. Differences and not similarities are stressed in group. The counselor frequently sets the agenda for what issues will be declared to be "crucial" to the patient's sobriety. These "choices" may reveal more about the counselor than they do about the patient.

The group process used in the chronic disease model is based on the group style of Lord Wilfred Bion. The groups have specific tasks, and the role of

the counselor is merely to keep the group or the community on task. The primary task of the group or the community is always the treatment of the addiction.

The psychiatric diagnosis is not treated by the group or the community. It is treated by the psychiatrist. It is the job of all staff members to make their primary investment in the maintenance and continued life of the program. In that spirit, the primary task must always be preserved. Therefore, anything such as a psychiatric diagnosis, that prevents the individual from attending to the primary task is actively treated. In that respect, the psychiatrist helps the patient by managing the psychiatric illness, whereas the patient attends to the primary task of treating his or her addiction.

COMMUNITY MEETING

The community meets daily lead by its officers. After the groups elect their leaders, those group leaders are eligible to be elected to office by the community. Leadership is passed on each week. The primary task of this meeting is the same as for every activity. The patients call the meeting to order and then read the community rules and boundaries (program rules). They will solve problems that develop within the community that are not specifically covered in the program rules. One community may have to solve the problem of how its members will help each other adhere to a 10-min telephone limitation, whereas another community may have to solve the problem of getting its members to therapeutic activities on time.

Community meeting is generally facilitated by only one staff member. This staff member may assist the community by clarifying a problem or refocusing the community. It is important that the facilitator work to empower the group and not determine it by solving its problems for them.

SMALL GROUPS

Groups occur daily at Malvern Institute. The groups are task oriented, and they are facilitated. Individual and interpersonal therapy is not done in the context of the group as it is with the Yalom model. All of the groups are focused on some aspect of addiction and recovery. They must fulfill one of the four basic goals of treatment and are coordinated with the lectures given that day.

Groups operate out of one of four basic "modes." These modes are hostile, hopeless, hopeful expectation, and working. Obviously, the goal of the group and its facilitator is to help the group achieve a working mode. A group is in a working mode when its members are able to stick to the task at hand. Groups can fall into helplessness and hopelessness; they can become hostile and direct their hostility to the counselor or to one another. They can also enter hopeful expectation mode, which on the surface appears to be positive activity. It is not activity that is based in reality, however.

The groups have one of four basic themes or tasks:

1. *Defense mechanism groups* occur twice a week. They dovetail with the lectures that define defense mechanisms and detail their use in the service of the addiction. Patients are given examples to watch on videotapes to further identify these mechanisms of denial. They will then participate in a group in which they relate the use of these defenses to themselves. The patients discuss how these defenses are used to avoid self-diagnosis. They discuss how to change this behavior. Acting out in the community may be discussed in the defense mechanism group so that the patients can relate this to their avoidance of treatment. It serves as a way of using peer interaction to keep community behavior under control. Confrontation is always done didactically. Patient are taught to confront in this manner, directly and by example.
2. *Step groups* occur once each week and go sequentially through the first three steps. These groups emphasize maintenance of sobriety. They are related to the educational lectures. For example, step 1 emphasizes how the disease process leads to powerlessness through the mechanisms of tolerance and withdrawal. Unmanageability stresses the problems stemming from the disease, such as legal problems, family problems, and so on. The need for abstinence and working the steps is emphasized. Step 2 stresses the importance of the group, AA, and reality testing. Step 3 stresses the group and why willpower does not work and what it means to turn one's will over.
3. The *education group* is the third type of task group. This group stresses familiarity with the present week's lecture material. Again, the group stresses relating the material to the individual members. They also must identify educationally weak areas in the group. This ensures that all of the members of a given community receive the information that is needed to self-diagnose. There is, of course, a certain amount of new learning that takes place with each new member as the group attempts to diagnose or determine what information an individual is missing and to develop ways in which the patient may make good on those deficits.
4. The *treatment plan group* is another type of group. This is the only group that may on occasion address a patient's self-defeating behavior and attempt to prescribe alternative behaviors that are more consistent with active treatment. Again, this is peer-led and patient-determined. Clients are expected to follow the guidelines of treatment planning and to develop goals and objectives.

Counselors are rotated through the different groups

so that no group identifies itself as belonging to a particular individual or vice versa. The counselor can make an intervention if the group is having trouble with the task, but he or she must first determine what mode the group is in and must address all of his or her comments to the group as a whole and never to individuals. This prevents projective identification with the group and further prevents acting out countertransference. The advantage of this kind of disciplined therapeutic interaction to dually diagnosed patients is obvious. Emotional turmoil and patient acting out is greatly decreased. Patients with Axis I diagnoses that could not tolerate more "invasive" or "penetrating" group techniques are generally able to tolerate these groups.

INDIVIDUAL THERAPY

The individual therapist has 10 major tasks in this model of treatment.

1. *Collect and assess a database.* This is a very important function in this model because some treatment must be deferred to the outpatient setting. It becomes very important to assess the aftercare needs of the patient and to make the appropriate referral.
2. *Develop, revise, and update individual treatment plans.* The plans are designed to educate, to relate learning to experience, and to bring about behavioral change. A detailed and relevant plan is made, and a copy is given to the patient.
3. *Provide cognitive and reality-oriented therapy.* It should be aimed at teaching patients helpful control of feelings. The emphasis should be on the prevention of regression. Therefore, patients are not encouraged into insight or expressive psychotherapy. "Conversion experiences" are not encouraged. The emphasis is on consistent and directed work and not self-castigation.
4. *Confront denial only by didactic methods.* There is nothing therapeutic about increasing the level of shame that an individual comes into treatment with because most of it is based on a moral understanding of addiction. It is very important that the staff model behavior that is consistent with that belief.
5. *Teach patients about defense mechanisms and how they are used to justify addictive behavior and to avoid treatment.* The more the behavior of questioning one's defenses is modeled for patients, the more they will do it. The more they are confronted forcefully, the more defensive they will become.
6. *Provide opportunity for patients to witness the use of defense mechanisms and to identify them.* Conflict, attitude, and behavior are never interpreted. The patients may make their own guesses about what dynamics their defenses may conceal, but this should not be encouraged or validated by the staff.
7. *Provide the patient with all the information you learn about him or her.* Stick to basic data and facts. Avoid asking the patient to believe things that you cannot support with data. Patients should be given useful data in the same format as they are given data about their addiction.
8. *Self-disclose only when appropriate.* This means that therapists do not disclose personal information when it has no benefit for the patient. It also means that unresolved issues are not divulged.
9. *Develop appropriate aftercare, and motivate the patient to accept and follow it through.*
10. Teach the patient the effective use of 12-step groups.

LECTURES

The topics of lectures are chosen on the basis of what patients need to know about addiction and the normal recovery process. They also need information about the basics of self-care. In the case of addicts, that means teaching them a practical working knowledge of 12-step groups and sober living skills. Lectures must be outlined well enough that anyone can take over the lecture and cover the important points. Topics are presented in a logical manner and are coordinated with the day's activities. Therefore, if a lecturer is absent on a given day, someone else must be able to step in and cover that topic. It must be covered point by point.

DIET

It is with some trepidation that I place diet under the heading of therapeutic activities. It is still fashionable in medical circles to state that if a person eats three well-balanced meals a day that person will get all the necessary nutrition. However, addicts are people who have run up a tremendous debt with reality. They are vitamin and mineral depleted by the time they come into treatment. They frequently attempt to digest and absorb food with a compromised digestive tract.

In addition, there is some evidence to suggest that an addict's need for protein, or the amino acids that are the building blocks of protein, are increased. The protracted withdrawal syndrome occurs out of a deficiency of neurotransmitters. Serotonin, for example, relies heavily on the amino acid tryptophan for its synthesis. It does not cross the blood-brain barrier itself; therefore, one of the few ways of increasing serotonin is to increase the amount of tryptophan delivered to the brain. Theoretically, at least, diet should be important to the process of recovery.

This, of course, does not even begin to cover the topic of diet for general food health. Typical rehabil-

ination food is high in caffeine, simple sugars, fats, and cholesterol. The theory is that recovering people need "hearty fare" and tasty food (usually high in fat) to keep their minds on treatment. I have been dismayed by the fact that middle-aged men, who have some risk of heart attack, experience increases in their blood lipid and cholesterol levels in their second week of treatment, not as a consequence of recovery but because of the diet that they were fed.

Caffeine is not a benign drug in the hands of active addicts and recovering individuals. In an addiction, it was all too often used to stimulant-load an individual who was lethargic and exhausted from alcohol and drugs. This kind of stimulant loading always incurs a debt to be payed later in neurotransmitter depletion.

Simple sugars have similar effects on people in recovery. Although chocolates may temporarily decrease a craving for alcohol, there is a "high" that occurs after eating and then a rebound depression state. This "low" feeling state is often accompanied by a recurrence of craving.

Sugar and caffeine loading also increase stress in an organism. Recovering people are particularly sensitive to stress. We believe that these eating habits have a very direct and negative effect on the protracted withdrawal syndrome and measurably increase the difficulty of recovery. Therefore, we not only teach diet and recovery to individuals in our program, we also feed them a diet that eliminates free sugar and caffeine and is low in fat.

CONCLUDING REMARKS

This model of treatment does not trivialize the many important issues of the recovering addict. It merely prioritizes the sequence of treatment to match the recovering patient's physiology and limitations. Many issues are deferred for outpatient treatment. The strength of this model lies in its restraint. The staff must place most of its energy into the maintenance of the program itself, which helps to prevent acting out of codependent and countertransference issues. In other words, it helps to prevent the staff members from acting on inappropriate thoughts, feelings, and attitudes from their own part that would be harmful to the patients and impede their progress. Its success with dually diagnosed patients suggests that those who treat the addict early in recovery have an obligation to remember and practice the first rule of Medicine: "First do no harm."

Raymond A. Johnson, MD
Department of Addiction Services
Northwestern Institute of Psychiatry
Fort Washington, Pennsylvania

Alcoholism: Disease Or Addiction?

Editor's Note: As editor of Professional Counselor, *I am afforded the opportunity to work with many noted professionals in the addictions field and the creative freedom to bring together experts who may have different viewpoints on controversial topics.*

Only a few years ago, it would have been difficult to imagine having two of the most noted authorities on addictions and relapse prevention agree to a point/counterpoint on the question: Is alcoholism a disease? Today they acknowledge that, while their convictions may conflict in some ways, there is also much that they agree upon.

This debate highlights their common ground as well as their differences. It is offered in the spirit of cooperation between these two schools of knowledge, with the hope that by studying their perspectives, we can unite our efforts to decrease the devastating consequences of alcohol and drug addiction. As always, we welcome comments and feedback from our readers.

— Richard Fields, PhD

Top 10 reasons why alcoholism is an addiction but not a disease

By G. Alan Marlatt, PhD

The great debate continues. I'm not going to say that I don't think there is such a thing as alcoholism. It's a serious problem. There are people in my family who have died from it. I'm very concerned about this problem but I'm also a researcher and a scientist who is trying to figure out what alcoholism is.

I don't think it's a biological disease. To think of it just that way sets us up for certain problems. Well, what is it then?

I'm going to argue that it's an addiction. It has some overlap with disease and with behavior and habits, but we don't have the full answer yet of what addiction is. It's a very slippery animal and it has multiple causes. I don't want to say there are no biological issues here; of course there are. But there are also psychological, social, and spiritual issues that are important to this discussion.

G. Alan Marlatt (left) and Terence T. Gorski

(Continued to page 56)

Flawed disease definitions have hindered alcoholism treatment

By Terence T. Gorski, MA, NCAC II

To intelligently discuss the issue of whether alcoholism is a disease, you first have to define the disease. When talking about disease, people use three terms interchangeably: a disease, a disorder, and a syndrome.

Our working definition for use in this discussion involves three criteria:

- Does alcoholism constitute a clinical syndrome marked by an identifiable group of signs and symptoms?
- Is there a disorder present that is marked by structural or functional impairments related to the syndrome?
- Is there an etiology or cause of the syndrome that can be pinpointed or identified?

Let's address and answer the first question. Is alcoholism a syndrome? The answer to this is an absolutely unqualified "yes."

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You can distinguish alcoholism from other disorders. These signs and symptoms were originally identified before the turn of the century, and they've been studied and clarified ever since. Many researchers and leading professional organizations, including the American Medical Association and the American Psychiatric Association recognize these signs and symptoms.

"Here was a fundamental error inadvertently interjected into the consciousness of the chemical dependency field: that there is only one type of alcoholism."

Body of knowledge

The first modern-day medical researcher to study alcoholism, which at that time was termed "inebriety," was Dr. Benjamin Rush. His idea was that there was a syndrome of alcohol-related medical problems that he felt could best be described as a disease. His description of the symptoms was incomplete and quite primitive, but his inquiry started a process of medical examination of alcoholism as a disease.

Dr. Rush was acting against a moral model of alcoholism, which defined alcoholics as bad people, immoral sinners who needed to repent in order to get well. The framework of alcoholism as a disease was new and revolutionary.

This medical thinking culminated in the late '50s and early '60s with the research projects conducted at the Yale and Rutgers schools of alcohol studies. These studies resulted in a significant body of data that built a convincing argument that alcoholism was a disease. This body of knowledge was so compelling that the Congress of the United States created the National Institute of Alcohol Abuse and Alcoholism to nationally implement treatment programs based essentially upon this model. This work was summarized in the book, *The Disease Concept of Alcoholism*, by E.M. Jellinek, which was published in 1960.

The problem that I had all along in the field of addiction is that most people treating alcoholics never went back to this original source document, which very clearly presented an understanding of alcoholism and divided it into five subtypes:

• *Alpha* alcoholics are purely psychologically dependent but do not have physical dependence or damage. Jellinek was clear to assert that psychological dependency on alcohol alone did not constitute a disease state. Not all people with alcohol problems have the disease of alcoholism, some of them are alcohol abusers or problem drinkers who do not have the disease state.

• *Beta* alcoholics are socially and culturally heavy drinkers who were not physically addicted to the drug but suffered alcohol-related physical health problems, such as liver damage, in the absence of any pronounced signs of physical or psychological dependency. Beta alcoholism, Jellinek pointed out, is not of and by itself a disease, although the secondary damage to the organ system may be a disease.

• *Gamma* alcoholics exhibit progressive symptoms of both physical and psychological dependency upon alcohol. Looking retrospectively at chronic-stage alcoholism, this condition does progress and this research looked at retrospective studies only. Jellinek did view gamma alcoholism as a disease. In its end stages there was related organ-system damage, and he proposed an unknown "X factor" in terms of some function in the metabolism of the brain that created this disease state.

• *Delta* alcoholism characterizes someone physically and psychologically dependent on alcohol, but the intensity of their drinking does not increase—they drink the same amount every day. They are maintenance drinkers. Essentially, I think Jellinek was describing well controlled gamma alcoholism. He also considered delta alcoholism a disease.

• The *epsilon* alcoholic he described as the periodic alcoholic, who today we would call relapse-prone. This person has a period of sobriety, then relapses, has a binge, goes back into recovery, stays sober for a long time, then has another binge. This is a gamma alcoholic who has moved into incomplete or partial recovery and has become relapse-prone.

Gamma, delta and epsilon alcoholics represent the disease state. It's important to stress that, according to Jellinek's topology, only gamma alcoholism and its two related subtypes, delta and epsilon — the plateau drinker and the periodic binger — met the criteria for disease. The person who experienced physical consequences because of alcohol but with the absence of dependency did not, nor did the purely psychologically dependent drinker.

Damage done

Where did we lose Jellinek's topology? Where did the damage occur?

The damage occurred because of an extremely brilliant gentleman named Dr. Maxwell Glatt. Shortly after the publication of Jellinek's disease concept, Dr. Glatt was so taken with the description of gamma alcoholism that he took the symptoms, operationalized them and put them on a chart, which he dubbed the Jellinek Chart. Try and find the Jellinek Chart in any of Jellinek's published works. You won't, because Maxwell Glatt published it in the *British Journal of Addictions*.

He then proposed a course of recovery. What Dr. Glatt did was operationalize gamma alcoholism so well that everyone became hypnotized by it. Here was a fundamental error inadvertently interjected into the consciousness of the chemical dependency field: that there is only one type of alcoholism, gamma alcoholism, that it is chronic, progressive, and eventually fatal, that everyone who has any kind of alcohol problem has the disease, and that if you have mild, or early-stage alcoholism, the progression is inevitable.

This is a fundamental error that flawed the chemical dependency field and led to

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neglecting and failing to respond to the needs of non-addicted abusers and non-addicted problem drinkers. When these people came to us for help, we took two inexcusable positions that said, "Take treatment you don't need" or "Keep drinking until you get really sick, then come back." Both of these positions were stock and trade in many chemical dependency programs.

Dr. Glatt later published an extensive book on alcoholism that presented his full overview, but unfortunately that book never became as popular as his simple, easy-to-use Jellinek Chart.

Simultaneously, a gentleman named Mark Keller, operating under the auspices of the World Health Organization, put together a cross-cultural, international lexicon of terms involving diagnostic labels for alcoholism, basically confirming that the phenomenon of alcoholism — this thing called gamma alcoholism and the other type, the non-addicted abuser — is, in fact, a cross-cultural phenomenon.

Enter the Institute of Medicine, which was commissioned to give a report to Congress. When I read that particular document, I was rather shocked because I viewed it to be a biased document primarily developed by a committee that did not understand the work that was going on in disease-model programs; did not understand the evolution of where the leading-edge thinkers were going in this field; and who really diminished the importance, at that time, of the major treatment approach to alcoholism, namely Minnesota-model treatment and its emerging and developing forms. Evidence of this is the extremely limited number of pages devoted to explaining, understanding or referencing that model, while very small, obscure behavioral studies were given pages of credit and reference.

I was really concerned when I read this because I realized that if this document went unchallenged, it would become the blueprint for reshaping chemical dependency treatment in the nation. I expressed my concerns to the leaders in the alcohol and drug treatment industry. They put together a very weak, disorganized response and let it die; that became one of the most powerful, organizing public policy documents ever published.

"I have a hard time tolerating people who say, 'Here's this group of patients who have alcohol problems who definitely don't meet a disease profile; therefore, nobody does and we should throw out the disease model.'"

What we are seeing today is that the blueprint for the Institute of Medicine report is the game plan that is reorganizing service delivery for alcoholism and other drug dependency. Unfortunately, I believe it's a biased and flawed approach. It's partially correct, but it does not represent a higher-order model because biases were built in against very effective forms of treatment for very sick people. It's sad, in my mind, some very dire consequences in terms of making treatment to certain subpopulations of alcoholics far less available than it was.

I think there is a broader base of treatment, but I also think there are people suffering from the disease of alcoholism who are not getting what they need publicly and privately. The document has benefited in many different ways.

Drawing the line

Let's look at it from a [illegible] where on one side is the non-addicted, infrequent abuser and on the other side of the line is the chronic, severely ill alcoholic. I don't know anyone who operates within a disease model of addiction who would contend that extremely mild forms of alcohol problems are a disease. They might say there are some factors that would indicate high risk, but the hardest-core disease advocate would never take a kid who got drunk for the first time and say, "You have a chronic, progressive, eventually fatal disease," and advise him to go into a long-term treatment program and never drink again.

At the other end of the line, there are some people with some very severe forms of alcoholism for whom not even the most hard-core behaviorists would say, "Gee, you don't have a disease. Your liver's falling out, you've got brain damage, you've got organ damage, you've been drinking a fifth a day for the last 12 years, you are nearly dead and in an intensive-care unit. Let's set up our little experimental drinking bar in your room and teach you how to drink in a controlled manner."

My point is, in the extreme positions there is a lot of concurrence. Would Dr. Marlatt agree that in the extreme latter scenario there are people who, in all practical senses, have the disease, and that there are people in the first scenario who, in all practical senses, don't — they're non-addictive abusers?

Where we've got the problem is the middle group. The key question is, where do we draw the line?

My basic principle is, I never knew anyone who died from abstinence. So, if in doubt, I say let's try abstinence. People with other biases say, "Well, controlled drinking is fine. If in doubt, put them on a control regimen. If it doesn't work, move toward abstinence."

The error I'd like to avoid in this discussion is what I call the "biased overgeneralization." As a disease-model advocate, I've had a lot of trouble with my colleagues who say, "Here are these people who definitely have a disease. Therefore, anyone with a drinking problem has a progressive, eventually fatal disease and should recover the way God intended him to recover, the way I did." That position is professionally untenable in my mind.

On the other hand, I have a hard time tolerating people who say, "Here's this

group of patients who have alcohol problems who definitely don't meet a disease profile; therefore, nobody does and we should throw out the disease model."

What I would like to see is a higher frame of reference capable of embodying and embracing both of these points of view. I am not going to argue that people with mild alcohol and drug problems have a disease. You can't win that argument because many of them probably don't at that point. But there is definitely a group of people who do. We must protect adequate services for this population. The key question is, how do we improve our diagnostic sophistication so that we can, in fact, get better at what we do?

When you look at the disease-model research you begin to find that the major subtypes of addiction are falling into three categories:

- *Primary alcoholism*: where alcoholism develops before any other psychiatric pathology. It has two subtypes, early onset, with people who seem to be more genetically and prenatally involved; and later onset, with people who are more environmentally influenced.
- *Secondary alcoholism*: where a psychopathology, primarily antisocial disorder or conduct disorders precede the development of addiction. There are two subsets of this; abuse disorders, and dependence disorders secondary to the psychopathology.
- *Reactive alcohol and drug abuse*: where a person drinks alcoholically and addictively in response to environmental stressors, such as Vietnam. When the person returns, the stressor is gone and they spontaneously stop or moderate their drinking.

When we're looking at the primary addiction, the newest research tells us this is a disease of the brain — specifically, a disease of brain-reward mechanisms. A person is born with a deficiency in brain-reward mechanisms, which creates a low-grade, agitated depression. When they find their drug of choice, their brain reacts by over-producing brain-reward chemicals, which produce a euphoria.

This feels so good that the person starts thinking about it a lot and develops an obsession with it. They feel an urge to do it, which is a compulsion, and this results in a craving. They have an innate, high tolerance. They're hangover-resistant, so they don't get very sick the next day.

"The disease model does not mediate against recovery."

During the '80s, the disease model brought more people into sobriety and recovery than any other approach to alcoholism or addiction treatment. The disease model does not mediate against recovery. One-third of the treatment programs were producing one-year recovery rates as high as 65 percent. They were effective. ■

Terence T. Gorski is a pioneer in the development of relapse prevention therapy. He is president of the CENAPS Corporation, a training and consulting firm in Homewood, Illinois, and the founder and clinical director of the Relapse Prevention Certification School, which conducts advanced training in the United States, Canada, and Europe. His books and articles have been published worldwide. He holds a bachelor of arts degree in psychology and sociology from Northwestern Illinois University and a master of arts degree from Webster University in St. Louis, Missouri. He is also a Nationally Certified Addiction Counselor and a Senior Certified Addiction Counselor.

FEEDBACK

***Professional Counselor* invites responses from our readers. The mental health and addiction fields continue to generate interest and controversy as they rapidly expand. We want to know what you think.**

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Our readers are also invited to submit articles on any topic relevant to mental health and addiction counseling. Writers' guidelines and editorial calendars are available. Send requests, proposals and manuscripts to the associate editor at the above address. Items requiring a response but not including a self-addressed envelope with sufficient postage will not be returned.

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For example, let's look at cirrhosis of the liver. I have no argument as to whether cirrhosis is a disease. The question is whether the behavior that exacerbates cirrhosis — i.e., drinking — is itself a disease.

Studying susceptibility

Let's look at the definition of disease that has driven the disease model. In the introduction of *The (Alcoholic's Anonymous) Big Book*, Dr. Silkworth gives his definition of the origins of the disease model. He says:

"We believe . . . that the action of alcohol on these chronic alcoholics is a manifestation of an allergy. The phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all and, once having formed the habit and found they cannot break it, once having lost their self-confidence . . . their problems pile up on them and become astonishingly difficult to solve."

"Relapse is the pivotal issue that determines whether the disease model works."

Although it doesn't necessarily have to be an allergy, (what he is proposing) is that only certain people are susceptible.

Later, in the opening paragraph of Chapter 4, it says: "In the preceding chapters you've learned something about alcoholism. We hope we have made it clear the distinction between the alcoholic and the non-alcoholic. If, when you honestly want to, you find you cannot quit entirely; or, if when drinking you have little control over the amount you take, you are probably alcoholic. If that be the case, you may be suffering from an illness which only a spiritual experience will conquer."

The interesting thing is that, yes, it's seen as a kind of disease there but the solution is a spiritual one, not a medical one.

Terry mentioned Jellinek's book, *The Disease Concept of Alcoholism*. Jellinek makes the case that may be certain subtypes can be thought of as diseases, whereas others cannot. This book, probably more than any other, had the most impact in getting this model going.

Jellinek's key passage says: "The current majority opinion, to which the present writer subscribes, is that anomalous forms of the ingestion of narcotics and alcohol, such as drinking with loss of control and physical dependence, are caused by physiopathological processes and constitute diseases."

He defines loss of control this way: "Recovered alcoholics speak of loss of control to denote that stage in the development of their drinking history when the ingestion of alcoholic drink sets up a chain reaction, so that they're unable to adhere to their intention to have one or two drinks only and continue to ingest more and more, often with quite some difficulty, contrary to their volition."

As I read over this, I found this other sentence about relapse, which I hadn't noticed before. Jellinek says: "I must add that the occasion for relapse is a voluntary one and does not form a part of the disease process except perhaps in a psychopathological sense."

In other words, relapse is psychopathological and the disease is physiopathological. The uniform disease model that came out of this type of thinking is the definition I'm going to take issue with. Relapse is the pivotal issue that determines whether the disease model works.

Top 10

I therefore propose a sort of David Letterman Top 10 list of reasons why I don't believe that alcoholism is a disease.

10 Drinking is a risk behavior, not a disease. Both drinking and smoking can become addictive behaviors and leading causes of potentially fatal diseases like cirrhosis and cancer. The behavior is one

thing, the disease consequence is another.

For example, when we look at a wide range of behavioral factors, approximately half of the 2,148,000 deaths in the United States in 1990 can be attributed to behavioral factors. Smoking, as we all know, is the number one killer; 400,000 a year are dying from tobacco-related causes. (In a recent study of mortality rates among alcoholics, it was reported that 60 percent of the mortality among alcoholics could be attributed to tobacco-related illnesses because of the high coincidence between smoking and drinking. Only 35 percent could be attributed to alcohol-related causes, such as cirrhosis).

Then we have diets and obesity as the leading cause of cardiovascular disease; HIV; microbial agents; toxic agents; firearms; motor vehicles; illicit drug overdoses; and more. These are all behaviors. At the Addictive Behaviors Research Center, where I'm working, we don't think that calling all these things "diseases that only certain people get" is very accurate.

9. Unlike biological disease, alcoholism can be eliminated or arrested by a voluntary decision made by the drinker.

This is the most optimistic thing about working with addiction problems. If you can create the right circumstances where the person can make a change, they can do it, and have done it, without necessarily having to turn themselves over to a doctor who treats them with some external agent like Antabuse or Naltrexone.

Decisions and cognitive factors are involved in the recovery process. It's a series of choices and decisions. There are forks in the road of recovery. Certainly there are decisions and choices that you get in the case of alcoholism that you probably don't get with most other diseases.

8. There is no official medical diagnosis of alcoholism, only degrees of alcohol abuse and alcohol dependence.

The *DSM-IV* model is basically a continuum model. When you bring all these definitions into it, you get more support from the continuum model than you do from the dichotomous, "either you have the disease or you don't have it" model.

"Decisions and cognitive factors are involved in the recovery process. It's a series of choices and decisions."

7. There is no single biological or genetic cause of alcoholism.

There are a lot of theories. It's not very specific anymore that it's just alcoholism. There seems to be a wide range of risk behaviors.

6. Effective treatments for alcoholism are almost always based on psychosocial, cognitive-behavioral or spiritual self-help groups, not on "medical treatments."

I'm on the advisory board for the National Institute for Drug Abuse, and the budget to try and find pharmacological interventions for, say, cocaine addiction, is incredible. A lot more money is going there than toward development of better psychosocial or behavioral programs.

5. Unlike with most diseases, many people resolve alcohol problems on their own, without treatment (e.g., maturing out, spontaneous remission).

We already know that most people who quit smoking did so on their own, even though nicotine addiction is very hard to overcome. Now we're finding the same is true with alcohol and other kinds of drug addictions. The number of people who resolve their problems on their own is quite large. This doesn't seem to fit with the progressive-disease model.

4. Loss-of-control drinking in alcoholics is triggered more by psychological factors (expectancy) than by the biological effects of alcohol.

Jellinek's book talks about how one drink is sufficient to trigger this loss of control. We always thought it had more to do with what belief the person had about the alcohol, not just the physical effects. That led us to develop a placebo design study, where we could manipulate what alcoholics were actually given to drink and what they thought they were given.

What about when you don't think you're getting alcohol but you are? If it's a disease, that should trigger loss of control because the alcohol is in your blood, even though you don't know it. What about when you think you're getting alcohol but there's no alcohol in the drink? Do you get loss of control there? Yes, you do.

The study found that when the subjects were led to expect tonic, without vodka, they drank very little. If they expected vodka with their tonic, they drank a lot. It didn't matter whether they were actually getting alcohol or not. So we don't find that the mere presence of alcohol in the bloodstream is causing the loss of control. There has to be awareness of the psychological factors.

3. Belief in the disease model of alcoholism predicts greater relapse, according to a recent prospective treatment outcome study at the University of New Mexico, part of a project funded by NIAAA.

Researchers gave a single questionnaire to people who were in traditional 30-day, residential, inpatient Minnesota-model treatment. It said, "To what extent do you think alcoholism is a physical disease?" on a scale of one to seven, with one being "it is totally a disease" and seven being "no, it's not a disease, it's just a question of willpower." In predicting the magnitude of relapse, the time it took to relapse, and the amount of relapse, one of the biggest predictors was the belief in the disease model: the more they endorsed the physical disease model, the more they relapsed.

2. The "father" of the disease model of alcoholism, Benjamin Rush, MD, supported a continuum model of drinking, including moderate drinking (i.e., temperance equals moderation, not abstinence).

What is it?

Finally, if alcoholism is not a disease, what is it?

I think it's an addiction to alcohol. It's an addictive behavior that has biopsychosocial determinants. I would also consider it an affliction because it hurts and it causes problems, so it has biopsychosocial consequences and increases the risk of disease.

Some would think of it as an appetite habit disorder, something to do with the mechanisms of the brain and how they affect behavior. Even in those models, however, there is an emphasis on what people do and what the reward and consequences are that shape the behavior, as opposed to it being simply a biological disease process.

Addictive behavior is the leading cause of disease, but the behavior is not the disease. It's what you do, not who you are. Smoking and drinking and high-risk sexual activities can bring on disease states, whether it's cancer, cirrhosis, you name it.

I don't have a problem with that. The question is, what's causing it?

It's a behavior, an addictive behavior that has a lot of different governing factors and reward mechanisms; and it's a learned behavior, there is a lot of modeling going on, there is a lot of psychological attachment and expectancies.

You put all that together and you can't blame the victims because they have these problems or they lack willpower. It's because they've come under the influence of all these mixed factors. The good news is, you can get out of it. There are a lot of ways to fall off the wagon but there are a lot of ways you can get back on. I think the addictive model is more embracing than the more narrow disease model.

Addiction is the word I prefer. The disease model implies that it is entirely physiological. I don't think there is enough evidence to prove that people have a disease before they even start to drink.

Just because we are not saying that alcoholism or drug addiction is a disease does not mean that there aren't biological or genetic factors that increase the risk. But when you go out to the public and talk about alcoholism, most people think that it's a genetic disease, that you either have it or you don't. People are not used to thinking about polygenic determinations that increase the risk, about being raised in a certain kind of environment and upbringing, about whether their folks drank or not.

That's different from the all-or-nothing belief of "you either have it or you don't." ■

G. Alan Marlatt is professor of psychology and director of the Addictive Behaviors Research Center at the University of Washington, where he has been a faculty member since 1972. He received his doctorate in clinical psychology from Indiana University and has served on the faculties of the University of British Columbia and the University of Wisconsin. He is the author of more than 150 published journal articles and several books on addiction treatment, including *Relapse Prevention* (1985) and *Assessment of Addictive Behaviors* (1988). His research has been recognized with a MERIT Grant award from the National Institute of Alcohol Abuse and Alcoholism (1989); a Distinguished Psychologist Award from the Washington State Psychological Association (1990); and the Jellinek Memorial Award for Alcohol Studies (1990).

Maternal Drug Abuse and Drug Exposed Children: Understanding the Problem

U.S. Department of Health and Human Services

EXECUTIVE SUMMARY

Drug abuse is a serious problem in the United States. In particular, the expanding popularity and highly addictive properties of crack cocaine have generated considerable concern at the local and national levels. With large numbers of women using illicit substances during pregnancy, Federal, State, and local policy makers and service providers are struggling to define how best to address the growing problem of infants exposed to drugs.

Analysis of NIDA's most recent National Household Survey on Drug Use (1991) indicates that the use of cocaine by women of childbearing age is still high. Of the approximately 59.2 million women in the childbearing age group (15 - 44 years), over 4.5 million are estimated to have used illicit drugs in the past month. Especially alarming is the fact that about 601,000 women in this age group appear to be current users of cocaine. There is, however, no accurate estimate of how many of these women are pregnant.

There are several overlapping populations of concern when one talks about maternal drug use. From the broadest perspective, the population of concern is women of childbearing age who use or are at high risk of using drugs, and their children. Of particular concern are pregnant substance abusers, mothers currently using drugs, children exposed to drugs in-utero, and children residing in drug using households.

This paper was written as a step toward defining the problem of maternal drug use and prenatal drug exposure for the U.S. Department of Health and Human Services (HHS) and its component agencies. Its authors include representatives from the variety of HHS agencies which have an interest in this issue. This paper is not intended to serve as a definitive analysis of the problem. However, we hope that it will help inform the field on varying aspects of the problem and the strategies which are evolving to help in its solution.

The discussion includes descriptions of the nature and extent of the problem of maternal drug-abuse and the prevalence of drug-exposed children; research on substance abusing women and their children; drug treatment and prevention services for mothers; child welfare and legal issues relating to drug abusing women and their children; and Medicaid and Social Security financing for this population. The paper concludes with observations about the nature of maternal drug abuse and effective strategies for intervention.

This paper does not address the emerging issue of the long term developmental needs of drug-exposed children. While research is underway to document possible implications for child development of parental drug use before and after birth, as well to develop appropriate interventions for affected children, such work has not yet produced sufficient consensus for a comprehensive discussion. It is clear, however, that drug-exposed children display a wide range of ability levels and that only a small proportion display serious, long term impairment. Materials under development both within HHS and the Department of Education will address this issue in the coming months and years.

Problem

Drug abuse among pregnant women and women of childbearing age is a complex and growing problem with several important inter-related components.

- Prenatal drug exposure has significant, although not yet clearly defined, negative effects on the infant and developing child. Low birthweight and premature delivery are among the most serious. Parental drug use also puts children at increased risk of child neglect and abuse.
- Drug using women and their children are a particularly hard to reach population.
- Strained drug treatment and social service systems throughout the Nation currently either lack the capacity or appropriate family orientation to effectively serve this population.

Strategy

Service providers are finding the needs of drug-exposed families so extensive that no one agency can address them all. Instead, the agencies must work together and pool their expertise and resources to serve these families most effectively.

HHS efforts regarding this population are focused on the following objectives:

- Conduct research in order to determine the nature and extent of maternal drug use; better understand the medical and developmental consequences of prenatal drug exposure on the fetus, infant, and developing child; and develop appropriate prevention and treatment approaches.
- Develop and disseminate effective interventions to:
  - Prevent drug use among women of childbearing age.
  - Treat drug addiction among women of childbearing age.
  - Prevent child abuse and neglect in families with substance abuse problems, and serve those children who have been abused or neglected because of their parents drug use.
  - Intervene with children who show or are at risk of developmental delays or other problems resulting at least in part from parental drug use.
- Continue to support drug treatment capacity by providing funds to States for prevention and treatment services.
- Improve the ability of the child welfare system to serve increased numbers of drug-exposed or drug-affected children and families.

- Provide medical insurance and disability income supports for eligible individuals (including many with substance addictions) and their children. These programs enable many to receive treatment who might not otherwise.

A number of offices within HHS play vital roles in carrying out the objectives described above. Detailed descriptions of specific programmatic efforts of each agency with respect to this population may be found in the companion document to this piece, "Maternal Drug Abuse and Drug-exposed Children: A Compendium of HHS Activities".

Research on the Effects of Prenatal Drug Abuse

The challenge to research is to design instruments and develop the methodologies to determine the nature, extent, and consequences of maternal drug abuse; enhance our understanding of the basic mechanisms of action of drugs and their effects when they cross the placenta; and to evelop and test new treatment and prevention strategies which address the myriad of problems facing drug abusing women and their children. In addition, more research is needed on the effects of paternal drug abuse on children.

To determine the incidence and prevalence of maternal drug abuse and its developmental, psychological, and physical effects, NIDA is supporting research to develop and improve approaches for identifying pregnant women and neonates at risk; provide estimates of the prevalence of drug use during pregnancy and the number of infants exposed to drugs during pregnancy; and determine the effects of drug exposure on a variety of outcome measures. Research on the optimal combination of treatment and other services, as well as settings in which such services are provided will permit us to make recommendations regarding model treatment strategies and options for providing such services. NIDA's basic research program is increasing the understanding of the effects of drug abuse on mothers and their offspring and laying the foundation for the development of medications appropriate to this population.

There has been little information on effects of paternal drug abuse on children until recently. One animal study has demonstrated a relationship between ingestion of morphine and alteration in normal development of offspring, and observed that these effects were long-term in nature. This research hints at the potential harmful effects of a father's drug use on his children.

Preventing and Treating Drug Abuse in Pregnant and Parenting Women

The many negative health and social consequences of substance abuse for a woman and her children demand that such abuse be prevented to the extent possible and treated in those for whom prevention is too late or unsuccessful. The challenge for HHS and for State, local, and private agencies supporting prevention and treatment activities has been to tailor appropriate and effective prevention messages and treatment strategies for high risk groups.

At the Federal level, HHS is working to develop, document, and disseminate effective models of substance abuse prevention and treatment.

Drug addiction is a chronic, relapsing disorder that is frequently accompanied by a host of medical, psychological, and sociological problems. The incidence of addiction-related health, mental health, social and emotional disorders is especially high in drug dependent women (as opposed to men), who typically are without family and community support systems or economic resources, and whose own family histories often include abuse and/or addiction. Treatment programs are often unprepared to meet the particular needs of women with children, including child care and development, parenting skills training and child abuse and neglect prevention, and addressing the consequences of addicted women's frequent histories of abuse as children and other domestic violence.

Child Welfare Services for Drug Abusing Families

The number of drug-exposed infants and children of drug abusers entering the child welfare system is creating a new set of demands that have yet to be properly addressed. Parental substance abuse significantly increases the risk of neglect, physical abuse, and sexual abuse.

During the 36 months between June 1987 and June 1989 the American Public Welfare Association estimates that the number of children in foster care in the U.S. increased approximately 29 percent, to 360,000 children. The States of California and New York were together responsible for 55 percent of this increase.

Assessment of the risks to the child is particularly complex and difficult in situations of illegal drug use. Intensive family service programs often will not accept drug involved families. The mother may deny drug use due to distrust of the child welfare authorities. In addition, child welfare caseworkers often doubt that promises of sobriety can be maintained.

Despite these uncertainties, most of the substance-exposed infants and children of drug users do not go into foster care placement. In New York, only about one-third of the substance exposed infants go into foster care immediately, and in a 1990 GAO study only 1,200 of the 4,000 infants reported to be born substance exposed were placed in foster care.

Many child welfare professionals are unfamiliar with the special care needs of drug-exposed children and do not have adequate preparation or resources to handle such a large proportion of high-risk cases. In-service training and staff education on drug effects, treatment, infant-parent interaction, and high-risk mother-infant pairs are essential supports for professionals and para professionals serving these children and their families.

Legislative and Judicial Responses to Substance Abuse in Women

For the most part, drug-exposed children are being served by the public child welfare system and the family courts, rather than the criminal justice system. However, a few States have begun to prosecute pregnant women as drug dealers, drug abusers, or as child abusers under criminal statutes. Some States have also enacted legislation to require reports of perinatal drug abuse to child protective service agencies, or similar authorities. Although, child welfare agencies adhere to a philosophy of preserving family unity, they frequently make out-of-home foster care placements to protect the child. Federal statutes require that States make "reasonable efforts" to rehabilitate and reunite the family, i.e., to provide services to the family, in order to qualify for certain Federal funds. When it is not possible to reunite the family, State laws govern the termination of parental rights and adoption. Federal legislation also provides fiscal support for adoption of children with special needs, which may apply to some drug-exposed children.

Financial Assistance Programs

The Medicaid program, administered by the Health Care Financing Administration (HCFA) is a Federal-State entitlement program that pays for the health care of certain categorically eligible low income individuals. For eligible individuals, States must provide, at a minimum, needed inpatient and outpatient hospital services, rural health clinic services, physician services, nurse midwife services, services in Federally qualified health centers, and EPSDT services for children under 21 years of age. Within the above categories, States can choose to offer a variety of alcohol and drug treatment services, for instance detoxification, outpatient day treatment, or methadone maintenance. Whether or not individual States cover such services depends on how they define services under the mandatory categories and whether they set limits on the amount of services available to an individual under Medicaid. At present, Medicaid does not pay for treatment of drug addiction or mental illness in residential treatment facilities of larger than 16 beds. HCFA is, however, sponsoring a series of waiver demonstrations allowing several States to experiment with the option of allowing such services for pregnant substance abusing women.

Mothers and children with substance addictions or substance-related disabilities may be eligible for payments and medical coverage under two disability programs administered by the Social Security Administration. These are the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs. While the disability eligibility criteria for the two programs are similar, SSDI requires the recipient to obtain insured status, which is accomplished by working for a certain period of time in a job covered by Social Security. SSI is a needs based program that does not require insured status. Minor dependents of SSDI beneficiaries are eligible for benefits based on their dependent status. Children of SSI recipients only receive benefits if they are disabled themselves.

Under both the SSDI and SSI programs, the mother must have a medically determinable physical or mental impairment that has kept, or is expected to

keep, her from working for at least 12 months, or is expected to result in death. The impairment must be demonstrated by medically acceptable diagnostic techniques–signs, symptoms and laboratory findings. In addition, a child can qualify for SSI disability payments in his or her own right, even if the parent is not disabled, if a child manifests a substantial reduction in ability to function independently, appropriately, and effectively in an age-appropriate manner because of a medically determinable impairment. Recently published childhood disability regulations include medical listings for psychoactive substance dependence disorders in children for the first time.

Conclusions

Drug using mothers and their children have multidisciplinary needs and will require the coordinated provision of services from a number of service systems and disciplines. Service providers who work with these families stress that cooperation, collaboration, and communication among the agencies and programs who see these families is essential.

Substance abuse by pregnant women and women with children is a problem of extreme concern to the U.S. Department of Health and Human Services and its component agencies. In this document we attempt to outline an understanding of this problem and a strategy toward its solution. In particular, we emphasize the following:

- Maternal drug abuse is a complex, multifaceted problem.
- It is possible to provide effective services to this population.
- Women and children have particular characteristics and needs which must be accounted for in service design.
- Maternal drug abusers have complex needs which cannot be solved with short-term interventions. Severely addicted women in particular may need long-term interventions at varying degrees of intensiveness over the course of their recovery.

The varied agencies within HHS are committed to working together to address the problem of maternal drug use and the needs of drug-exposed children. As has been described above, substantial progress has been made in understanding the nature of the problem and developing strategies to address the needs of this population. By conducting research, developing and disseminating effective interventions, supporting State and local service capacity, and through medical and disability insurance payments for eligible individuals, HHS carries out its commitment to healing and strengthening families affected by maternal substance abuse.

INTRODUCTION

PURPOSE

Drug abuse is a serious problem in the United States. The low cost of crack cocaine coupled with its highly addictive properties are especially troublesome. Substance abuse by women of childbearing age, particularly during pregnancy and during the early years of child rearing, has resulted in increasing numbers of children coming to public attention for their protection. Federal, State and local policy makers and service providers are struggling to define how best to address the growing problem of infants exposed to drugs and mothers unable to provide proper care and nurturance for their young.

This paper draws from the perspective of various programs from within the Department of Human Services which have responsibilities concerning drug using mothers and their children. It is not a definitive analysis of the problem. However, we hope that it will help inform the field on varying aspects of the problem and the strategies which are evolving to help in its solution.

This paper is one of several products generated by the Sub-Group on Substance Abusing Women and Their Children of the Department's Ad Hoc Drug Policy Group. Its companion piece, "Maternal Drug Abuse and Drug-exposed Children: A Compendium of HHS Activities," details the variety of efforts the Department has underway which relate to these populations. Taken together, we anticipate that these pieces, and others the group may decide to produce in the future, can represent a coherent vision of this Departments involvement in addressing the needs of substance abusing women and their children, and in preventing the future abuse of drugs by women of childbearing age.

The discussion which follows includes descriptions of the nature and extent of the problem of maternal drug abuse and the prevalence of drug-exposed children; research on substance abusing women and their children; drug treatment and prevention services for mothers; child welfare and legal issues relating to drug abusing women and their children; and Medicaid and Social Security financing for this population. The paper concludes with observations about the nature of maternal drug abuse and effective service strategies for this population.

This paper does not address the emerging issue of the long term developmental needs of drug-exposed children. While research is underway to document possible implications for child development of parental drug use before and after birth, as well to develop appropriate interventions for affected children, such work has not yet produced sufficient consensus for a comprehensive discussion. It is clear, however, that drug-exposed children display a wide range of ability levels and that only a small proportion display serious, long term impairment. Materials under development both within HHS and the Department of Education will address this issue in the coming months and years.

urine for drugs and collection of data on the infants birth weight and length of stay in the hospital. Data will be available in 1992-1993.

Problem

The problem of maternal drug use has several inter-related components. While described here in broad terms, later discussions provide more detail about specific aspects of the problem and approaches toward its solution. Throughout these discussions it must be remembered that polydrug use (the use of more than one drug) is the norm among drug abusing women. Most will use alcohol and marijuana in addition to cocaine, for instance, and therefore talking about a crack user or a cocaine exposed infant, for instance, is in many cases misleading.

There are several overlapping populations of concern when one talks about maternal drug use. From the broadest perspective the population of concern is women of childbearing age who use or are at high risk of using drugs, and their children. Of particular concern are pregnant substance abusers, mothers currently using drugs, children exposed to drugs in-utero, and children residing in drug-using households.

Prenatal drug exposure has significant, although not yet clearly defined, negative effects on the infant and developing child. Details remain unclear, however, in part because effects are dependent on the specific drug as well as on the amount used, duration of use, and timing of exposure during pregnancy. In addition to direct biological effects, parental drug related behavior can have negative consequences for children independent of direct drug exposure (e.g., increased risk of child abuse or neglect).

Drug using women and their children are a particularly hard to reach population. In addition to the general denial associated with drug use, initial reports indicate that fear of child protection agencies may discourage some maternal drug abusers from seeking treatment or other services. In addition, poor and minority women are disproportionately represented among substance abusing mothers (at least among those identified through public systems) and face the same under service that these populations face regarding most health care services.

Strained drug treatment and social service systems throughout the Nation currently lack either the capacity or appropriate family orientation to effectively serve this population. As will be discussed in more detail later, child welfare caseloads in many parts of the Nation are far beyond levels allowing adequate services and supervision. In addition, drug treatment programs are rarely operated with a family focus, and [illegible] the possibility of effective treatment for pregnant women or women with children.

HHS considers and treats addiction as a disease. Nonetheless, it is critical to remind those contemplating drug use, drug users who have not yet become addicted, and those who are struggling to recover from addiction that they have responsibility for the course of their lives. For such individuals,

establishing personal responsibility and a commitment to a healthy lifestyle is a vital part of prevention and recovery.

Strategy

The issue of maternal drug abuse is complex and extremely emotional. Service providers are finding the needs of these families so extensive that no one agency can address them all. Instead the agencies must work together and pool their expertise to serve these families most effectively.

HHS efforts regarding this population are focused on the following objectives:

- Conduct research in order to determine the nature and extent of maternal drug use; better understand the medical and developmental consequences of prenatal drug exposure on the fetus, infant, and developing child; and develop appropriate prevention and treatment approaches.

- Develop and disseminate effective interventions to:

  - Prevent drug use among women of childbearing age.

  - Treat drug addiction among women of childbearing age

  - Prevent child abuse and neglect in families with substance abuse problems, and serve those children who have been abused or neglected because of their parents drug use.

  - Intervene with children who show or are at risk of developmental delays or other problems resulting at least in part from parental drug use.

- Continue to support treatment capacity by providing funds to States for prevention and reatment services.

- Improve the ability of the child welfare system to serve increased numbers of drug-exposed or drug-affected children and families.

- Provide medical insurance and disability income supports for eligible individuals and their children (including many with substance addictions). These programs enable many to receive treatment who might not otherwise.

These goals are consistent with Secretary Sullivans Goals and Program Directions for HHS. (For a full discussion of Goals and Program Directions see The FY1991-FY1992 HHS Program Directions Plan.)

The importance which the Department places on the objectives outlined above is consistent with the President's special emphasis, and top priority placed in the National Drug Control Strategy, on addressing the issues associated with substance abusing women. The Administration will continue to foster access

to and expansion and improvement of treatment services for pregnant women and their children.

A number of offices within HHS play vital roles in carrying out the objectives described above. These are listed immediately below and include components of the Public Health Service (which oversees the health side of the Department's activities), the Administration for Children and Families which oversees the Department's human services activities, as well as the Health Care Financing and Social Security Administrations. Detailed descriptions of specific programmatic efforts of each agency with respect to this population may be found in the companion document to this piece, "Maternal Drug Abuse and Drug-exposed Children: A Compendium of HHS Activities."

Within the Public Health Service (PHS)

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)
- National Institute on Drug Abuse (NIDA)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- Office for Substance Abuse Prevention (OSAP)
- Office for Treatment Improvement (OTI)

National Institute on Child Health and Human Development (NICHD)
Health Resources and Services Administration (HRSA)
- Maternal and Child Health Bureau (MCHB)

Within the Administration for Children and Families (ACF):

Administration on Children, Youth and Families (ACYF)
Administration for Native Americans (ANA)
Administration on Developmental Disabilities (ADD)

Elsewhere in HHS:

Health Care Financing Administration
Social Security Administration

The efforts of these various agencies come together in order to carry out the goals of better understanding the conditions and service needs of drug abusing mothers and their children, developing effective interventions to meet those needs, and financing services for those in need.

United States General Accounting Office

Report to the Chairman, Subcommittee on Human Resources, Committee on Ways and Means House of Representatives

FOSTER CARE

Parental Drug Abuse Has Alarming Impact on Young Children

for a substantial portion of each state's young foster children in 1991: 44 percent in California, 81 percent in New York and 29 percent in Pennsylvania.

Results in Brief

The 1991 population of young foster children is significantly different from the 1986 population in the locations reviewed in a variety of ways: the 1991 population size is much larger, more of these children entered foster care due to some form of neglect, their biological parents are more likely to abuse drugs, these children have more health-related problems and are at high risk for further problems due to prenatal drug exposure,[3] and they are more likely to be eligible for federal maintenance payments.

The number of young foster children increased at almost twice the rate of the general foster care population. Neglect and caretaker absence prompted an estimated 68 percent of removals, up from 47 percent in 1986. We estimate that families where at least one parent was a drug abuser increased from 52 percent to 78 percent. An increasing percentage of children had serious health-related problems in 1991 and most of them were prenatally exposed to drugs. Specifically, an estimated 58 percent of young foster children had serious health-related problems in 1991 compared with 43 percent in 1986. Those at high risk for problems due to prenatal drug exposure increased from 29 percent to 62 percent over this period. Cocaine was the most prevalent drug children were prenatally exposed to in both years; documented prenatal cocaine exposure increased from 17 percent to 55 percent between 1986 and 1991. A larger percentage of young foster children qualified for federal maintenance payments in 1991 than previously. At the same time, the growing number of young foster children increased overall maintenance expenditures, compounding their financial impact on government. Federal and state governments in these three states alone spent over $2 billion in 1992 to maintain foster children of all ages.

These changes have implications for federal foster care and health care programs. Both federal and state expenditures have felt the impact of the growth in the number of young foster children and the decline in their overall level of health. Further, two broad service needs overlap foster and health care programs. First, drug abuse treatment programs for biological mothers and pregnant women are needed to reduce the risks associated with prenatal drug exposure and the likelihood that children will be

[3]We included alcohol abuse in our definition of drug abuse. However, the documented incidence of alcohol use was low, about 6 percent in 1991 and 3 percent in 1986.

removed from their families. Second, services to address the health and developmental needs of drug-exposed children are needed to treat their problems. While few alternatives to foster care currently exist for many of these families, meeting both of these service needs should increase the possibility that such families can be reunified and leave the foster care system. However, drug abuse, to the extent it continues to occur, will remain a hidden contributor to the costs of various federal programs.

Background

While the federal, state, and county governments and foster parents share responsibility for providing care and services to foster children, the Department of Health and Human Services (HHS) is responsible for the management and oversight of federal programs benefiting foster children. The programs are authorized primarily by the Social Security Act. The act, in part, authorizes expenditures to (1) maintain foster children who are eligible under the Aid to Families with Dependent Children (AFDC) program, (2) assist states in providing child welfare services, and (3) provide medical care. Primarily, HHS establishes federal regulations and monitors states' compliance with them for children placed in federally funded foster care and other programs under the act and administers federal funding for them.

Federal expenditures for the administration and maintenance of AFDC-eligible foster children are authorized under title IV-E of the Social Security Act. Those expenditures increased from about $637 million in 1986 to over $2.2 billion nationwide in 1992. The federal portion of foster care maintenance costs varies by state and is linked to a state's Medicaid matching rate. The federal portion ranges from 50 percent to 83 percent of the maintenance cost for AFDC-eligible foster children; states or counties are responsible for the full cost of maintaining foster children who are not eligible for AFDC benefits. Thus, payments to foster parents for the care of an AFDC-eligible foster child are comprised of federal, state, and in some cases county monies.

In addition to maintenance funds under title IV-E, federal funds authorized in other titles of the Social Security Act may be used to provide medical and other needed services to foster children. States may participate in programs such as title IV-B, federal matching grants for various child welfare services; title XIX, Medicaid, for medical services for foster children; and, title XX, block grants for a wide array of social services for children. Data were unavailable to estimate the additional federal, state, and county expenditures for these other services for foster children.

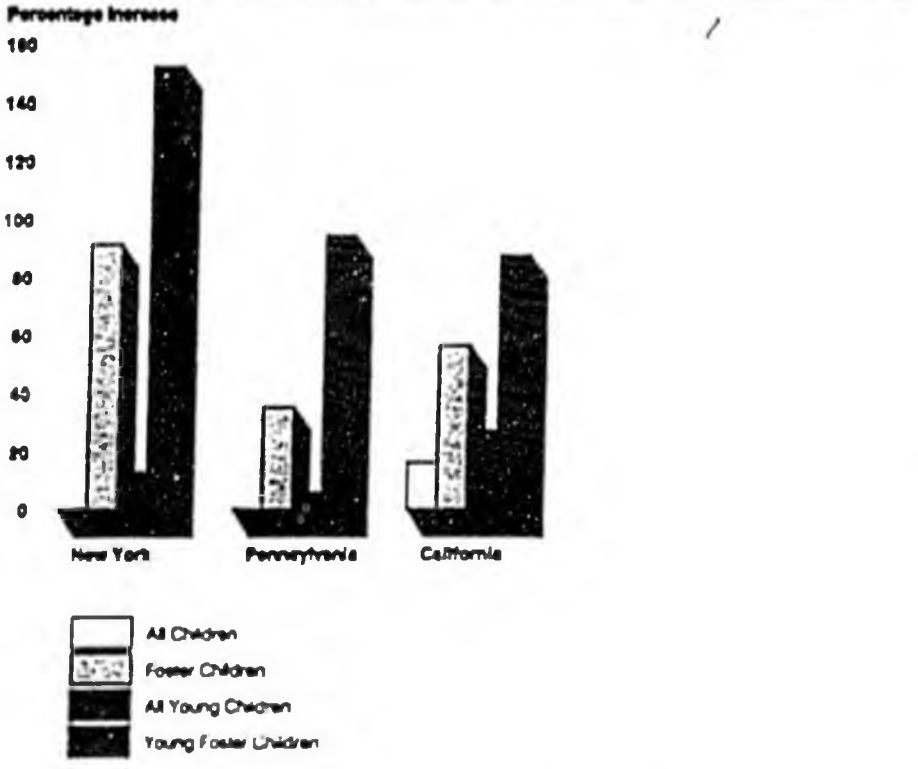
However, we previously reported that median costs associated with newborn medical care for infants known to be prenatally drug-exposed were approximately $1,100 to $4,100 higher (in 1989 dollars) than for other infants. Further, an HHS study provides an example of Medicaid costs in California from 1986 to 1988 for children from birth to 24 months of age. HHS reported a 2-year average Medicaid expenditure of $1,551 for children who were not identified as being prenatally exposed to drugs compared to $2,285 for those who were known to be exposed.[4] Further, medical expenses for drug-exposed foster children from birth to 12 months of age were 62 percent greater than the medical expenses for drug-exposed children who were not in foster care.

More Young Children in Foster Care

The foster care populations in the states reviewed increased dramatically between 1986 and 1991, with the number of young foster children increasing at a faster rate. The total foster care population in these states increased 66 percent while the number of young foster children increased 110 percent. During the same years, the total number of young children in these states increased 19 percent, indicating that a greater percentage of all young children in these states entered foster care in 1991 than entered previously. (See fig. I and tables II.1-II.4 in app. II.)

[4]An Exploratory Analysis of the Medicaid Expenditures of Substance Exposed Children Under 2 Years of Age in California, Office of the Assistant Secretary for Planning and Evaluation and Health Care Financing Administration, HHS (1990) (study prepared by SysteMetrics, a division of MEDSTAT Systems, Inc., Cambridge, Mass.). The average was calculated for all children receiving Medicaid benefits in California, not just foster children. It also excluded costs for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and delivery services at birth. However, we believe that this is a reasonable minimum estimate of average costs for foster children as well.

Figure 1: Increase in Foster Care and Child Populations in Three States Between 1986 and 1991



Note: Part of New York's increase in foster children is due to the provisions of the New York Supreme Court case, Eugene F., which required all foster children placed with relatives to be included in foster care caseloads and eligible for services.

Pennsylvania's count of "Young Foster Children" consists of all foster children under age 5, as its aggregate data did not break out children under age 3.

California and New York foster children counts represent all children in foster care at any time during the review year; Pennsylvania data for foster children represent year-end counts, as comparable data were not available.

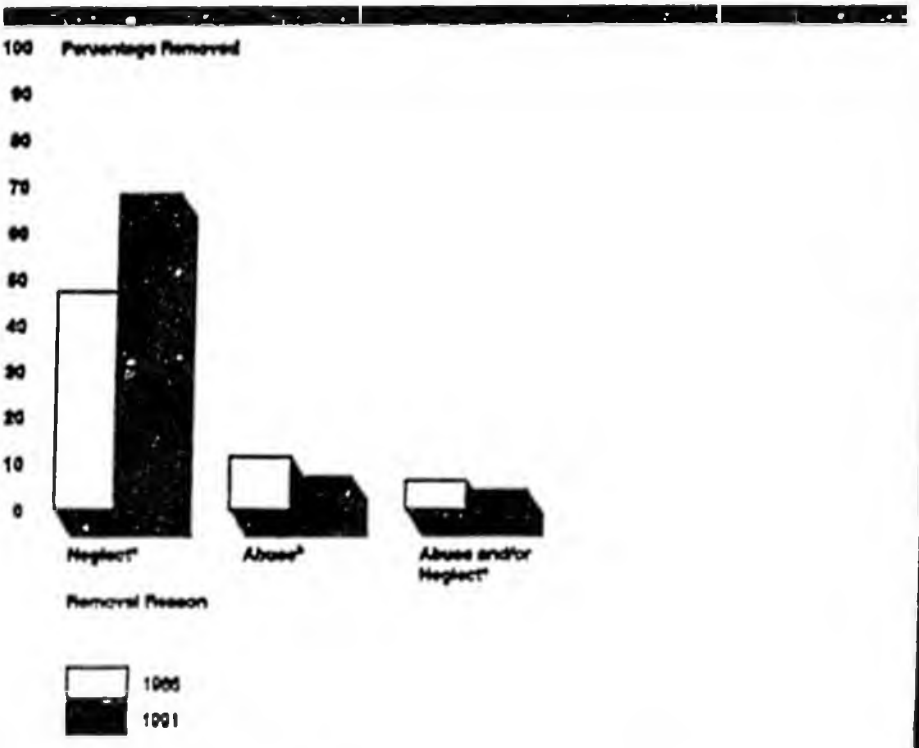
Sources: California and New York—state databases; Pennsylvania—aggregated state data; except "All Children and All Young Children"—Bureau of the Census midyear estimates.

Neglectful or Absent Parents Triggered Most Removals From Home

Neglect and caretaker absence or incapacity were the primary reasons why young children were removed from their families in both California and New York, the states where data were available. Together, these reasons accounted for approximately 47 percent and 68 percent of the removals in 1986 and 1991, respectively. No other reasons for removals,

such as physical abuse, accounted for a large portion of the entries of young children into foster care in either year. For example, all types of abuse accounted for 11 percent of the removals of young children in 1986 and 7 percent in 1991. (See fig. 2 and table II.6 in app. II.)

Figure 2: Reasons for Removal of Young Children From Home in California and New York



Note: There were other reasons for removals that did not account for significant portions of total removals. In addition, some cases only show broad service program categories, such as "court ordered placement," others are listed as unknown or error.

[a]Includes removals due to neglect, caretaker absence or incapacity, relinquishment, and voluntary placements.

[b]Consists of physical, sexual, and emotional abuse.

[c]Consists of New York data only. This state uses up to two reasons for removal, thus, abuse and/or neglect can be cited. Further, the definitions of some reasons for removal, such as Health/Safety, refer to abuse and/or neglect.

Source: State electronic databases.

Drug Abuse Further Impacts Troubled Families

To better describe the parents' situation around the time their children were removed from home, we reviewed random samples of case files for certain difficulties that families face in the three locations reviewed. Of these situations, estimated increases in the number of parents who abused drugs or had other children in foster care are significant between 1986 and 1991. Fully 78 percent of the young foster children reviewed had at least one parent who was abusing drugs or alcohol in 1991 compared with 52 percent in 1986. Families with other children in foster care increased from 68 percent to 79 percent. Further, families with no other children decreased from an estimated 18 percent to 11 percent during this time.

Families in 1991 had additional serious problems in common with their counterparts in 1986 in the three locations. For example, the percentage of young foster children who came from families with at least one parent absent was high in both years, estimated at about 70 percent. In addition, over 27 percent of the young foster children in these years came from families where both parents were absent from the home around the time of the child's removal, according to our estimates. (See fig. 3 and table II.7 in app. II.)

Childhood Education, Winter 1996 v73 n2 p66(4)

Retrieve

Explore

Prenatal drug exposure: meeting the challenge. *Linda C. Sluder; Lloyd R. Kinnison; Dennis Cates.*

Abstract: Early childhood educators face an enormous challenge in children with prenatal drug exposure. These children present severe cognitive, social, behavioral and motor deficiencies that require special nurturing and encouragement from early childhood professionals. Among the approaches that research and experience have identified as the 'best practices' are a small learning area, self-directed exploration, adult intervention in cooperative play and work activities and an adjustment period to new activities. Community-based, family-centered approaches undertaken jointly with local and state agencies, focusing on caregiver training, counseling and parenting skills training are advised.

Educators and child care providers today face a challenging new community of children identified as one of the fastest growing at-risk populations in America (Poulsen, 1992). These children have been labeled as "crack babies," "prenatal drug exposed," "peri-natal cocaine addicted" or "substance exposed infants and children" (Kinnison, Sluder & Cates, 1995, p. 35).

The mainstream media first identified such children in the early 1990s, focusing on demographic projections and associated statistical implications. The pressing issue now, however, is that these children have reached school age. As these children enter early childhood programs, educators must be prepared to nurture and encourage them.

Children with prenatal drug exposure exhibit a complex range of cognitive abilities and behaviors (Chasnoff, 1992; Howard, Beckwith, Rodning & Kropenske, 1989). Wright (1994) emphasizes that identifying specific traits is difficult, however, because prenatal exposure has diverse effects.

THE CASE OF TWO CHILDREN

Treavor

To the casual observer, Treavor appears to be a typical 5-year-old. He lives with his grandparents, who provide him with a caring and nurturing environment. His size is average for his age. Although his gross motor development appears to be age appropriate, he has some difficulty with fine motor tasks. In general, his physical

responses are spasmodic, limiting his ability to independently accomplish directed activities, such as placing wooden pegs into specific holes.

Psychoeducational test evaluations (e.g., measures of cognitive ability and adaptive behavior) indicate that Treavor functions in the severe-profound range of mental retardation. He becomes excited and distracted when individuals enter the learning environment, often soiling his diaper or outer clothing.

Treavor's receptive language is adequate to deal with simple tasks. He is able to follow basic verbal directions and participate, to some extent, in classroom activities. Treavor usually responds during group language activities with gestures and grunts or by showing recognition thro ugh directed eye movements. He is able to identify size ("big" and "little"), pictures of his immediate family, and his teacher and classmates when their names are given as prompts. Over the past year, the teacher noticed that Treavor improved in receptive language, attempts at expressive language, motor skills and attention span. Treavor attends a half-day early childhood program for disabled children.

Melissa

Melissa, a 2nd-grader, participates in a special education resource room one hour each day. She is small for her age, but otherwise displays no physical indications of prenatal drug exposure. While pregnant, Melissa's birth mother ingested alcohol, marijuana and various other drugs, including, possibly, cocaine. Melissa lives with adoptive parents in what appears to be a positive environment.

Melissa suffered from seizures at an early age, for which anticonvulsive medications were prescribed. Additionally, she takes Ritalin daily to help control her attention deficit disorder with hyperactivity and possible obsessive conduct disorder. A psychoeducational assessment indicates that Melissa's cognitive ability is above average. Her reading skills range from one to two standard deviations above the mean. Melissa's math achievement is on grade level and her written language skills are one standard deviation above the mean. Assessments indicate that she has average oral language development. In contrast to the assessment scores, Melissa's classroom teacher reports extreme variations in her daily academic performance.

Melissa's teachers maintain daily logs that illustrate her erratic behavior. Her teachers say that Melissa "tries hard, [is] inattentive, lacks small muscle control, [is] slow, in constant motion and has extremes in emotions." She appears to work best in a relatively small space and in one-on-one teaching situations.

In the regular classroom, she is compulsive - always giving an answer. She can also be mentally inflexible, needs constant redirection and has limited attention. Her regular education teacher is frustrated and has threatened to resign if Melissa is not removed from her classroom.

Melissa's medication has been invaluable. Without prescriptive intervention, her behavior is unpredictable. Consequently, she does not seem to have control of her actions. Records document that prior to taking her medication, Melissa had, among other things, threatened to beat her adoptive mother. After receiving treatment, Melissa was remorseful and expressed sorrow for such behavior.

COMPOUNDING ISSUES

Approximately 375,000 children are prenatally exposed to illicit drugs each year (Behrman, 1990; Feig, 1990). A rapidly growing proportion of these children are exposed to crack cocaine. Feig (1990) estimates that 30,000 to 50,000 "crack babies" are born each year.

A survey by the National Institute on Drug Abuse (1989) revealed that approximately 9 percent of all women of child-bearing age admitted to using illicit drugs. The number of women in this age group testing positive for drug use increased from 25 percent in 1972 to 40 percent in 1988. Other data indicate that prenatal drug use has remained at a consistent level ("Children of Cocaine: Facing New Issues," 1990). Women who use drugs while pregnant come from all socioeconomic and ethnic backgrounds (Feig, 1990; Weston, Ivins, Zuckerman, Jones & Lopez, 1989).

The severity of cognitive, social, behavioral and motor deficiencies are compounded by the multiple ingestion of tobacco, alcohol and combined drugs. Table 1 offers some behavioral characteristics that may be associated with prenatal drug exposure.

COMPLICATIONS

Motor Development

Although a small number of drug-exposed children exhibit gross motor difficulties, the influences on fine motor development are far more apparent. Researchers report that cocaine-exposed infants and toddlers often avoid eye contact and negatively respond to multiple stimuli (Zuckerman, Jones, La Rue & Lopez, 1990). Other studies suggest that these infants appear to have underdeveloped muscle tone and poor reflexes, and that their arms and hands may tremble when they reach for objects (Daberczak, Shaner, Senie & Kendal, 1988; Feig, 1990). Behrman (1990) suggests that such visual-perceptual and fine motor problems persist as these children mature. Van Dyke and Fox (1990) suggest that fetal exposure to various types of illicit drugs (e.g., cocaine or cocaine used with other drugs) may cause other developmental problems. These complications' characteristics may be similar to those of hyperactivity.

Cognitive Development

Many factors related to prenatal drug exposure directly and indirectly influence cognitive development. Drugs such as cocaine may force blood vessels in an expectant woman to constrict, reducing the blood flow and decreasing the amount of oxygen delivered to the fetus's brain (Woods & Plessinger, 1990). Bellisimo (1990) emphasizes that the "high" brought on by drug use may cause the fetus to suffer small strokes or seizures. These findings suggest that central nervous system damage and subsequent learning problems are possible.

Children prenatally exposed to drugs tend to perform more poorly on tests designed to measure concentration, group interaction and the ability to cope within an instructional environment, according to Viadero (1990). Further studies suggest that these children are

often disorganized, unstructured, irritable, less goal-directed and have problems processing information.

Language Development

Drug exposed infants and children are less likely to spontaneously vocalize or use gestures to communicate. In preschool, these children experience prolonged difficulty in articulating, identifying pictures and using expressive language (Chapman & Worthington, 1994).

Some children may have better success with receptive language (what is understood), as in Treavor's case. In this instance, receptive language may be superior to expressive language development. Treavor's behavior suggests he understands oral language, but cannot verbally communicate.

Affective-Behavioral Development

Children prenatally exposed to harmful substances may undergo a variety of emotional and behavioral swings, sometimes shifting rapidly from apathy to aggression. "A giggle becomes a scream, or a response to a question becomes an outburst" (Bellisimo, 1990, p. 25). Changes in environmental stimuli, such as visitors or minor disruptions in routines, may prompt the child to suddenly act uncontrollably. Melissa's behavior is characteristic of these extremes. It appears that prenatally drug exposed children commonly insist on addressing tasks in their own terms and persistently refuse to comply with requests.

These children interact poorly with others. Cocaine-exposed infants may become easily frustrated and throw temper tantrums when adults provide inconsistent directional cues (Bellisimo, 1990; Howard et al., 1989). Often, the children resist attachments to new adults or children. Some children actually avoid adult interactions.

Play Development

Howard, Beckwith, Rodning and Kropenske (1989) observed less representational play among drug exposed children. Instead, their play was characterized by randomly scattering toys, and then indiscriminately picking up and discarding them. These behaviors are in sharp contrast to children's typical play behavior.

Substance exposed infants and children often have difficulty initiating independent play activities. Consequently, they aimlessly wander through the learning environment. Many of these youngsters do not seem to have the necessary skills to spontaneously stack blocks or engage in representational play. They appear confused and unable to select a particular material for play or focus.

ACCEPTING THE CHILD

Children with suspected prenatal drug exposure need assurances from the adults in their lives. Educators who work with this population must understand the child's social, legal and educational needs. Unfortunately, accurate information about the extent of prenatal drug exposure is limited. Admitting that their child has been prenatally exposed to drugs places the mother or parents at risk for legal action. Moreover, as many states consider

prenatal drug exposure to be child abuse, admission of such activity will be rare.

Other issues also prevent parents from fully disclosing their drug use. Increased public awareness of the effects of prenatal drug exposure places the parent in a precarious situation. Many fear the reactions of their families, friends, the community and their children. Fetal alcohol children interviewed in Michael Dorris's The Broken Cord (1989) expressed difficulty understanding their disability and their parents' reasons for engaging in drug use.

Often, these children come from chaotic and dangerous home environments where the potential for continued drug abuse is high. Their mothers may be estranged from the family because of their drug use, which perpetuates a lack of support systems for both mother and child. Careful consideration and effort must be given to ensure that extensive time and opportunity are provided for these children to develop bonds with the family or other caregivers.

IMPLICATIONS AND SUGGESTIONS

Children who are exposed prenatally to illicit drugs present myriad challenges for early childhood professionals. The cognitive and behavior extremes associated with prenatal exposure precludes drawing up an explicit list of "best practices" or pedagogical approaches.

Compounding the problem is researchers' inability to systematically identify children who have been exposed to illicit drugs. Many research studies have samples that are too small with poorly defined subjects or no control groups (Chapman & Worthington, 1994). Other studies have been narrowly defined and use highly selective strategies, offering limited general application.

The following suggestions for early childhood professionals are based on the most current review of research and experience. Educators should pay special attention to the learning environment, ensuring that programs are predictable and restricting the number of nonessential people who enter and leave the environment. Howard et al. (1989) reported that a small room or learning area is superior to large, open areas.

Education professionals must carefully consider these children's unique learning styles when determining the classroom environment and teacher-to-student ratios. Daily routines must allow the children to engage in self-directed exploration. The educator or care provider, however, must always be aware that these children do not tend to engage in spontaneous activities. Adult intervention may be necessary to direct the child toward cooperative play and work opportunities.

Many potentially volatile situations can be diffused by alerting children to transitions and providing time to adjust to new activities. When a child is cognitively and emotionally involved with a special activity, adults can reduce children's frustration by providing notice that the activity is about to end. A statement such as "We have five more minutes left in math before lunch" will alert the child that the activity is closing.

CONCLUSION

Educators and care providers must be aware that children may exhibit multiple disabilities - including physical, medical, emotional, social and/or educational. A team of professionals should work together to focus on individual children's needs. Community-based, family-centered solutions should be emphasized, as should confidentiality.

Early childhood education and care providers need to establish close working relationships with local and state agencies. Joint efforts should promote specific caregiver training, substance abuse counseling, activities to raise mothers' self-esteem and training in basic parenting skills. These efforts may be university-based or associated with community and state agencies. Only through such collaborative efforts can substantial help be given to children with prenatal drug exposure.

Table 1

BEHAVIORAL INDICATORS OF PRENATAL DRUG EXPOSURE IN YOUNG CHILDREN

Motor Development

- Awkward eye and hand coordination
- Trembling arms and legs when reaching for objects
- Excessive fidgeting and/or hyperactivity
- Clumsy or immature use of tools such as spoons, crayons or small toys

Language Development

- Limited early vocalizations
- Prolonged articulation errors
- Difficulty in picture identification
- Problems following directions
- Limited vocabulary

Play Development

- Reluctance to initiate play activities
- Aimless wandering through the play area
- Inability to stack blocks
- Apparent confusion in some play situations

* Awkward understanding of and response to social cues
* Occasional aggressive behavior in group situations

Affective Development

* Avoidance of eye contact
* Low tolerance for change of environment or caregiver
* Difficulty in dealing with changes in routines
* Low ability to self-regulate own behavior
* Frequent limit testing
* Decreased response to verbal praise as a reinforcer
* Poor interactions with caregivers
* Increased frequency of temper tantrums
* Fearfulness of strangers

Cognitive Development

* Decreased imitative play
* Less pretend play or exploration of the environment
* Difficulty concentrating
* Disorganization
* Inability to structure work or play activities
* Diminished ability to stay on task
* Less goal-directed behavior
* Increasingly disruptive behavior
* Greater need for a more controlled learning environment

Adapted from: Kinnison, L., Sluder, L., & Cates, D. (1995). Prenatal drug exposure: Implications for teachers of young children. Day Care & Early Education, 22(3), [illegible]

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Linda C. Sluder is Associate Professor, Early Childhood and Lloyd R. Kinnison is Professor, Special Education, Texas Woman's University, Denton. Dennis Cates is Associate Professor, Special Education, Cameron University, Lawton, Oklahoma.

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Substance use initiation among adolescent children of alcoholics: testing protective factors. *Andrea M. Hussong; Laurie Chassin.*

Abstract: The possession of cognitive coping skills, a perception of having individual control over outside events and a highly organized family environment help adolescent children of alcoholics (COAs) resist using alcohol or drugs. A three-year study of 267 adolescents, including 127 COAs, measured the buffering effect of such factors, as well as those of self-awareness and behavioral coping skills, upon the adolescent use of drugs and alcohol by COAs. High family organization and either very high or very low levels of coping ability also helped adolescents who were not COAs resist drug and alcohol use.

Objective: Past research suggests that adolescent children of alcoholics (COAs) are at heightened risk for alcohol and drug use. However, not all COAs use substances during adolescence. The current study investigated whether five factors (self-awareness, perceived control, family organization, behavioral coping and cognitive coping) buffer COA risk for substance use initiation during adolescence. Method: A community sample of 454 COA and matched control families was recruited to participate in a 3-year longitudinal study, involving annual computer-assisted interviews with adolescents and their parents. Subjects were selected for the current study if they had complete data at all three assessment periods and showed either abstinence throughout the study or substance use initiation after the first wave of assessment. A subsample of 267 (127 COAs, 147 controls; 147 male) of the original participants was included in the current analyses. Results: Logistic regression analyses found some support for the buffering hypothesis in that COAs with greater perceived control or extreme (very low or high) levels of cognitive coping were less likely to initiate substance use than their peers. Main effects suggested that adolescents reporting high family organization and either very low or very high levels of behavioral coping were less likely to initiate substance use over the course of the study. Conclusions: These findings suggest that highly organized families and behavioral coping efforts may deter substance use initiation. Moreover, perceived control over one's environment and cognitive coping may buffer adolescents from the risk associated with parent alcoholism for substance use. (J. Stud. Alcohol 58: 272-279, 1997)

 A GROWING INTEREST in primary prevention has led to a search for groups at high risk for experiencing negative outcomes, who are critical targets for preventive intervention. This movement can clearly be seen in the field of adolescent substance use where research

substantiates that children of alcoholics (COAs) are at an increased risk for experiencing a variety of negative outcomes, including early onset of alcohol and drug use (Chassin et al., 1991; Sher, 1991; West and Prinz, 1987).

Such substance use has been related to other problem behaviors in adolescence such as delinquency and precocious sexual behavior (Donovan and Jessor, 1985; Donovan et al., 1988; Jessor and Jessor, 1977). Problem Behavior Theory, proposed by Jessor and Jessor (1977), suggests that these behaviors are all related to an underlying tendency toward deviancy. If this is the case, then initiation of substance use may serve as a marker for a heightened tendency to engage in a deviant style of behavior. Moreover, substance use initiation may signify a growing influence of deviant peer relations (Curran et al., in press) and gateway exposure to later, more problematic outcomes such as alcoholism and drug abuse (Robins and Pryzbeck, 1985). Although not all early substance use results in such later problems, initiation of substance use in early to middle adolescence remains an important target of preventive intervention due to its potential association with these negative outcomes. For this reason, the current article focuses on COAs' heightened risk for initiating alcohol and/or drug use in adolescence.

Past research suggests that COA risk for substance use may involve heightened physiological responses to alcohol (e.g., stress response dampening), temperamental or personality predispositions (e.g., behavioral undercontrol or negative emotionality) and a host of environmental factors (e.g., poor parenting, stress, deviant peer associations; see Sher, 1991, for a review). However, not all COAs use alcohol or drugs during adolescence. Although some studies have investigated factors that block or buffer adolescent risk for substance use involvement (Hawkins et al., 1992), very little of this work has been directed at COAs. Moreover, those studies that have investigated such factors in COAs have been hampered by methodological weaknesses.

Past research has suggested that COA risk for alcohol and drug use may be buffered by regularity of family rituals (Wolin et al., 1980), social support (Barrera et al., 1993; Ohannessian and Hesselbrock, 1993), care-giving environments within the home (Werner, 1986) and low maternal regard for alcoholic fathers (McCord, 1988). Many of these studies, however, are limited by lack of a control group so that the buffering effect of a hypothesized protective factor cannot be appropriately evaluated (e.g., Werner, 1986; Wolin et al., 1980). Even when control groups are present, few studies directly test these buffering or moderation hypotheses (e.g., Clair and Genest, 1987). Studies have also been limited by an indirect ascertainment of parental alcoholism (e.g., relying on offspring rather than parent report). Moreover, these studies are cross-sectional and fail to identify temporal precedence of protective factors and negative outcomes. Longitudinal studies are vital in order to determine whether potential protective factors are indeed worthy targets for preventing negative outcomes.

The current study addressed these methodological weaknesses by utilizing a high risk, community sample (with a matched control group), direct ascertainment of parental alcoholism and a longitudinal design. Potential buffering effects were tested for five hypothesized, protective factors of COA risk for substance use initiation in early adolescence: self-awareness, perceived control, family organization, behavioral coping and cognitive coping.

Protective factors

These five factors all emphasize the importance of environmental and intrapsychic resources for reducing the risks that are faced by COAs. Research suggests that COAs, compared to non-COAs, report higher levels of stress, lower self-esteem and self-efficacy and higher levels of depression and anxiety (see Sher, 1991). Based on these negative outcomes, one hypothesis states that COAs come to use substances as a means of coping with stress and negative affect. To the extent that COAs can maintain a sense of self-efficacy and utilize resources for coping with this stress, this risk may be reduced. A heightened sense of self-awareness, a greater sense of perceived control, possibly produced by an organized and predictable family environment, and the availability of cognitive and behavioral coping resources may all serve a protective function. Although these factors may deter substance use in any adolescent, they are hypothesized to be especially important for COAs in overcoming their greater risk for this outcome.

The first of these possible protective factors, self-awareness, drew research attention both as a predictor of adolescent substance use in general and as a buffer against the specific risk for substance use faced by COAs. Hull (1981) suggested that high self-awareness sensitizes individuals to the negative impact of stressful life events, resulting in a higher likelihood of substance use as a way of lowering a painful state of self-awareness. However, Chassin et al. (1988) found no support for this hypothesis; rather, they suggested that self-awareness may increase adolescents' sensitivity to social and legal proscriptions against alcohol use, thereby decreasing the likelihood of adolescent drinking. In addition, self-awareness may serve a protective function for COAs. As suggested by Chassin et al. (1988), self-awareness may increase COAs' self-reflection regarding the potential consequences of alcohol use as modeled by alcohol-abusing parents. Moreover, heightened self-awareness can provide a greater sense of control over personal reactivity to stress, a means for knowing when to draw on coping resources and an ability to distance oneself from the problems of an alcoholic parent. These factors can all play an important role in decreasing the negative impact of parent alcoholism on adolescents. In a cross-sectional study, Rogosch et al. (1990) found such a buffering effect of self-awareness on COA risk for concurrent alcohol-related problems and alcohol consumption in an adolescent sample. Although supportive of this buffering hypothesis, this study was limited by indirect ascertainment of parental alcoholism and lack of longitudinal data.

A second possible protective factor is a heightened sense of personal control over external events. Adolescents with high levels of such perceived control reported less substance use in a school-based study by Newcomb and Harlow (1986). High perceived control may allow adolescents to more actively seek out mechanisms for coping in their environment, ruling out the need for substance use to regulate negative affect. Moreover, high perceived control may be a deterrent to negative affect more generally as suggested by inverse correlations between depression and perceived control, attributed to mechanisms described by Seligman's learned helplessness models (Abramsonetal., 1980; Seligman, 1975). Finally, adolescents with high perceived control may be more active agents in their environments, feel greater esteem and self-efficacy and be less reactive to social or peer pressures to use substances. These protective mechanisms may be especially important for COAs, whose sense of perceived control might function to counter the feelings of chaos or lack of control engendered by an unpredictable alcoholic home. However, this buffering effect of perceived control has yet to be tested in the COA literature.

A third potential protective factor, family organization, was first suggested as a buffer against parent alcoholism risk in research by Wolin et al. (1980). These authors suggested that if parental alcoholism does not jeopardize family rituals (i.e., the family maintains family celebrations, consistent dinner times, etc.,) then there is lessened risk for intergenerational transmission of alcoholism. An organized family may provide a stability of routines that is sufficient to maintain the adolescent's functioning and to minimize the negative impact of an alcoholic parent. Moreover, family organization may provide the adolescent COA with a sense of personal control or self-effficacy through the predictability of the home environment. Direct tests of this moderation hypothesis were not possible in the Wolin et al. (1980) study, however, because a control group was not utilized.

The final two potential protective factors concern coping strategies. Even though some studies have examined whether alternative coping mechanisms may decrease substance use during adolescence (e.g., Wills and Shiffman, 1985), the moderating effect of coping on COAs' risk for substance use has yet to be directly studied. However, findings from a study of COAs suggest that coping may be an important correlate of adjustment among this subpopulation (Claire and Genest, 1987). Although the authors did not statistically evaluate a buffering effect, they found nonsignifica correlations between coping and adjustment (i.e., depression and self-esteem) for controls but significant correlations for COAs such that greater coping was associated with improved adjustment. Moreover, this pattern of correlations was found for problem-focused, but not for emotion-focused, coping. These findings indirectly suggest a significant buffering effect of problem-focused coping on COA risk, such that COAs who possess adequate and successful problem-focused coping skills should be less likely to use substances. This supposition, however, is premature because this buffering hypothesis was not directly tested for substance use outcomes by Claire and Genest (1987).

Both problem- and emotion-focused coping were originally described as effective or adaptive mechanisms by Lazarus and Folkman (1984), who developed this typology. However, other research has suggested that alternative forms of adaptive or active coping may be especially important as protective factors (see Wills and Hirky, 1996). For example, Wills (1986) found that behavioral coping (e.g., information seeking, decision making and direct action) predicted lower levels of alcohol use. Cognitive coping is a second type of active coping that includes problem-solving efforts and reframing distressing situations. The current study investigates the protective function of these two forms of active coping (i.e., behavioral and cognitive coping) in reducing COA risk for substance use

In sum, the current study examines the ability of five factors to buffer COA risk for adolescent substance use initiation. Moreover, several limitations of previous research are overcome by directly ascertaining parental alcoholism, appropriately testing moderation hypotheses, utilizing a longitudinal design and surveying a high-risk, community sample with a matched control group. The presence of greater self-awareness, perceived control, family organization, behavioral and cognitive coping are hypothesized to reduce risk for substance use initiation related to parent alcoholism.

Method

Participants

The sample for the current study was a subgroup of adolescents participating in a larger, 3-year longitudinal study. Of the original 454 adolescents, 10 (2.2%) were lost due to attrition and were not included in the current subsample. Moreover, because the current study compared stably abstinent adolescents to those who initiated substance use after Year 1, 177 of the remaining 444 subjects (40%) were excluded due to other patterns of substance use (e.g., stable use, cessation of use; see Measures section). The final sample of 267 was 55% male and primarily non-Hispanic white (75%) and Hispanic (25%), with an average age at Time 1 of 12.3 years. Adolescents having alcoholic parents comprised 45% of the sample (120 COAs, 147 controls), with 16 (or 6% of the full sample) having two alcoholic parents. As far as parent education was concerned, 36% of mothers and 34% of fathers had completed high school only and 24% of mothers and 30% of fathers had received a college or professional degree.

Recruitment procedures

Recruitment procedures are presented in detail elsewhere (Chassin et al., 1992). COA families were recruited using court records (n= 103), wellness questionnaires from a health maintenance organization (n = 22) and community telephone surveys (n = 120). COAs had to be of Anglo or Hispanic ethnicity, Arizona residents, aged 10.5-15.5 years and English speaking. Moreover, one biological and custodial parent had to meet DSM-III (American Psychiatric Association, 1980) criteria for alcohol abuse or dependence, or Family History-Research Diagnostic Criteria (FH-RDC) (Endicott et al., 1975) based on spouse reports (if the alcoholic parent was not interviewed). Demographically matched controls were recruited using telephone interviews. Controls were screened to match the COA subject in ethnicity, family composition (8% one-parent and 92% two-parent families, the latter including either two biological or step parents), age and socioeconomic status. Neither biological nor custodial parents could meet DSM-III criteria (or FH-RDC criteria) for alcohol abuse or dependence.

Recruitment biases are discussed in detail elsewhere (Chassin et al., 1992). Subjects who refused participation were more likely to be Hispanic and, if there was an arrest record, more likely to be married at the time of the arrest. However, the sample was unbiased with respect to alcoholism indicators that were available in archival records. Moreover, in support of the representativeness of the alcoholic sample, the parents' comorbidities were similar to those reported in the Epidemiological Catchment Area Study (Helzer and Pryzbeck, 1988; see Chassin et al., 1991).

Procedure

The procedures are described in detail elsewhere (Chassin et al., 1991). Data were collected using three, annual, computer-assisted interviews with the adolescents and their parents. Confidentiality was reinforced with a Department of Health and Human Services Certificate of Confidentiality and informed consent was given by all study participants.

Measures

The measures of interest were part of a larger interview battery and, with the exception of parent alcoholism and parent education, were reported by adolescents. Adolescent substance

use was assessed at each of the three waves to determine trajectories of use. All other variables in these analyses were taken from the Wave 1 interview. Correlations among the protective factors are depicted in Table 1.

TABLE 1. Correlations among predictor variables

	Awareness	Perceived control	Family organization
Age	.11(a)	-.09	.11(a)
Awareness	--	-.01	.12(a)
Perceived control		--	.23([dagger])
Family organization			--
Behavioral coping			
Cognitive coping			

	Behavioral coping	Cognitive coping
Age	.03	.01
Awareness	.20([dagger])	.10(a)
Perceived control	.08	.02
Family organization	.27([dagger])	.04
Behavioral coping	--	.39([dagger])
Cognitive coping		--

(a) p [is less than] 10.

([dagger]) p [is less than] .001.

Demographics. Demographic measures were child's age, gender,parent education (a mean of mother's and father's education) and ethnicity (either non-Hispanic white or Hispanic).

Parent alcoholism. Adolescents were categorized as children of alcoholics (COAs) if either parent met DSM-III criteria for diagnoses of alcohol abuse or dependence. A computerized version of the Diagnostic Interview Schedule, Version III (DIS) (Robins et al., 1981), was administered to parents at the initial assessment and provided alcohol diagnoses based on the DSM-III criteria of alcohol abuse or dependence. In cases where a biological parent was not directly interviewed (5% of mothers and 22% of fathers across the COA and control groups), the reporting parent was used as the informant. Items from the FH-RDC were administered for this purpose.

Self-awareness. The private self-awareness subscale from the Self-Awareness and Consciousness Scale (Fenegstein et al., 1975) was adapted to assess self-awareness. Two items were rephrased (e.g., "I reflect about myself a lot" was changed to "I think about myself a lot") for ease of administration to young adolescents and one item was deleted to increase the internal consistency of the scale. A mean of the resulting nine items produced a scale with an internal consistency of .64. Observed responses ranged from 1.56 to 4.89 (on a five-point Likert scale), with a mean ([+ or -] SD) of 3.4 [+ or -] .66.

Perceived loss of control. Perceived control was measured with three items from Newcomb and Harlow (1986). These items asked adolescents to report how frequently they have felt that they were not in control of their lives, that their success was simply a matter of chance and that other people were running their lives. A mean of these three

items produced a scale with an internal consistency of .71. Observed responses ranged from 1.33 to 5.0 (on a five-point Likert scale), with a mean of 4.4 [+ or -] .75.

Family organization. A six-item scale assessed the extent to which families stuck to a pretty regular schedule and routine, had difficulty making plans due to the interference of unexpected events and could count on promises being kept by family members. This measure was developed by project staff drawing from family rituals research by Bennett and Wolin (e.g., Steinglass et al., 1987; Wolin and Bennett, 1984; Wolin et al., 1988), the Family Routines Inventory (Jensen et al., 1983) and Bloom's (1985) factor analytic study of family environment measures. The resulting measure consisted of a five-point Likert scale ranging from strongly agree (1) to strongly disagree (5). A mean of the resulting six items produced a scale with an internal consistency of .54. Observed responses ranged from 1.5 to 4.8, with a mean of 3.1 [+ or -] .61.

Coping. The coping measure comprised six items that assessed behavioral coping (e.g., "When I have a problem, I change a behavior that contributes to the problem") and seven items that assessed cognitive coping (e.g., "When I have a problem, I try to go on as if nothing had happened") developed by Wills (1986). A mean of the behavioral coping items produced a scale with an internal consistency of .58. Observed responses ranged from 1 to 5 (on a five-point Likert scale), with a mean of 3.56 [+ or -] .58. The cognitive coping scale had an internal consistency of .63. Observed responses ranged from 1.5 to 4.8, with a mean of 3.3 [+ or -] .62.

Adolescent substance use. A measure of substance use patterns over the three annual assessment periods was constructed by forming two trajectories: complete abstinence and increasing use. Such categorical or pattern-based approaches to defining substance use can be found in other studies of adolescent substance use. For examples, Johnson and Pandina (1991) created a trichotomous substance use measure in which items assessing the extent of alcohol, marijuana and cocaine use were surveyed to form the categories of no/low use, moderate use or high use. Similarly, Kandel's stage theory of adolescent substance use (Kandel, 1975; Kandel et al., 1978) has been used in multiple studies to categorize substance use along a continuum of stages of substance use involvement. These stages range from gateway use of cigarettes and/or alcohol, to marijuana use to other illicit drug use. Such categorical indices can be especially useful in longitudinal studies in which changes in substance we involvement are of primary interest.

To determine group (trajectory) membership in the current study, adolescent substance use within the past year was assessed (at each wave of measurement) using three sets of items measuring: alcohol use (two items: use of beer, wine or wine coolers and use of distilled spirits), heavy alcohol use (two items: number of times intoxicated and number of times having five or more drinks in a row) and illicit drug use (eight items: use of marijuana, amphetamines, barbiturates, tranquilizers, hallucinogens, cocaine/crack, opiates and inhalant drugs). A composite variable of substance use was then computed in the following manner. First, substance use was categorized within each assessment period as one of the following: (0) complete abstinence from alcohol and drug use, (1) alcohol use but no heavy alcohol or any drug use, (2) either heavy alcohol or drug use. These three levels of substance use involvement, taken at the three assessment periods, yielded 27 possible patterns of use. However, some of these patterns can be logically collapsed (e.g., increasing, decreasing, stable, abstinent or inconsistent patterns of use) and others did not appear in the data.

Two of these patterns were of central interest in the current study: (1) stable abstinence from alcohol and drugs over the 3-year period and (2) substance use initiation after Time 1. Increasing patterns included only those who were abstainers at Time 1 and initiated use at either Time 2 or 3 (moving from abstinence to alcohol, heavy alcohol or drug use). In the current subsample of initial abstainers, 179 adolescents abstained from substance use throughout the 3-year interval and 88 increased their substance use involvement. Although the latter group combines different types of substance use, the group showed predominantly alcohol use (with 42% reporting five or more drinks in a row, with a mean frequency of 2-3 times within the past year). Marijuana use was reported by 14% of this group with a mean frequency of 2-3 times within the past year (for Waves 2 and 3); 12% reported use of illicit drugs other than marijuana, with a mean frequency of 1-2 times within the past year (at Times 2 and 3).

Results

Because of the dichotomous outcome measure in the current study (i.e., stable abstinence versus increased use), the five protective factor models were analyzed with logistic regression. Prior to testing these models, preliminary logistic regression analyses tested whether possible covariates (i.e., age, gender, parent education and ethnicity) predicted substance use. Because only age was found to be a significant predictor of increased substance use over time, gender, parent education and ethnicity were not retained as covariates. Next, interactions between age and each of the predictor variables were tested to determine whether these terms should be included as additional covariates in the models. No such interactions were found.

Each of the final five logistic regression models predicted substance use outcome (abstinence versus increased use) from the following predictors: age, parent alcoholism diagnosis,(1) the protective factor of interest (both linear and quadratic effects) and interactions between the protective factor and parent alcoholism (two terms representing interactions between parent alcoholism and the linear and quadratic effects of the protective factor). Quadratic effects of protective factor predictors were included in these models to provide strict tests of the hypotheses and determine whether these effects departed from linearity (Pedhazur, 1982). Buffering hypotheses, the central questions of the study, were investigated by testing the interactions between parent alcoholism and potential protective factors (either the linear or the quadratic term). Prior to interpretation of the final models, the effects of potential influential outliers were tested through logistic regression diagnostics (Hosmer and Lemeshow, 1989). Influential outliers were identified only in the perceived control model, and were removed from that analysis alone. The effects of these outliers are discussed further below.

In all five models, both COAs (odds ratios [ORs] from 3.1 to 5.3, unstandardized betas (b) from 1.1 to 1.6, Wald's [chi square] from 10.9to 14.8, 1 df; all p's [is less than] .001) and older adolescents (ORs from 1.5 to 1.6, Wald's [chi square] from 13.8 to 17.2, 1 df; all p's [is less than] .001) were more likely to initiate substance use than were control subjects or younger adolescents.

The logistic model testing self-awareness as a protective factor found no main or interactive effects. Also, family organization did not interact with parent alcoholism to

predict substance use, but it did exert a direct influence. This main effect showed that adolescents from highly organized families were less likely to initiate substance use over time than were adolescents from less organized families (OR = 1.7, b = -.50, Wald's [chi square] = 4.87, 1 df; p [chi square] .05).

In testing the effects of perceived control, logistic regression diagnostics identified seven influential outliers. Prior to removal of these outliers, no significant effects were found within this model; however, after their removal, a significant interaction between the linear effect of perceived control and parent alcoholism was found to predict substance use onset (OR = 4.5, b = 1.5, Wald's [chi square] = 5.3, 1 df; p [is less than] .05). To probe this interaction, separate logistic regression models estimating the effect of perceived control on substance use outcomes found a marginally significant, buffering effect for COAs (b = - .8, p = .08) and no effect for controls (b = .7, p = NS). Although the effect of control significantly varied by parent alcoholism, this effect hovered around nonsignificance for both COAs and controls. Thus, COAs with greater perceived control were somewhat less likely to initiate substance use than were COAs with lower perceived control. For controls, perceived control was unrelated to initiation (although the trend was for greater perceived control to predict an increased likelihood of substance use initiation).

Behavioral coping had a significant quadratic effect on substance use onset (OR = 2.1, Wald's [chi square] = 3.68, 1 df; p = .05) and cognitive coping had a marginally significant quadratic effect on substance use onset (OR = 2.0, Wald's [chi square] = 3.22, 1 df; p = .07). Adolescents reporting either very low or very high levels of either form of coping were more likely to abstain from substance use over time than were those reporting moderate levels of coping. Analyses found no significant interactions between behavioral coping and parent alcoholism; however, a marginally significant interaction was found between the linear effect of cognitive coping and parent alcoholism (b = 2.6, Wald's [chi square] = 2.97, 1 df; p = .09).

This interaction between cognitive coping and parent alcoholism was probed by estimating separate logistic models for both COAs and controls. In these models, a significant quadratic effect of cognitive coping was found on substance use initiation for COAs (b = -.94, p [is less than] .05), but no significant effects were found for controls. Compared to controls, COAs had a higher risk for substance use involvement that weakened at extremely high or extremely low levels of cognitive coping. The linear effects of cognitive coping in these two models were nonsignificant, though tending toward a buffering direction for COAs (b = - .67, p = .11) and toward no effect in controls (b = .27, p = .43). Together these linear and quadratic effects suggest that COAs' risk for substance use onset as compared with that of controls was buffered by cognitive coping.

Discussion

Consistent with past research, both children of alcoholics and older adolescents were more likely to initiate substance use than were non-COAs or younger adolescents. The greater likelihood of substance use initiation found for COAs supports previous literature that has identified this population as at risk for potential negative outcomes (associated with substance use) and, thus, as an important target for preventive intervention (e.g., Sher, 1991). The ability of five factors (self-awareness, perceived control, family organization, behavioral coping and cognitive coping) to buffer this risk was examined in the current study.

As predicted, perceived control exerted a significant buffering effect on COA risk for substance use initiation, although these effects were found to be weak within separate analyses for COAs and controls. COAs who report greater perceived control may be more likely to resist peer pressure and, perhaps, to take responsibility for themselves and respond appropriately to their environments. Moreover, these adolescents may also be less prone to periods of depression linked to feelings of learned helplessness. These mechanisms by which perceived control buffers stress may be particularly important for adolescents living in an alcoholic family in which unpredictable and uncontrollable stress may be more likely to occur. Based on this finding, preventive interventions targeting COA risk for substance use initiation might strive to offset the influences of an unpredictable home environment by providing a personal sense of control or self-efficacy regarding life events.

In terms of coping as a protective factor, a quadratic relation was found between both cognitive and behavioral coping and substance use onset. Although the effect for cognitive coping differed for COAs and controls, these findings suggested that both particularly high and particularly low levels of coping lessened risk for substance use initiation. This finding supports previous literature in which increased coping reduced risk for substance use (e.g., Wills and Shiffman, 1985). That is, adolescents who mobilize coping strategies are less likely to initiate substance use. However, quadratic effects have not been tested in previous literature.

The relation between particularly low levels of coping and reduced risk for substance use involvement is less clearly interpretable. Post hoc analyses investigated the hypothesis that low levels of coping may indicate the absence of a need for coping (i.e., a very low level of environmental stress). If environmental stress was very low, substance use initiation would be less likely. However, this hypothesis was not supported by the data when stress was operationalized as uncontrollable major life events.(2) An alternative measure of stress (i.e., daily stressors) may be more relevant to further investigations of this possibility.

In addition to quadratic effects of cognitive coping on substance use, this coping strategy functioned to some extent as a buffer of COA risk for substance use initiation. Because alcoholic homes may be more chaotic, and alcoholic parents may foster an environment that is less responsive to children's attempts to cope behaviorally, COAs who are able to develop such alternative coping strategies as cognitive coping that bypass parental involvement may be more successful in managing their stress and avoiding substance use. Moreover, emotion-focused coping has been particularly effective in overcoming uncontrollable life stressors (Compas et al., 1991; Forsythe and Compas, 1987), and the present measure of cognitive coping contains items tapping emotion-focused strategies. It is possible that cognitive coping directed at emotional strategies is also most effective in overcoming the uncontrollable stress experienced by COAs. This moderated effect was not found for behavioral coping.

Although failing to support a buffering hypothesis, family organization was found to directly influence substance use initiation in the general population of adolescents. Adolescents reporting higher levels of family organization were less likely to initiate substance use over the course of the study. Wolin et al. (1980) also found this relation in a sample of COAs. However, the protective effect of family organization does not appear to

be limited to COAs. This finding suggests that, regardless of parental alcoholism, stability and predictability of family interactions may be important in detering adolescent substance use initiation.

Finally, in contrast to findings by Rogosch et al. (1990), the current study failed to support the role of self-awareness as a protective factor. Direct ascertainment of parent alcoholism in the current study, as compared with the indirect (i.e., student report) method used by Rogosch et al. (1990), may have decreased measurement error, which would lead to a clearer picture of the actual relations among these variables. Moreover, the current analyses tested the prospective relation of self-awareness to substance use initiation whereas Rogosch et al. (1990) tested concurrent relations. Self-awareness may be one of the many correlates of adolescent substance use but it does not appear to prospectively predict substance use initiation.

It is also important to consider some limitations of the current study. In particular, the moderate reliability of some of the protective factor measures (particularly family organization and coping) reduced the statistical power to detect interactions with parent alcoholism. Moreover, other research has supported the multidimensional nature of coping as it impacts mental health (e.g., Carver et al., 1989). Alternative conceptualizations of coping (e.g., positive reinterpretation and growth, restraint, seeking emotional social support) may be considered that both better capture the most relevant aspects of coping with respect to COA risk and better differentiate efficacious and ineffective coping strategies with regard to deterring substance use. In addition, sample size constraints prohibited an empirical integration of the five protective factors (i.e., analysis of a single model containing all five protective factors and their interactions with parental alcoholism). Further examination of the relations among these protective factors and their simultaneous influence is considered an important direction for future research.

Finally, the study examined only two patterns of substance use involvement (i.e., abstinence and increased use). Although these are two important patterns for adolescence, other types of protective factors may be important in predicting, for example, escalating versus stable levels of substance use or the transition from substance use to substance abuse. In addition, initiators in this study may be seen as representing a heterogeneous population that combines in a single group those who began using various amounts of alcohol or drugs after the first wave of assessment. Other interesting comparisons might include those who initiate substance use early with those who initiate use late in adolescence, those who first use low amounts of alcohol with those who first use alcohol heavily or who first use drugs, and those who maintain low levels of alcohol use with those who continue to escalate their substance use throughout adolescence. Unfortunately, such comparisons could not be made in the current study because of the small number of adolescents representing these various groups of initiators.

In sum, the current study found that perceived control and cognitive coping buffered COA risk for substance use initiation. Moreover, behavioral coping and cognitive coping were quadratically related to substance use involvement such that adolescents reporting either particularly high or particularly low levels of coping were less likely to initiate substance use over time than were adolescents reporting only moderate levels of coping. Family organization also served to decrease the likelihood of substance use initiation for both COAs and non-COAs. Based on these findings, preventive interventions targeting groups at high risk for substance use initiation (i.e., COAs) may want to consider the special role

of perceived control in buffering COA risk, and preventive interventions for both COAs and non-COAs should consider strategies for increasing family organization. Future research efforts should consider additional types of protective factors, other patterns of substance use over time (i.e., stable versus escalating substance use involvement) and the mechanisms by which these protective factors exert their influences.

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Notes

(1.) A number of analyses were performed to assess the feasibility and appropriateness of assessing parental alcoholism by this dichotomous variable. First, the decision to collapse diagnoses of alcohol abuse and alcohol dependence was supported by nonsignificant differences between these two diagnostic groups on all independent variables and on the dependent variable. Second, the dichotomous variable (0 = control family, 1 = parent alcohol abuse/dependence) was replaced by a continuous count variable of parental consequences and dependency symptoms experienced within the past year. All logistic regressions were reanalyzed with this continuous predictor variable. The only change in findings occurred in the cognitive coping model in which the interaction between the quadratic effect of cognitive coping and parent alcoholism was the only protective factor effect found in the model. Third, findings did not vary when parent alcoholism was assessed by a trichotomous measure of breadth of family alcoholism (i.e., number of alcoholic parents) instead of the dichotomous parent alcoholism measure. Fourth, these findings also did not change when parent antisocial personality disorder was entered as a control variable in the model.

(2.) Logistic regression analyses involving cognitive and behavioral coping were conducted to determine whether the quadratic effects of coping (i.e., specifically, the effect of low coping) remained after controlling for environmental stress (operationalized as uncontrollable life events). Even when stress was controlled in this manner, behavioral coping (b = - .73, OR = .48, Walds' [chi square] = 3.55, 1 df; p = .06) and cognitive coping (b = - .68, OR = .5, Walds' [chi square] = 3.2, 1 df; p = .07) continued to show quadratic relations with prospective substance use involvement. Thus, abstinence among adolescents with very low levels of coping cannot be completely explained by low levels of environmental stress.

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