

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9216 HOUSE JUDICIARY

G.C.I.

POSITION STATEMENT

GCI supports legislation introduced by Rep. Pete Kelly, HB 416, to allow full competition for local phone service in Alaska. The bill is very similar to legislation that was passed in 1991 to allow long distance telephone competition in Alaska. Just like that 1991 legislation, the bill is needed to break the regulatory logjam at the Alaska Public Utilities Commission so that Alaskans can receive better local phone service at lower prices.

The legislation simply establishes a policy in favor of local phone competition and it gives the APUC a deadline to implement whatever regulations it deems necessary for competition to proceed. Passage of the legislation will benefit all Alaskans.

This legislation is necessary because the APUC recently determined that full competition cannot be allowed in Fairbanks and Juneau until after it completes various other proceedings to ensure that competition does not harm "universal service." Unfortunately, based on progress to date, the APUC will not complete those other proceedings for at least several years.

Background

The U.S. Congress passed the Telecommunications Act of 1996 over two years ago, and that Act established a pro-competitive national policy for all telecommunications services. The APUC has known for over two years that local competition was coming, yet it has failed to complete the regulatory reforms it says are necessary for competition to proceed. Now the APUC's own delay in implementing the reforms is given as the APUC's reason for delaying competition even in cities such as Fairbanks and Juneau.

Full local competition under the Telecommunications Act allows new entrants to serve customers in three ways: through complete resale of the incumbent carrier, entirely through the competitor's own facilities, or through a combination of the competitor's facilities and "unbundled elements" obtained from the incumbent. Full local competition is also dependent on other regulatory requirements, such as "number portability" so that customers can change carriers without giving up their phone number.

Full competition has already begun in Anchorage, where both GCI and AT&T Alascom have entered the market. Every business and residential customer in Anchorage now has a choice between local phone companies. Prices have already come down, and new services have been introduced. Competition in Anchorage is already bringing the same benefits to Anchorage that long distance competition brought to Alaska.

GCI is prepared to provide local service in other communities across Alaska, beginning with Fairbanks and Juneau. However, the APUC has denied GCI the ability to provide full competition outside of Anchorage, based on a provision of federal law that defined all local phone companies outside Anchorage as rural.

The APUC Ruling

The reasons that APUC gave for denying GCI's request to bring full local competition to Fairbanks and Juneau are remarkably similar to the reasons that the APUC delayed long distance competition for 8 years. The APUC stated that competition could not begin without assurances that "universal service" would be protected.

The current APUC did not say "no" to competition forever. Instead, it said that various reforms needed to be implemented to protect universal service before competition could proceed, and it would reconsider full competition after those reforms are implemented. Again, this action was virtually identical to the APUC's actions while it was considering long distance competition: The APUC never said competition was prohibited, it just said further action and consideration was necessary, but the APUC never completed those other actions until the Legislature established a deadline.

Benefits of Competition

Today, the fears of the APUC regarding long distance competition seem almost silly. None of the fears came true. Long distance competition has benefited all Alaskans and it has harmed none. Prices for long distance service have been reduced by more than 25%, and the quality of service has improved. Many locations that previously had double hop analogue service that would barely support FAXes now have digital, single hop service.

But history is now repeating itself in the local market, and the APUC is again delaying competition because of the same fears. It is again time for the Legislature to break the APUC logjam that is delaying competition, just as the Legislature broke the logjam in 1991.

The importance of telecommunications to Alaskans -- and the benefits that come with full competition for telecommunications services -- cannot be overstated. The amazing growth and technological advances in the telecommunications industry have been fueled by competition, while at the same time prices have fallen. Competitive forces will bring the same benefits to local phone service. In Anchorage, competitors have invested millions of dollars in new switching and fiber optic equipment, making new services available to consumers. New, high speed "broadband" services are available over competitive systems designed to bring consumers in full range of telecommunications services.

With the passage of HB 416, these benefits will be available to citizens in other locations across Alaska. The APUC can prevent "cream skimming" and ensure widespread benefits from competition by requiring any new competitor to service the entire area served by an existing company. As high quality services are extended to new locations, the entire State economy will benefit from the upgraded telecommunications infrastructure.

Without the Legislature's involvement, a world of technological "haves" and "have nots" will be created in Alaska. The "haves" will be living in Anchorage, with high quality broadband access, while the "have nots" will reside in the remainder of the State.

The citizens of Alaska already know that benefits will flow from local service competition. In a poll conducted on behalf of GCI, over 75% of the citizens of Fairbanks and Juneau said they want competition in the local telephone market. By similar percentages, the citizens said competition would bring lower prices and new technology. And over 80% of the citizens said their community was not too rural for local phone competition.

History has proven, over and over, that competition in telecommunications benefits consumers. The citizens already know that. Enacting HB 416 will be in accordance with the will of the people and it will benefit all Alaskans and the State's economy.

America's Missing Infrastructure:

The third shoe drops

All eyes are on the states.

IT'S BEEN 14 YEARS since the first shoe dropped—the 1984 Divestiture ruling that precipitated the separation of local and long distance services, breaking up the Bell monopoly. The second shoe dropped when the Telecommunications Act of 1996 transformed the local monopoly into an open, competitive arena. Now, a third shoe has dropped—in the unlikely state of South Dakota.

In this second of a four-part series of articles, we describe the role for industry leaders and government entities to thrive in the post-Act information marketplace. Part I appeared in our Jan. 1 issue.



The Telecom Act promised exciting, new, advanced communications services offered affordably to all U.S. consumers. But the Act has fallen short of its goal. Two years since the passing of this historic legislation, we ask:

- Where are the exciting advanced data, video and multimedia networks to meet current and future needs at home, at business, in schools and in hospitals?
- Was the law all that was needed to achieve meaningful change?
- What new communications capabilities do home and small-business users have that they did not have 15 years ago?
- Where are the revenues from the billions of dollars poured into research and development (R&D) each year, and where are the advanced products and services resulting from those investments?
- Why are the goals of the Act still not achieved?

DIVERGENCE

The industry faces alternative pathways:

- Grow the marketplace pie by deploying a new, advanced telecom infrastructure to support public data, video and multimedia networking at higher and higher speeds; or
- Seek a larger share of the existing pie, which consists of plain old telephone service (POTS) and special services for limited markets.

The industry's traditional choice—to preserve the past and gain a larger slice—will leave data, multimedia and video users' needs unmet and market opportunities unfulfilled. No amount of time can make this path meet the goals of the Act.

It has become clear that the main beneficiaries of the Act are the industry's attorneys. Incumbent local exchange carriers (ILECs) have implemented a two-part response to the Act, which ostensibly entails "foot dragging"

on implementing the Act's provisions and pursuing mergers and acquisitions. Using a series of protracted legal actions to delay and/or avoid opening up their networks to competition at affordable prices, ILECs apparently want to outlast the politicians and competitive LECs (CLECs).

ILECs have launched a flurry of mergers and acquisitions, valued at more than \$88 billion, within their traditional arenas (Bell Atlantic/Nynex: \$23 billion; SBC/Pacific Telesis, \$16.7 billion; etc.) and outside their traditional sectors (US West/Time Warner and US West/Continental Cable at about \$20 billion together). These mergers, which typically result in large debt and loss of talent and resources, push the industry further from deploying the needed advanced infrastructure which would enable ILECs to take advantage of the explosive growth in the fully switched, fully available, public data,

video and multimedia network services markets.

UNTAPPED OPPORTUNITY

The Telecom Act, coupled with dramatic technological advances over the last 20 years, have created an exciting arena with new rules, new players and untapped market opportunities. The existing network has been opened for resale. Advanced digital and optical technology renders bandwidth a commodity, and creates a world in which features and services are paramount. Although danger lurks for the ill-informed as charlatans tout impossible claims about their product or technology's capabilities, there are vast opportunities for savvy players.

For years, the traditional telecom sector has failed to meet market needs for services that are affordable, switched, feature-rich, and support public data, video and multimedia networking. With a long history as regulated monopolies with a limited vision and strategy for anything other than telephony services, they have demonstrated since divestiture that they are uninterested in the challenges and opportunities ahead. They have resisted the deployment of advanced technologies which could have affordably delivered fully switched, advanced services at the increasing bandwidth rates required by users.

The ILECs have chosen instead to protect the imbedded POTS network and artificially high pricing schemes. They maintain a premium pricing mechanism for bandwidth, roughly based on the number of voice calls a given circuit can carry rather than the actual cost of providing the service and the inherent value of the applications it supports. This policy ignores the ability of technology to deliver virtually infinite amounts of bandwidth at prices comparable to POTS.

However, ILECs' days are numbered. Competitive market forces eventually will establish bandwidth as a commodity as they recognize that new features and services will deliver differentiating value and high-margin returns. This is a great opportunity for facilities-based CLECs.

To compete successfully, companies must provide differentiation based on service offerings, not simply price.

KEY TO SUCCESS

The three keys to success in the post-Act arena are *infrastructure, infrastructure, infrastructure*. A fully switched network infrastructure must be deployed to meet narrowband, wideband and broadband networking needs.

To compete successfully, companies must provide differentiation based on service offerings, not simply price. As the power of technology is applied to slash the price of bandwidth, reseller margins will be placed under intense pressure. In the long run, the facilities-based competitor that can control its own destiny has the advantage; it can use digital and optical technology to offer advanced network features and services at dramatically lower prices.

Without this new infrastructure, ILECs and resellers will be forced to carve up the existing telephony market pie, providing limited advances over the current voice infrastructure and forcing smaller and smaller margins as more players enter the field.

Telecom brownouts already are occurring throughout the United States as users, lacking a viable data networking alternative, use and abuse the voice network with everything from credit-card verifications (short holding times) to Web browsing activities (long holding times). The voice network was not designed to handle data traffic—it is the wrong tool for the job.

There is no need to burden the traditional voice network's higher layers with data and video traffic that can cause extensive blocking, overloading and backhauling. A new network infrastructure with a new class of switches provides an attractive alternative path for all carriers. Customer information can be transported to numerous competitive, alternative networks and new service providers (as the Act envisioned), and the traditional voice network can be protected from abuse and eventual destruction.

A NEW ROLE FOR LEADERS

The competitive environment and market needs for advanced services combine to establish new roles and opportunities for those willing to step up. New industry leaders must break out of the "connect and collect" mentality to build an advanced infrastructure that meets present and future needs. Those who cling to past monopolistic tenants of providing limited offerings and few features at high prices will be left in the dust.

New leaders will leverage the many advanced digital and optical technologies (now dormant on the shelves of the world's great supplier R&D labs) and will enjoy the resulting large slices of a new, richer, information market pie.

A NEW ROLE FOR STATES

For state governments, the Act has created a role with new responsibilities. Given the complexity and capital-intensive nature of deploying a new infrastructure, strategic leadership is essential to establish the correct direction. Without cohesive leadership, a patchwork of incompatible, dissimilar network solutions with limited, selective areas of coverage will result—and it will prove far more complex than making a call across the 30-odd incompatible voice telephone company networks that served New York City at the beginning of the 20th century.

Proper incentives and protection must be provided to ensure that the playing field is free from unfair competition when deploying these new networks; however, an open and competitive environment must be maintained, as mandated by the Telecom Act.

There is no longer a regulated "keeper of the network" who manages the integrity and direction of the infrastructure and looks out for the consumers by ensuring that regions do not enter into the information age with information haves and have-nots. States must step up and fulfill this role. While state public utility commissions (PUCs) have historically provided regulatory guidance, they have not set comprehensive strategic policy.

(Indeed, these PUCs will be quite busy for the foreseeable future as they carry out issues related to the Telecom Act, such as arbitrating disputes and establishing wholesale pricing schemes for resellers, etc.)

THE THIRD SHOE HAS DROPPED

South Dakota knows well the hardship that a lack of public infrastructure can bring. It is among the few states without a major east-west or north-south railroad. Many of its small towns dried up when the interstate highway system bypassed them, and the state lost much of its commercial air service with the deregulation of the airline industry. As the information age progresses, South Dakotans must have an advanced communications infrastructure to compete and thrive in the new millennium—or the state will “dry up” as a whole.

History was made last year when South Dakota's governor and state legislature overwhelmingly voted into law a new telecommunications policy to ensure that all state residents enjoy the benefits of a well-defined, advanced telecom infrastructure.

The law (see box below) establishes direction and leadership. It focuses on the considerable resources that industry players spend each year on a common infrastructure solution. It provides specific direction and goals for the state by defining three new networks required to meet South Dakota's current and future communications needs:

- A narrowband network, which leverages existing copper voice telephone lines to achieve a 10-fold increase in capacity over the digital switched network, delivering up to 144 kbps capacity;
- A wideband (transitional) network, which stretches the copper lines to their limit and launches use of some fiber optic lines, and will range in capacity from 144 kbps to 45 Mbps, yielding a 1,000- to 3,000-fold increase in capacity; and
- A broadband network, delivering switched fiber optic networking to the desktop at speeds ranging from 150 Mbps to 622 Mbps to 4.8 Gbps to into the Terabit range, establishing a 100,000- to several million-fold increase in capacity over today's networks.

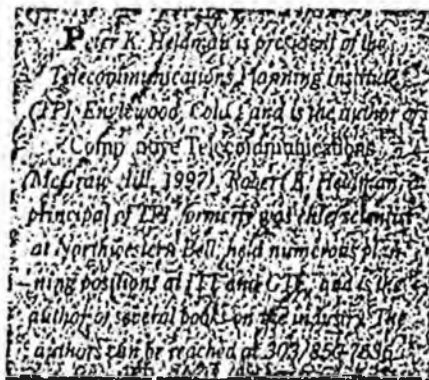
The law details technologies, standards, capabilities and minimum user interface requirements for the networks. Existing plant is to be leveraged and new plant established to form an open infrastructure, as envisioned by the Telecom Act. The new networks should implement phased-in deployment, which allows a cadre of new, non-

traditional facilities based service providers to join in. The law further directs the South Dakota PUC and other branches of state government to promote and establish these networks in all actions, decisions and policies.

Seeking a standardized network solution that meets user needs for security, survivability, addressability, robustness and affordability, the law defines the exact infrastructure. The stakes are great; indeed, this state cannot afford to pursue a limited or wrong solution.

The eyes of the nation will be on South Dakota and other states to see whether service providers are serious about providing a new infrastructure for data, video and multimedia services—or whether they will abandon America's future market opportunities. Who will manage, direct and incent the deployment of the new advanced infrastructure? It's up to the states and industry to provide the answer.

The genie cannot be put back into the bottle. ILEC efforts to foot-drag the inevitable inroads of competition will fail in the end. A better course of action is to acknowledge the untapped market opportunities for advanced networking services. Shareholders and consumers are better served as service providers use their resources constructively to compete in the market, rather than in the court room. South Dakota's leadership has embraced this new environment, and can be a model for other states, as well as ILECs, CLECs, equipment suppliers and end users, to follow. ■



Peter K. Heidman is president of the Telecommunications Planning Institute (TPI), Englewood, Colo., and is the author of "Competition in Telecommunications" (McGraw-Hill, 1997). Robert K. Heidman, principal of TPI, formerly was the scientist at Northwestern Bell, held numerous planning positions at ILECs and CLECs, and is the author of several books on the industry. The authors can be reached at 303/854-7896.

SOUTH DAKOTA'S TELECOMMUNICATIONS POLICY ACT

"It is the intent of the legislature that South Dakota have a telecommunications infrastructure that meets the advanced communication needs of the state's individual citizens and its communities of interest, including our schools, medical facilities, businesses and all levels of government. To achieve this intent, three new networks, accessible by all South Dakotans, will be established; a narrowband network, a wideband network and a broadband network. Together, these three networks will form South Dakota's new advanced Public Communications Network Infrastructure.

These three networks will fully support the following capabilities requirements: ubiquitous, feature-rich, standard, secure, private, survivable, robust, addressable, switched, symmetric, affordable and available.

Communications services will be reasonably and affordably priced to promote the growth and usage of each of these three new networks, leveraging the power of technology to provide ever increasing bandwidths at ever diminishing cost of facilities.

Classes of service will be created for network services in order to establish a new service-based and value-based pricing model.

The new narrowband, wideband and broadband communications networks will be established in a manner ensuring that all the citizens of South Dakota realize the advantages of the forthcoming information age, including economic development, educational opportunities, a heightened level of medical care, and better, more efficient service from all levels of government."

---South Dakota Statute Chapter 42-31

2/19/98

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FAIRBANKS

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*Editorial Page Editor***Phone repairs**

The Alaska Public Utilities Commission last month snipped the wires carrying competition to local phone service in Fairbanks, but Rep. Pete Kelly is playing repairman.

Kelly, R-Fairbanks, has introduced legislation that would require the APUC to approve local service applications from companies that show they are "fit, willing and able" to provide the service. The bill could help speed the arrival of more choices and even better prices in Fairbanks. It's worthy of support.

On Jan. 8, the APUC rejected an application from GCI to provide local phone service in Fairbanks. GCI wanted the commission to reject an exemption in recent federal law that protects PTI's local monopoly. Congress deregulated much of local phone service in 1996 but allowed the states to decide whether to allow local service competition in their communities with 50,000 or fewer lines. APUC members decided against competition for both Fairbanks and Juneau.

The commissioners may eventually allow competition anyway, but this bill should speed up the process and set some parameters for such decisions.

The legislation doesn't completely gut the regulatory process. It retains and acknowledges the commission's responsibility to determine whether a company is able to provide local phone service. However, if the company is able, the commission would have to approve the application within 90 days.

Currently, the commission has another step in its process. It must determine whether competition for local phone service is required for the "convenience and necessity" of the public. Kelly's bill makes the blanket determination that, yes, competition is a necessity.

As a result, decisions about where to seek local phone service more often would be made not by the government but by the individuals paying for that service. That's where the decision belongs.



Bill to hasten phone competition

By LEE JORDAN
Alaska Star Editor

A measure designed to hasten competition for local telephone service in areas other than Anchorage was introduced Tuesday by Rep. Pete Kelly of Fairbanks. It was prompted by a Jan. 8 decision of the Alaska Public Utilities Commission (APUC) to delay opening Fairbanks and Juneau to the type of battles being waged for customers in Anchorage.

"History has proven competition gives consumers lower costs, increased technology and more choices. I can't see anything wrong with those outcomes," Kelly said in announcing the filing of House Bill 416.

That bothers Greg Berberich, vice president of corporate services for Matanuska Telephone Association (MTA).

"Congress specified that they set aside rural companies to be regulated by state commissions," he said. "The Legislature is trying to circumvent the system."

Supporters of the bill said the regulators have not given enough thought to the savings for consumers.

"The APUC decision makes no mention of the benefits to customers from competition. Instead, they concentrated on possible harm to utilities," said GCI spokesman David Morris.

(See PHONES, Page 3)

2-19-98 Chugiak - Eagle River Alaska Star

PHONE:

(Continued from page 1)

GCI, which is engaged in an all-out effort to snag customers from the city-owned Anchorage Telephone Utility (ATU), had petitioned for the right to offer local telephone service in Juneau. It was that petition that resulted in the Jan. 8 decision.

"Customers all agree they want competition," Morris said, referring to surveys conducted by his company. "They see what happened on the long distance side. When competition began, a number of hidden charges suddenly went away."

Anchorage is the only part of Alaska where competition is allowed in the local telephone service arena. Because of that, ATU is under attack by both GCI and AT&T Atascom.

"It's premature for our state legislature to get involved, given all the intricacies at the APUC and Federal Communications Commission levels," Berberich said.

Despite GCI's assertions that customers will benefit, Berberich said "some may and some may not. We're seeing around the country that competition is not necessarily lowering costs but is creating a class of haves and have-nots."

The MTA executive acknowledged that "competition drives price to cost." Rural utilities, however, "are very high cost companies."

"Congress wanted the state commissions to look at individual situations to make sure there would be enough support to keep affordable service" throughout a utility's service area "after the cherry-picking is over." That term refers to signing up blocks of easy-to-serve customers, leaving the more expensive ones to the established company.

Without the playing field being leveled by the state regulatory commission, "competition is a risk," Berberich said.

Telephone service "has been a monopoly for the past 45 years," the MTA official said. "It's not going to change overnight."

Front page story

LEE B. JORDAN
Editor and Publisher

12-11-97

"Some values are ... like sugar on the doughnut, legitimate, desirable, but insufficient, apart from the doughnut itself. We need substance as well as frosting." —Ralph Tyler Flewelling

Telephone disparity questioned

People who live or work in Chugiak - Eagle River have been paying one of Alaska's highest rates for telephone service. Fellow member-owners of Matanuska Telephone Association (MTA) pay \$60 per year less. That disparity has been going on for nearly 20 years. The Palmer-based utility considers the 55 percent higher charge to still be justified by 1978 reasoning. That is surprising.

Even with competition looming, no one at the telephone utility has taken a look at leveling the playing field in the area closest to their competitors — an area that represents 31 percent of MTA's total access lines. That's not only surprising but disturbing.

THE RATE DIFFERENTIAL was implemented after MTA and the Anchorage Telephone Utility (ATU) worked out an agreement whereby calls could be made toll-free between Chugiak - Eagle River numbers and those in Anchorage and on the military bases. Such calls until then had been long-distance calls, costing 30 cents or more, plus tax, in 1970s dollars.

To make the service possible, microwave transmitters were set up at Eagle River and atop ATU's East Wire Center on DelBarr Road. As the Chugiak - Eagle River population grew, more microwave facilities were added and more recently, a fiber-optic cable was extended along Glenn Highway.

Chugiak - Eagle River Chamber of Commerce, then the only organized voice for the community of 8,500 people, joined individual residents in asking for the toll-free service. Told it would be necessary to pay more on their monthly bill to offset the added expense — and also MTA's loss of income from a share of the long distance calls — the telephone users agreed to pay more.

BUT THAT WAS almost 20 years ago. Twenty years before that, the area's handful of houses was connected by Army surplus field telephones hooked to wire strung through the woods.

Today, Chugiak - Eagle River has a population of more than 30,000 with nearly 14,000 active telephone lines. Telephone wars have burst out all over the place, with three companies — including MTA — competing for customers in the Anchorage market. Utilities are offering 10-cents-a-minute rates for calls across the globe. Cellular phones, while presently more costly, offer the convenience of being in contact anytime, virtually anywhere.

Technology has changed considerably during that time. Those microwave units 20 years ago were advanced equipment at the time. Today, the cable alongside Glenn Highway can carry thousands of conversations at a tiny fraction of the old costs.

MTA TELLS US that cost is not a factor in the rate differential assessed in Chugiak - Eagle River. It's based instead on what MTA thought it would be worth to local residents to eliminate the long distance tolls. If we wanted toll-free calls that much, they'd be happy to oblige. MTA convinced the Alaska Public Utilities Commission that the rationale was sound.

Local customers who are discovering that the disparity has continued so long without review may well be justified in asking for an accounting from the utility they own.

They should also ask why nothing has been done to prepare for competition that they know is only two years down the road. That time frame is significant because MTA claims that it takes two years to get a change in the rate structure. GCI asserts, on the other hand, that ATU customers saw immediate savings as soon as GCI announced it was entering the game.

THE TELECOMMUNICATION INDUSTRY is changing faster than most people can comprehend. MTA itself has jumped into the deep end of the pool with its own ventures into the competitive field. Let's wish the best for our cooperative. At the same time, let's make sure that all the members are being treated fairly. Sixty dollars a year to call Anchorage over an in-place line is pretty expensive — especially when you consider that one can have a nice chat with Aunt Susie in Great Neck, N.Y. for less than a buck.

'Free' MTA service costs \$5

By LEE JORDAN
Alaska Star Editor

Chugiak - Eagle River residents pay \$5 more per month for residential telephone service than do their friends with a cabin near Talkeetna. But it costs them nothing to make a call to Anchorage, something that comes extra for the remote-area person.

Sen. Rick Halford of Chugiak has asked his staff to review the disparity in rates of Matanuska Telephone Association (MTA), hoping to learn if the difference in the 19-year-old rate structure is fair to the co-op's members in the southern part of the district.

As of Oct. 31, MTA served 44,891 access lines. Of those, 13,849 are in Chugiak - Eagle River.

Basic residential service in Chugiak - Eagle River is \$13.90 per month as compared to \$8.96 in Talkeetna, Clear, Healy, Palmer and other localities within the vast MTA service area. A proportionally higher surcharge is also applied to business telephone service.

According to figures compiled by Halford legis-

lative aide Bill Stoltze, only Elim's Mukluk Telephone system charges more than MTA's Chugiak - Eagle River rate - 40 cents more. Anchorage Telephone Utility (ATU) customers in Anchorage pay \$9.77 per month. Under the two-way agreement, they can call Chugiak - Eagle River numbers toll-free.

"We were both a little surprised at the rate difference," Stoltze said. "We knew we were paying more than other parts of MTA and we knew we were paying more than Anchorage residents."

They weren't aware the difference came to \$60 a year.

Why is the rate so much higher for one portion of the service area?

"Extended area service," said Don Reed, manager of regulatory affairs for MTA.

In 1978, Chugiak - Eagle River residents said they wanted to be able to call Anchorage and the military bases without having to go through long
(See RATES, Page 2)

RATES:

(Continued from Page 1)

distance operators.

The rate for that service was determined by setting a value on the average customer's local area long distance calls, a charge at that time of about 30 cents per call.

"It was an evaluation — market value — and is not based on costs," Reed said. Customers were willing to pay the higher amount and the Alaska Public Utilities Commission (APUC) accepted it.

Customers still seem willing to pay more based on the long-standing formula, Reed said. There has been no request for a review of the rate structure and the utility has no plans to file for a revision — a process that MTA Vice President Faye Palin said would take two years.

The spectre of competition is a concern to the utility, Palin and Reed both said. It has not, however, spurred them to look at lowering rates.

Competition in the telephone industry has mushroomed following passage of the Telecommunications Act of 1996. Congress actually encouraged competition for local service, said David Morriss of GCI.

ATU and AT&T spokespersons both told The Star they have no plans to attempt to serve Chugiak - Eagle River.

GCI, on the other hand, has already announced

that it plans to begin local telephone service in Chugiak - Eagle River within two years.

Customers of ATU "saw a lot of hidden charges disappear just as soon as GCI announced we were going into local service," Morriss said. Referring to what he said were charges "just for the privilege of using ATU," he said, "they don't see those kind of 'gotchas' now."

"Cutting rates in an effort to slow competition may not be a good idea," said Steve Ex, the only Chugiak - Eagle River resident on the five-member MTA board. That could hurt the cooperative, Ex said.

"We're having to borrow money to keep up with building more infrastructure because of the fast growth within our service area," said the director.

Rates for local service make up only about 17 percent of MTA's income, Ex said. The remaining 83 percent comes from a federal program to subsidize rural telephone service and from MTA's share of long distance charges. The utility's many subsidiaries do not contribute significantly to MTA's income, he said.

All of Alaska except for ATU's Anchorage area is classified as rural under the 1996 act. It is that designation that provides the federal subsidies that supplement MTA's telephone service rates. An APUC ruling that would remove the "rural" designation for Juneau is being watched closely by utility players.



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March 11, 1998

The Honorable Jeannette James, Chair
House State Affairs Committee
Alaska State Legislature
P.O. Box V
Juneau, AK 99801

Dear Representative James,

Thank you for the opportunity to add my support to HB 416 " An Act relating to competition in the provision of local exchange telephone service. I support this bill because of my fundamental belief that competition in the marketplace is in the consumer's best interest. Modern technology is making competition in telecommunications economically sound public policy, and it should be reflected in our regulatory policy.

It has been my observation that regulatory agencies are inherently cautious and conservative with regard to major policy changes. For that reason I do believe that it is appropriate for the legislature to establish general policy in statute as outlined in HB 416.

Sincerely,

Steve Frank

March 10, 1998

**Alaska State Legislature
House State Affairs Committee
Alaska State Capital Building
Juneau, AK 99801-1132**

To Whom It May Concern:

I can choose the stores where I shop, I can choose what kind of car I drive, I can choose my airline, I can choose what entertainment I want, basically I can choose most everything in my life. A few years ago there were things I couldn't choose because it wasn't technically feasible, but as we have advanced technologically, many of those areas have opened up so that competition is possible.

One of those areas now should be my local phone service. There is no reason I can see that Anchorage should be the only area in Alaska where companies can compete for customers. It's through this healthy competition that businesses start improving their services and becoming better and more efficient because that's how they vie for customers. Obviously, the customers are better off because the service is better and the costs are reduced.

In short, I want to see competition in local phone service.

Thank you for your consideration,

John Guiggey

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March 11, 1998

State Affairs Committee
Alaska State Legislature
State Capital (MS-3100)
Juneau, AK 99801-1132

Dear State Affairs Committee Members:

As a citizen of the second largest community in Alaska, I encourage you to support competition for local telephone service. Fairbanks cannot remain non-competitive while Anchorage and other communities in the United States realize new services and technology. The only way we will have the new technology required is by allowing competing companies the opportunity to serve this area.

I spend many hours doing research on the internet. Many hours have been wasted, while I wait for screens to appear on my monitor. I have the highest speed modem which can be supported by the lines coming into my home. I can purchase faster modems, however, it would not result in any improvement. I know that if competition is allowed, more options will be available at more affordable rates than currently exist.

Please vote in favor of House Bill 416.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robin L. Dodson", with a long horizontal flourish extending to the right.

Robin L. Dodson

Dr. David B. Hoffman
P.O. Box 83161, Fairbanks, AK 99708-3161
907-474-2141 - dhoffman@alaska.net

DATE March 12, 1998

TO Representative Jeannette James, Chair
State of Alaska
House State Affairs Committee

CC Representatives: Pete Kelly, John Davies, Tom Brice, Gene Theriault, Al Vezey
Senators Bert Sharp, Mike Miller, Gary Wilken

RE: HB 416 - Local Phone Service Competition

The recent APUC decision to classify Fairbanks as a rural community and therefore exclude it from local phone service competition was a disappointment. Representative Kelly's recent proposed legislation HB 416, to override APUC's decision is refreshing news. I sincerely hope that the State Affairs Committee will support this initiative.

The changes in communications technology available to the public will change more over the next five years than it has changed over the past 50 years. Fairbanks should not be left out?

I use Internet connectivity every day as a consultant and frequently find that, despite the fastest modem available, I am still denied numerous files, upgrades, software and animation that are available to most others in the U.S. For example, I recently tried to download a simulation language from Powersim Inc. Because of the size of the files, I ended up calling the company and asking them to mail the nine disks and the manual.


Protecting PTI's monopoly will slow the innovations that are already available elsewhere. Fairbanks is home of the University of Alaska Fairbanks, Arctic Region Supercomputing Center, the new International Arctic Research Center, several new satellite remote sensing earth stations, Alyeska Pipeline Service Co. headquarters, and many other organizations. These organizations attract many talented people and I am concerned that the lack of incentives for communications innovations here will hurt the community's ability to attract and retain people who are accustomed to these services for themselves and their families.

As I read about high-speed communications developments, like Internet, ISDN, and cable modems, I realize that, if Fairbanks is not able to offer the current innovation, future advancements will be very slow in coming. And if they come in a monopoly environment, they will be far more expensive. The APUC ruling says to me, "If you want modern, competitive communications options in Alaska, move to Anchorage".

PTI and its new parent company, Century, are mature well-developed, financially sound corporations that can handle competition. Deregulation has brought innovative communications to millions. Decisions that restrict competition here in Alaska exclude students, the business community and the general public from both the economic and technological benefits.

Thank you.

Sincerely,



David B. Hoffman



Sebastian Hair and Nail Design

Kevin E. Griffin, Salon Owner

*505 Old Steese Hwy., Suite 121 * Fairbanks, Alaska 99701 * (907) 451-6657*

March 9, 1998

State of Alaska
House of Representatives
State Affairs Committee
Juneau, AK 99801

Dear Members of the House State Affairs Committee,

As a small business owner I am constantly striving to reduce my overhead. The telephone is the way most of my clients set appointments. It is a necessary tool like the other equipment in my salon. The difference is that I can arrange for different suppliers for my other equipment and services. I can't for my phone service.

I am an ardent supporter of competition. I compete in my profession and it's not always easy, but I am continually trying new ways to improve what I do and how I treat my clients. I also recognize that I benefit by working with suppliers and other businesses who have to compete for my business.

The purpose of my letter to you is that I would like to see competition wherever it is possible. I would like to see competition for my phone service.

Sincerely,

Kevin E. Griffin

Rusty Bickerstaff · P. O. Box 55862, North Pole, AK 99705-5862

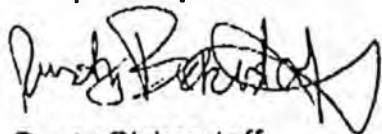
TO: House State Affairs Committee
Alaska State Legislature
State Capital (MS 3100)
Juneau, AK 99801-1132

RE: HB 416

Prices continue to drop for my long distance telephone service, but I haven't noticed any reductions in my local service - in fact, quite the contrary. There is no doubt in my mind that if PTI had to compete for my business, suddenly, there would be some reductions available to me! Quite frankly, that makes me more than a little frustrated.

You have the opportunity to correct this situation. I respectfully request that you keep the customers in mind when you look at HB 416.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Rusty Bickerstaff", written in a cursive style.

Rusty Bickerstaff

Nick Stepovich
543 Second Avenue
Fairbanks, AK 99701

March 6, 1998

House State Affairs Committee
Alaska State Legislature
State Capital (MS 3100)
Juneau, AK 99801-1132


Dear Committee Members:

As a lifelong member of the Fairbanks community, I am frustrated that I cannot choose the company with which I do business for my local telephone service. Monopolies were common in days past. There is no reason, these days, that local telephone service cannot be opened up to other businesses who are able and interested in serving the Fairbanks area.

I support HB 416, introduced by Pete Kelly.

Sincerely,

Nick Stepovich

A handwritten signature in black ink, appearing to read "Nick Stepovich", written over the printed name.

March 11, 1998

Alaska State Legislature
House State Affairs Committee
State Capital Building
Juneau, AK 99801

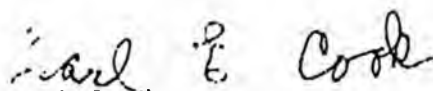
TO: House State Affairs Committee Members
RE: House Bill 416

Fairbanks has been my home for over sixty years. During those years, many changes have transformed our community from a somewhat remote town to a city with amenities one would find most everywhere - the result of free enterprise.

Through the years, monopolies have been allowed in some industries due to barriers too substantial to allow for reasonable and reliable service to the population being served. As new technology is developed, those barriers are being eliminated. Today, there are far fewer monopolies than existed just a short 15 years ago.

Local telephone companies, historically monopolies, are seeing competition now in Anchorage and the other 49 states. There does not appear to be any reason for areas outside Anchorage to be excluded from the benefits of competition in this industry. The decision to only allow competition in Anchorage appears to be arbitrary.

Sincerely,


Earl E. Cook
238 Well Street
Fairbanks, Alaska 99701
453-3637

Alaska Telephone Association

201 E. 56th, Suite 114
Anchorage, AK 99518
(907) 563-4000
FAX (907) 562-3776

David Fauske
President

James Rowe
Executive Director

Legislative Briefing - February 1998

▶ **HB 416 - An Act relating to competition in the provision of local exchange telephone service**

With the 1996 Telecommunications Act, Congress mandated competition as a national policy. The Act also mandated the preservation and advancement of Universal Service at affordable rates. Congress recognized the problems associated with competition in rural areas and specifically placed upon each state public utilities commission the responsibility for determining when the delivery of telecommunications services in a competitive environment would be in the public interest. HB 416 would circumvent the intent of Congress and eliminate any public interest determination.

Since the Act was passed, the FCC has been very busy promulgating regulations; many of which have been challenged and overturned in court. These rulemakings involving access charges, universal service and separations reform are very complex, will have significant impact on Alaskans and must be carefully deliberated. Some of the determinations that will come from the state need prior resolution at the federal level. In other cases the APUC seeks more data upon which to make informed decisions. HB 416 interferes with the commission process necessary to maintain universal service and affordable rates in Alaska.

▶ **Sufficient funding for the APUC**

The Telecommunications Act of 1996 has significantly increased the workload of the commission. We support funding levels sufficient to serve the public needs.

▶ **Passage of locate standards legislation this session**

The state has long needed standards for locating and identifying underground utilities. A bill soon to be introduced in the Senate Labor and Commerce Committee will address those standards.

Post-it* Fax Note	7671	Date	# of pages	2
To	<u>PALLA</u>	From	<u>Jim</u>	
Co./Dept.		Co.		
Phone #		Phone #		
Fax #		Fax #		

0-LS1568B

HOUSE BILL NO. 416
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTIETH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE KELLY

-- Introduced: 2/16/98
 Referred: State Affairs, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to competition in the provision of local exchange telephone
 2 service; and providing for an effective date."

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

4 * Section 1. AS 42.05 is amended by adding a new section to read:

5 Sec. 42.05.870. Competition in local exchange service. (a) The legislature
 6 finds that

7 (1) modern, affordable, efficient, and universally available local and
 8 long distance telephone service is essential to the people of the state;

9 (2) local exchange telephone service should be provided competitively
 10 wherever possible;

11 (3) technological advances, reduced costs, and increased consumer
 12 choices for local exchange telephone service, resulting from the adoption of an
 13 appropriate competitive market structure, will enhance the state's economic
 14 development;

HB0416a

-1-

HB 416

New Text Underlined (DELETED TEXT BRACKETED)

1 (4) the benefits of competition in local exchange telephone service
2 should be available to consumers throughout the state;

3 (5) the commission should oversee competition in local exchange
4 telephone service to ensure that the competition is fair to consumers and competitors;

5 (6) the commission should provide for competition in a timely manner
6 and should adopt regulations that eliminate impediments to entry for local exchange
7 carriers fit, willing, and able to provide service.

8 (b) By December 31, 1998, the commission shall adopt

9 (1) regulations on universal service and access charges that are
10 compatible with full competition in the provision of local exchange telephone service
11 using all methods allowed by 47 U.S.C. 251 - 276 (Telecommunications Act of 1996);
12 and

13 (2) any further regulations necessary to allow and promote local
14 exchange competition, using all methods allowed by 47 U.S.C. 251 - 276
15 (Telecommunications Act of 1996), in the service areas of all local exchange carriers
16 that served 1,500 or more access lines on January 1, 1998.

17 (c) The commission shall approve or deny applications to provide competitive
18 local exchange telephone service within 90 days after the filing of a complete
19 application and shall consider competitive local exchange telephone service to be a
20 service required for the convenience and necessity of the public under AS 42.05.241.
21 The commission shall approve an application on a finding that the applicant is fit,
22 willing, and able to provide the service. If the commission fails to approve or deny
23 an application within 90 days after the commission has received a complete
24 application, the application is considered approved.

25 (d) A local exchange telephone company that is exempted in whole or in part
26 from complying with all or a portion of this chapter may not be regulated by a
27 municipality under AS 29.35.060 or 29.35.070.

28 * Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

Alaska State Legislature

REPRESENTATIVE
PETER KELLY

Mailing Address:

119 N. Cushman, Suite 203
Fairbanks, Alaska 99701
(907) 456-8161



While in Juneau
State Capitol
Juneau, Alaska
99801-1182
(907) 465-2327

House District 31

House Of Representatives

February 25, 1998

Memorandum

To: Representative Pete Kelly
Joe Ambrose, Office of Senator Robin Taylor

From: Bruce Campbell

Re: Discussion points from John Magyar, Tom Friesen, Ketchikan Utilities

Ketchikan sees HB 416 as being targeted directly at the disassembly of the Ketchikan phone utility.

Page 2, lines 25 to 27, subpart (d) prohibits municipal regulation "in whole or in part". Ketchikan has a municipal utility that includes phone, electricity, water, & sewer. Their attorney interprets this language to mean that if the phone portion of the utility system is no longer regulated by the municipality, then the remaining portions of the utility will no longer be regulated by the municipality, and therefore they will be regulated by the APUC. They fear that regulation by the APUC will be far more expensive than regulation by the municipality.

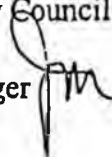
A more general concern is that HB 416 overrides the federal competition act by making a blanket finding that competition is in the public interest and overriding the rural exemption. Cherry-picking, residential v. commercial rate inequities, and other issues may not be well settled by this bill.

The most general concern is the speed with which the Legislature may move, leaving the possibility of unintended consequences for service providers and rate payers.

KETCHIKAN PUBLIC UTILITIES

Memorandum

To: The Honorable Bob Weinstein & City Council

From: John A. Magyar, KPU General Manager 

Date: February 24, 1998

Subject: House Bill H416 - Local Telephone Competition

The attached bill has been introduced by Representative Pete Kelly. It appears to be a follow-up to GCI's attempt to accomplish the elimination of the rural exemption legislatively having failed to do so before the APUC.

The rural exemption, which was established in the federal legislation and FCC regulation and which applies to Ketchikan, provides some protection to small local carriers while permitting some local competition. Under current regulation, a competitive carrier can build infrastructure and compete with the incumbent carrier without restriction. A competitive carrier also can buy tariffed service from the incumbent carrier at wholesale rates by classification (residential, business, trunk) and resell those services to local users.

One intent of this bill, among others which also disregard the protection and processes in the federal legislation, is not to provide for such competition but to require the incumbent carrier to sell portions of existing service (outside wiring, switching, transport to long distance carriers) at an APUC determined discounted rate for the portion of our service taken and allow the competitor to resell the portions of service to any classification. Ketchikan has had a tradition of subsidizing residential service through higher business rates as has been the practice throughout the U.S. Under this bill, the elements of our network would be priced at one rate with no consideration given to the class of service. A competitive carrier could buy a portion of our network and resell it to business with no subsidy for residential service. It wouldn't take long before every business in town would buy its local service from the new competitor while KPU's residential rates would have to climb immediately to offset this loss of revenue.

Additionally, this legislation would have the effect of eliminating municipal rate regulation—KPU telephone rate regulation would pass from City Council to the APUC. KPU and Ketchikan appear to be singled out in this portion of the legislation. While we may be the only municipally owned telco left that is not under APUC local regulation, there are cooperatively owned telcos also under self-regulation who would not be affected by this bill.

We joined with a rural coalition in fighting this before the APUC and are continuing our effort on the legislative front.

JAM:ml

Attachment

H:\USER\NANCY\WINWORD\TEMPLATE\DATA\007-Q5MM.DOC



Yukon Telephone Company, Inc.

P.O. BOX 873809

WASILLA, ALASKA 99687

TELEPHONE 907-373-8007

March 10, 1998

Bruce Campbell
Alaska State Legislature
State Capitol (MS 3100)
Capitol Room 411
Juneau, AK 99801-1182

Dear Mr. Campbell:

Thank you for meeting with us in Juneau. Time is a very valuable commodity and I appreciate the time you took to listen to our concerns. Yukon Telephone Co. Inc. (YTC) and Tanana Power Co. Inc. (TPC) have been in business for over thirty years providing infrastructure in rural Alaska. Once again here is a short recap of our concerns.

HB 416, at this particular time, is harmful to the telecommunication industry. This bill opens up local telephone competition in many places in Alaska without considering the public interest. The 1996 Telecommunications Act passed by Congress gave the authority to the state Public Utility Commission to implement local competition if it was in the public interest. The Alaska Public Utilities Commission has already made the decision whether competition is in the public interest in Juneau, Fairbanks, and Ketchikan. This bill is simply an attempt to override the APUC decision. What is best for all the residents of Alaska should be the guide when making decisions concerning competition. Competition is simply a tool, not an end in itself. HB 416 should not be passed as it tries to bypass the consideration of what is in the public interest.

The APUC needs sufficient funding in order to regulate properly and do it's job. YTC and TPC support a properly funded APUC.

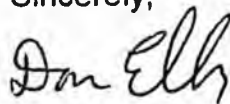
SB 330, the cable locate bill out of the Senate, sets down rules protecting utilities and contractors when excavating near underground utilities. This bill is long overdue and deserves support.

Though there is no legislation regarding Power Cost Equalization (PCE), this issue is of utmost importance. Affordable electricity for rural Alaska is the key for development. PCE is an integral part in keeping electricity affordable in rural Alaska. However, there are some positive changes which need to be done to improve the program: 1) Changing the method of PCE compensation from a cost base to an efficiency base,

2) Making all PCE participants accountable to the State of Alaska, 3) Tie all state funding of rural electrical projects together with the idea of driving down the cost of electricity, 4) Set up a stable mechanism for PCE funding, and 5) Take steps to lower the artificially high cost of fuel in rural Alaska.

Thank you for your time and consideration. Please feel free to contact me if you would like additional information.

Sincerely,



Don Eller

Bruce

Thank you for listening to us. I realize that Representative Kelly would like to see local competition in Fairbanks. HB 416 removes the public interest consideration from deciding whether competition should be allowed in many communities. This is the troublesome part of this bill. I am not against competition, let's see how it works out in Anchorage the biggest market in Alaska before experimenting with other more sensitive Alaskan markets. Thanks for your consideration.

FAX

May 7, 1998

Subject: Deregulating Local Phone Lines
House Bill # 416

To: Judiciary Committee, Alaska House of Representatives

From: Dayne Clark, CPA, Financial Utility Analyst

I have worked with both regulated and non-regulated utility activities and applications to deregulate markets. While generally speaking competition may decrease rates and increase services, it does not always do so. Beneficial deregulation depends on the industry, the type of service and location. While long-distance service benefited from deregulation, local phone service in rural Alaska may not benefit. This needs to be carefully evaluated before deregulating. The Alaska Public Utilities Commission is not opposed to deregulation. They just want to make sure that it is feasible by watching what happens to deregulation in Anchorage.

Long-distance phone service benefited from deregulation.

Long-distance phone service is like flying a jet between Anchorage and Seattle,
The following is a very simple illustration of what happened in long-distance service.

You fly a plane to Seattle every day and it is 50% full, so you sell 20% of the seats to a wholesaler who sells the seats and now your plane is 70% full. In this case you increase the number of people serviced at minimum additional expense. The additional passengers occupied the used seats. (This is not the case with local phone service.)

Local phone service in rural Alaska MAY NOT benefit from deregulation.

Local phone service is like flying a single passenger plane.

Deregulation allows the competition to use your plane to fly the person and they only have to pay you a percentage of the market rate, say 70%, and you supply the pilot, fuel and do the maintenance. (No economies of scale here.)

or

Local phone service is like operating a large manufacturing plant.

Deregulating allows someone else to come in and use the equipment in your plant to sell services. But only one of you can use the equipment to service a customer. How many businesses do you know that could operate efficiently by allowing the competition to use their equipment and facilities to service their existing customers? (Extremely difficult to do business and provide equitable deregulation.)

We need to carefully evaluate before we deregulated local phone service in rural Alaska or we could slow down the installation of newer technology that would greatly benefit rural Alaska. What business is going to invest in new equipment if the competition can use it?

From: Dayne Clark, CPA, Financial Utility Analyst

**Free Market Analysis
of
Long-distance and Local phone service.**

Long-distance Phone Rates, Deregulation and Economic analysis.

A simple Free Market System analysis helps us to understand why the advances in technology and deregulation benefited long-distance phone service and lower rates. The three key elements that enable deregulation

The demand for long distance service is ELASTIC. This means that as the price decreases a consumer will buy more of the good or service. You can purchase long-distance service in small units, 1 minute, and you can easily purchase it when you need it.

Business use of long-distance phones increases as rates decrease. - Many businesses use the phone to solicit sales from customers. If phone rates decrease, then you can afford to call more potential customers until marginal revenues equal marginal costs, or the total cost of making the next sale equals the potential revenue.

Technological advances increased the capacity and reduced costs per minute. The technological advances allowed the company with the long-distance equipment to service more customers and at the same time reduce the cost to service on a per minute basis.

Local Phone Service, Deregulation and Economic Analysis

A Free Market System Analysis shows that deregulation of Local Phone service is subject to the same key elements as long-distance service, demand, consumption and technology. Because local phone service is different from long-distance the results are different.

The demand for local phone service is INELASTIC. This means that as prices decrease, consumers do not buy more. You purchase local phone service in large units of time, a month, and you can not easily purchase additional units as you need them like you can long-distance service. Not too many people are going to run out and purchase an additional phone line because rates are decreased through competition. Thus, the customers are spread over two or more businesses and you lose the economies of scale that benefit rural phone service.

Technological advances in local phone service are not the same. While technology has increased our ability to transmit more data over local lines, we need fiber optic cable installed in the rural areas to really increase the ability to transmit data and increase services. **The technology to provide services over cable is still very limited and not readily available.** Thus, we need to make sure that deregulation will enhance services, not just allow someone else to make money off of another company's local telephone lines.

HB 416

April 5, 1998

HOUSE STANDING JUDICIARY COMMITTEE

Representative Joe Green, Chair

Alaska State Legislature

State Capitol (MS 3100)

Room #118

Juneau, Alaska 99801-1182

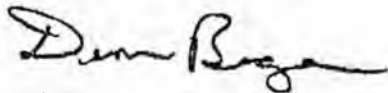
Dear Representative Green:

As a resident of the Valley for 17 years and a member/owner of MTA, I am writing you to express my concern over HB416. Prior to living in the Valley, I lived in the Glennallen area for over eight years and was a member/owner of CVTA. I am well aware of the fact that my local service has been kept low and affordable because of subsidies and the "watch dog" efforts of the APUC.

Don't get me wrong. I am in favor of competition. But who will GCI and other carriers be responsible to if they are allowed to enter our area? With MTA I am able to vote and elect the Board of Directors. Where do the Board of Directors for GCI work and live? Not in the Valley that's for sure! Perhaps we need to slow down and study the effects before allowing competition in the Valley. I watched as competition came to the Valley in the form of Carr's grocery store. We no longer have Koslowsky's and the small meat markets. Carr's did not bring prices down but they did succeed in running the small guys out. I don't want to see this happen to MTA. They're the ones bringing low costs (to the customers) to the Valley as well as Healy.

Please slow down a little before passing HB416. We don't need this "Bill" at this time. Only GCI will benefit not the member/owners of MTA. I care about the Valley. It's where I live and work. I don't want to see MTA forced into selling GCI local service at "wholesale" rates and GCI in turn reselling those services to the Valley. MTA and it's member/owners brought low cost phone service to the Valley; don't allow MTA to be forced out in the name of "competition". Don't allow GCI to take unfair advantage of hastily enacted rules; that would only help GCI's profits not the people of the Valley.

Sincerely,



Dennis Begen
HC04 9363
Palmer, AK 99645

THIS IS A PHOTO COPY OF ONE OF A LARGE BUNDLE OF THESE CARDS THAT ARE AVAILABLE IN THE ORIGINAL FILE.

Dear Chairman Green:

I urge you to stop passage of HB 416. If the bill passes it will mean that my local residential telephone rates will more than double. This will cause a severe hardship to myself and all rural residents.

Competition in rural areas simply means that our phone rates will move closer to the actual high costs of providing service to our community. We will have to pay much more for the same service. Please don't allow this to happen.

Emil Gundersen

Name

Joie Gundersen

Marina M Gundersen

Address

Emil Gundersen
Box 33
Sand Point AK 99661



THE HONORABLE JOE GREEN
CHAIRMAN HOUSE JUDICIARY COMMITTEE
AK STATE LEGISLATIVE
STATE CAPITAL
120 4TH ST RM 118
JUNEAU AK 99801-1182



HB

430

Alaska State Legislature House of Representatives

Committees
Rules Committee, Chair
Legislative Council
International Trade & Tourism
Military & Veterans Affairs
World Trade & State/Federal Relations



Interim:
10928 Eagle River Rd. Suite 141
Eagle River, AK 99577

Session:
Alaska State Capitol
Juneau, AK 99801

SPONSOR STATEMENT (REVISED) HB 430

This bill denies recovery for noneconomic damages (e.g., pain, suffering) to those convicted of driving while under the influence of intoxicating liquor, or any controlled substance and to uninsured motorists who were injured while operating a vehicle. The bill provides one exception: when an uninsured motorist is injured by a subsequently convicted drunk driver. With this one exception, an insurer is not liable for noneconomic damages.

This bill would limit the liability of certain people to sue to recover losses suffered in accidents. This measure prohibits the recovery of noneconomic losses in certain car accidents. Specifically, an uninsured driver or a driver subsequently convicted of driving while intoxicated at the time of an accident could not sue someone at fault for the accident for noneconomic losses. These drivers could still sue for economic losses. However, an uninsured motorist injured by a drunk driver in an accident could still sue to recover noneconomic losses from the drunk driver.

This legislation should reduce the number of lawsuits handled by the courts, reducing court related costs. The legislation should also result in fewer lawsuits filed against state and local governments with savings as a result of avoiding these lawsuits. Further the legislation could result in lower costs or "premiums" for auto insurance.

I urge your support for this legislation

Representative Pete Kott

Juneau Office (907) 465-3777 Toll Free 1-800-861-KOTT(5688) Fax (907) 465-2819
Eagle River Office (907) 694-8944 Fax (907) 694-8945 E-Mail: representative_pete_kott@legis.state.ak.us





Rick Mystrom,
Mayor

ANCHORAGE POLICE DEPARTMENT

4501 South Bragaw Street • Anchorage, Alaska 99507-1509

Telephone (907) 786-8500

<http://www.ci.anchorage.ak.us>



Service since 1921

March 10, 1998

Representative Pete Kott
Alaska State Capitol (MS-3100)
Juneau, Alaska 99801-1182

Dear Representative Kott:

This letter is written in support of HB 430, an act related to non-economic damages claimed by drunk drivers and uninsured motorists.

Each year, hundreds of accidents involving drunk drivers are investigated by the Anchorage Police Department. Most are the direct result of intoxication. Despite stepped-up enforcement and increased penalties, many continue to drive while under the influence. These uncaring individuals should not be allowed to benefit from the damage they cause.

Motorists who drive without insurance should also be prevented from claiming non-economic damages, since they refuse to assume responsibility for their actions.

We therefore encourage this legislation in an effort to relieve the courts of unnecessary lawsuits and reduce the cost of insurance for responsible drivers.

Sincerely,

Duane S. Udland
Chief of Police

DSU/ros

LESSMEIER & WINTERS

LAWYERS - LLC

124 WEST 5TH STREET
JUNEAU, ALASKA 99801MICHAEL L. LESSMEIER
GREGORY W. LESSMEIER
SHELDON E. WINTERS
DETH LEIBOWITZTELEPHONE: (907) 586-5912
FACSIMILE: (907) 463-3020

March 31, 1998

Representative Pete Kott
Alaska State Legislature
State Capitol, Room 432
Juneau, Alaska

Re: HB430

Dear Representative Kott:

I am writing on behalf of State Farm in support of House Bill 430. From our point of view the issue raised by this bill is one of fundamental fairness. The intent of the bill is to require motorists to themselves be financially responsible at least to the minimum limits required by law if they themselves are going to expect to recover non-economic damages. While many side issues have been raised which we will certainly attempt to respond to, we believe the issue raised by House Bill 430 is one of fundamental fairness and we also believe the concept is one that members of the driving public will wholeheartedly endorse.

Over the past five years, our ratio of uninsured motorist claims to bodily injury claims in Alaska has ranged from approximately 17 to 21 percent. Over the last ten years, the ratio of uninsured motorist claims to bodily injury claims has ranged from a low of 16% to a high of 23%. Regardless of whether we are at the low end of a trend or at the high end, it is thus apparent that every Alaskan faces a significant degree of risk from uninsured motorists. We believe the enactment of HB 430 cannot help but reduce the number of uninsured motorists on our roadways.

Those that oppose this legislation have inquired about the percentage of reduction in insurance premiums one would expect to see if this legislation were enacted. Because insurance rates are based on so many different factors we cannot make a specific statement as to the effect this legislation would have on the number of uninsured drivers in Alaska. What we can say is that we believe this will help our experience in Alaska and we remain committed to passing on any savings that might accrue to Alaska insureds. As I am sure you know, State Farm Mutual Automobile Insurance has recently returned approximately 6.6 million dollars to Alaskan policyholders. It reduced automobile insurance premiums by 2.4 percent. We believe that legislation like HB 430 will help this trend continue.

As you know, California through the initiative process passed similar legislation in November of 1996. While the California legislation has been in effect for a little over a year and it has been challenged in Court, California's Insurance Commissioner said it has already lowered insurance rates by 5%. Mercury Insurance Group, now California's sixth largest automobile insurer, has applied for and received a rate reduction. While it is too soon for us to make any definitive statements about the effect of the California initiative, it again it is hard to see how the effect will be anything but positive.

A number of concerns were raised at the hearing regarding how HB 430 would actually work. For

LESSMEIER & WINTERS
LAWYERS • LLC

Representative Pete Kott
Alaska State Legislature
March 31, 1998
Page 2

example, one of the issues raised concerned the effect of this law on the driver of uninsured automobile who is injured in an automobile accident which is not at all their fault. If HB 430 is passed, such a person would be able to recover all economic damages, but would be prohibited from recovering non-economic damages since they chose to drive a vehicle without insurance in violation of the law. While the opponents of HB 430 argue it is unfair for what they term as an innocent victim to be deprived of recovery non-economic damages, we believe that focus is misplaced. A person who chooses to drive without insurance in violation of the law can hardly be said to be free of fault. In fact, Justice Frederick Woods of the California Supreme Court explained this concept of fault when he said "taxpaying, law-abiding citizens will no longer need to support those who choose to break the law" by not buying automobile insurance. Justice Woods, of course, was describing exactly what happens with uninsured drivers: those who are insured and follow the law do indeed support those who choose to break the law by driving without insurance. It is this wrong that HB 430 is designed to rectify.

A second concern raised by those who oppose this bill is the concern that an insurer might refuse to pay what is owed pending the outcome of a criminal trial to determine whether a vehicle was being operated in violation of A.S. 28.35.030. As we understand it, the concern is that an insurer might withhold payment for economic losses pending the outcome of the criminal trial on the operating under influence issue. This sort of conduct is already prohibited by A.S. 21.36.125 (13). In other words, it is already against the law for an insurer to withhold payments which it clearly owes simply because it cannot determine whether additional payments are somehow owed. Again, we do not see this as a legitimate concern which justifies opposition to this legislation.

A third concern raised has to again do with what opponents of this legislation term as another category of innocent victim, that being the person who relies on someone else to insure a vehicle but the vehicle ultimately turns out to be uninsured. Certainly there are a variety of reasons as to why a vehicle might not be insured but the fact is the law mandates liability insurance. When someone drives without liability insurance, they are breaking the law. The true victim in such a situation is the person who is injured by such a financially irresponsible driver, not the financially irresponsible driver.

If there is further information we can provide, please let us know. Thank you.

Sincerely,

LESSMEIER & WINTERS

By: 
Michael L. Lessmeier

ALLSTATE INSURANCE GROUP

LAW AND REGULATION
3100 Zinfandel Dr., Suite 400
Rancho Cordova, CA 95670

Writer's Direct Dial 916-852-4888
Telecopier 916-852-4953

THERESA BODOY
Government Relations Manager

February 26, 1998

Representative Pete Kott
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

Via Facsimile

**RE: HB 430 - An Act Relating to Noneconomic Damages Resulting From An
Automobile Accident (SUPPORT)**

Dear Representative Kott:

I am writing on behalf of the Allstate Insurance Company which is the number 2 insurer in the state of Alaska. Allstate supports HB 430 in its efforts to put a practical, common sense approach in place to deal with individuals who do not comply with the state law requiring drivers to insure their vehicles. HB 430 is fair and balanced because it allows uninsured drivers involved in an accident to still recover damages from the other driver for economic losses, such as medical care and lost wages even though they are breaking the law, yet work to restore balance to our justice system. Currently uninsured motorists enjoy the fruits of the insurance system without contributing to it; fairness dictates that individuals who do not contribute directly to the costs of the insurance system should do so indirectly, by foregoing some (but not all) of their damages.

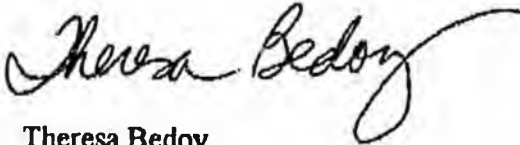
Opponents contend that laws like HB 430 arbitrarily singles out uninsured motorists to ease the financial burden on others. They also argue that similar laws violate equal protection because it has a disparate impact on the poor and on ethnic minorities. In California where Proposition 213, "The Personal Responsibility Act of 1996," was passed by an overwhelming majority (76.8%) and has been upheld by the state's Supreme Court, those who defend Prop. 213 state that the distinction between insured and uninsured drivers is not arbitrary because uninsured motorists drive in violation of the law.

Proposition 213 is fair; the law's requirement that access to pain and suffering damages is directly related to relieving the inequitable financial burden placed on those drivers who do comply with the financial responsibility laws displays this balance. Defenders of Prop. 213 also state that the law affects rich and poor alike; observing that many drivers from poor neighborhoods carry auto insurance while many from wealthy neighborhoods do not.

HB 430 fixes a justice system that is out of balance and is about fairness. It is aimed at those who break the law. It stops uninsured drivers from cashing in on those insured drivers who shell out their hard-earned money to carry auto insurance. It puts back in balance the question of fairness in a system that allows an insured driver to be sued for all he has yet protects an asset proof uninsured motorist who hits them.

Allstate would appreciate your "AYE" vote on this legislation.

Respectfully Submitted,



Theresa Bedoy
Government Relations Manager

cc: House Judiciary Committee



**National Association
of Independent Insurers**

2600 River Road, Des Plaines, IL 60018-3286

TRISHA M. CONNORS
COUNSEL

February 24, 1998

*Trisha
File w/ Packet*

Honorable Pete Kott
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

RE: HB 430
NAII POSITION: SUPPORT

Dear Representative Kott,

I am writing on behalf of the National Association of Independent Insurers (NAII) and its 570 property and casualty company members to support your Personal Responsibility Act, HB 430. As you know, this bill would preclude uninsured motorists from "winning the lottery" in an accident caused by an insured driver.

Specifically, HB 430 would provide that drivers who choose to violate your state's mandatory auto insurance law cannot collect pain and suffering damages following an accident in which an insured driver was at fault. The uninsured driver will recover for his or her actual medical costs, wage loss and car repair, but he or she would not collect from the insurance pool for the non-economic losses he or she may have suffered.

The NAII supports HB 430 because it is fair. Drivers who obey the law and buy insurance pay premiums to protect themselves from injury and from lawsuits by other people they may accidentally injure in an accident. Drivers who violate the law and do not pay these premiums should not **benefit** from their illegal activity.

Thank you again for introducing this important bill. I hope to see it enacted during the 1998 session.

Sincerely,

Trisha M. Connors
Trisha M. Connors
Counsel

cc: House Judiciary Committee



February 24, 1998

The Honorable Pete Kott
Alaska House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Kott:

I wish to express USAA's strong support for House Bill 430, which you and Representative Mulder have introduced. I am also expressing similar support for Senate Bill 283.

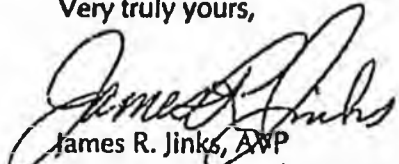
As evidenced by a similar measure enacted by ballot initiative in California, the measure you propose will be a self-enforcing measure to effectively deal with Alaska's uninsured motorist problem. At the same time, the act will save millions of dollars for the large majority of Alaska drivers who buy insurance and operate within the law. It will also provide those same savings to businesses and self-insured entities such as state and local government agencies.

As you probably know, California voters (who are generally regarded as more liberal than the voters of other western states) approved Proposition 213, California's Personal Responsibility Act, in 1996 with a 78% majority of those voting. The measure has withstood all legal and constitutional challenges and has been upheld by two California appellate courts. A year later insured motorists still give the measure a 78% approval rating and, astonishingly, uninsured motorists also give the measure a 78% approval rating.

You may be aware that USAA has continued to question the effectiveness of uninsured motorist data base programs which are expensive to our policyholders and provide them with no benefits for the extra expenses they incur. Additionally, the data base program is only effective in keeping track of the vehicles that are registered. It does nothing to impact the vehicles registered in other states or which are simply not registered. In contrast, the measure you have proposed would reduce consumer costs, be self-enforcing and, most importantly, restore some fairness for those who do obey the financial responsibility laws.

.. hopeful that you will aggressively pursue enactment of House Bill 430 this session. If I can provide any assistance in that effort, please call on me.

Very truly yours,


James R. Jinks, AVP
USAA Senior Legislative Counsel

JRj:djn

LEONARD THOM KELLEY
MICHAELA KELLEY

KELLEY & KELLEY
ATTORNEYS AT LAW
821 'N' STREET, SUITE 208
ANCHORAGE, ALASKA 99501
TELEPHONE: (907) 276-8165

March 3, 1998

Representative Pete Kott
126 Chichagof PL
Chugiak AK 99567

Dear Representative Kott:

I am in your district and am expressing my opposition to HB 430 and SB 283, which you have introduced with Representative Kott. I have grave concern. This proposed legislation is classest and attacks the most poor and weak of our community.


This bill would have the effect of denying compensation for non-economic damages for non-negligent persons. For example, a husband and wife are driving home from celebrating their 25th wedding anniversary by having a nice dinner and some wine in late December. The husband and wife are impaired by alcohol. They are legally stopped at a red light, insured and wearing their seatbelts. The husband and wife are rear-ended by a tractor trailer truck that is speeding and has summer tires on. The husband and wife are pushed several hundred feet into the intersection. The couple sustained broken legs and injuries to their head that are permanent in nature. Their lives will never be the same. Under House bill 430 and Senate bill 283, the husband and wife would not be entitled to compensation for non-economic damages.

HB 430 and Senate bill 283 deny compensation to non-negligent drivers because they are impaired or uninsured. In other words, a negligent/reckless and or intentional act by an insured (or uninsured) person visited upon an innocent impaired or uninsured victim would not be liable for general damages (pain and suffering and loss of enjoyment of life). The negligent/reckless and or intentional acts would be absolved because one is impaired or uninsured, even when the impairment or lack of insurance has nothing to do with what caused the accident or harm. Just because one is irresponsible (impaired or uninsured), does not mean they can be harmed or run over by insured or uninsured negligent people.

I have represented folks that were impaired passengers and on one occasion an impaired driver and through no fault of their own was injured by the act of a clearly reckless driver. Alaskans that are under the influence as drivers, passengers or pedestrians are often times injured through no fault of their own. These people are entitled to compensation when they are hurt by the negligent conduct of another. If ones impairedness is a causal factor in the injuries sustained - then a jury can take those facts into consideration and render a verdict accordingly. One should not be denied compensation for real injuries simply because they are impaired or uninsured.

If you have any questions feel free to contact me directly at my home (907) 688-4829 or
at my office (907) 276 - 8185

Sincerely,


Leonard T. Kelley

CC: Randy Phillips 405 4979

405 2819

MEMORANDUM

February 19, 1998

SUBJECT: Sectional Summary of HB430, An Act relating to noneconomic damages suffered by drunk drivers and uninsured drivers

A sectional summary of a bill should not be considered an authoritative interpretation of the bill—the bill itself is the best statement of its contents.

Section 1 of the bill amends AS 09.17.010(a) and adds the wording "Except as provided under AS 09.65.215, in"

Section 2 of the bill amends AS 09.65 by adding a new section:

Subsection (a) prohibits the recovery of civil damages for noneconomic losses if the person was

(1) injured while operating the vehicle in violation of AS 28.35.030 and was convicted of the violation or

(2) the owner or operator of a vehicle involved in the accident and was not insured as required by AS 28.22.011

Subsection (b) provides one exception if the injury resulted from the operation of the other vehicle by another person who is subsequently convicted under AS 28.35.030

Section 3 of the bill applies the legislation to a cause of action that accrues on or after the effective date of the Act.

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
 a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____ APPROVES PREVIOUS: (Dept/Date) _____
 fiscal note(s) _____ fiscal note(s) _____

zero fiscal note(s) _____ zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>Paul Davis</i>	/			
<i>Carla Bunde</i>			✓	
<i>Carla Bunde</i>			✓	
<i>John Bunde</i>			✓	
<i>John Bunde</i>				✓

CHAIR'S SIGNATURE *Carla Bunde*

FISCAL NOTE

No: 2

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Bill Version: CSHB 434 (HES)
(H) Publish Date: 5/2/98

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

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: \$0.0

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
Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Phone: 465-2680
Date: 05/01/98
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

$$480 \times .05 = 24 \times \$369 = \$8.9 \times 12 = \$106.3$$

FY01-04 Penalties

$$400 \times .05 = 20 \times \$7.4 = \$7.4 \times 12 = \$88.8$$

U-LS0495\P.1
Lauterbach
5/4/98

AMENDMENT

By Representative Norman Rokeberg

OFFERED IN THE HOUSE

TO: CSHB 434(HES)

1 Page 1, line 1, following "Act":

2 Insert "relating to family self-sufficiency plans under the Alaska temporary
3 assistance program;"

4 Page 1, following line 5:

5 Insert a new bill section to read:

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

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

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

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

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

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

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

21 Page 1, line 6:

22 Delete "Section 1"

23 Insert "Sec. 2"

(H.S0495)P.1

- 1 Renumber the following bill section accordingly.

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



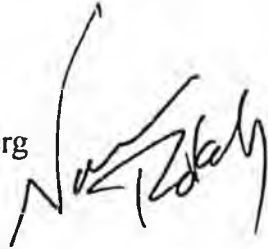
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FAX: (907) 258-2910

SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

MEMORANDUM

TO: Representative Joe Green
Judiciary Committee

FROM: Representative Norman Rokeberg 

DATE: April 22, 1998

SUBJECT: Hearing Request -CSHB 434, Drug Testing of Welfare Recipients

Consider this memorandum a request for a hearing on CSHB 434 pending referral from House HESS. I would appreciate a hearing being scheduled next week.

This bill provides the Division of Public Assistance and the Division of Alcoholism and Drug Abuse to screen A7AP participants for alcohol and substance abuse and require treatment for those participants who are found to have an alcohol or substance abuse problem

Attached is a committee packet which includes the following:

1. HESS Committee Substitute
2. Sponsor Statement
3. Sectional Analysis
4. Supporting Documentation

If you have any further question regarding this bill, please contact Mr. Randall Lorenz, on my staff at 465-4695. Thank you for your consideration.

Attachments

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.

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."

(Continued to page 16)



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

(Continued to page 56)

(Continued from page 15)

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.

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 psycho-

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

logically 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

(Continued to page 54)

(Continued from page 16)

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

"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.'"

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.

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 had, in my mind, some very dire consequences in terms of making treatment to certain sub-populations 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 backfired in many different ways.

Drawing the line

Let's look at it from a linear standpoint, 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 later 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

"The disease model does not mediate against recovery."

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.

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 CEMAPS 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.

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(Continued from page 17)

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 maybe 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

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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.



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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.

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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 those 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 *Assessments 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 Jullinek Memorial Award for Alcohol Studies (1990).

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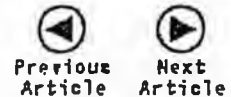
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Journal of the American Academy of Child and Adolescent Psychiatry, April 1997 v36 n4 p495(8)

Psychopathology in preadolescent sons of fathers with substance use disorders. *Duncan B. Clark; Howard B. Moss; Levent Kirisci; Ada C. Mezzich; Rebecca Miles; Peggy Ott.*

Author's Abstract: COPYRIGHT 1997 American Academy of Child and Adolescent Psychiatry

Objective: While preadolescent children of parents with substance use disorders (SUDs) are known to have more behavior problems, depression, and anxiety than expected, psychiatric disorders in these children and their relationships with parental disorders have not been systematically investigated. This study compares the psychiatric disorders of preadolescent boys of fathers with and without SUDs and examines the relationships between offspring and parental psychopathology. **Method:** Fathers (i.e., probands) of boys 10 through 12 years old were recruited to represent families of boys with paternal SUD (high risk or HR: n = 113) and boys without paternal SUD (low average risk or LAR: n = 170). These boys (i.e., index cases) and their biological parents participated in structured diagnostic interviews, and diagnoses were determined by the best-estimate method. **Results:** Disruptive behavior disorders and anxiety disorders were more prevalent in HR than in LAR index cases. Logistic regression analyses examining the relationships between parental and index case psychopathology indicated that parental childhood psychiatric disorders were more strongly predictive of index case psychiatric disorders than parental adulthood psychiatric disorders, including SUDs. **Conclusions:** Inasmuch as HR boys had increased rates of disruptive behavior disorders and anxiety disorders, these disorders may be important targets for early intervention to prevent the development of SUD, as well as the morbidity associated with these disorders. Prevention efforts and studies of the transmission of liability for psychiatric disorders in children should carefully consider parental childhood characteristics. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(4):495-502. **Key Words:** substance abuse, psychopathology, risk factors.

Full Text: COPYRIGHT 1997 American Academy of Child and Adolescent Psychiatry More than 6 million children in the United States are living with a parent with a substance use disorder (SUD) (Kumpfer and DeMarsh, 1986). While it is generally acknowledged that being the child of a parent with a SUD increases liability for a variety of adverse outcomes, there has been little systematic research with regard to the early development of psychiatric disorders in these high-risk children. Studies of adult children of parents with SUDs typically show that such offspring report more antisocial

behaviors, negative affect, and corresponding psychiatric disorders than control adults (Luthar et al., 1993; Sher, 1991; Sher et al., 1991). Previous studies have focused primarily on children of parents with alcohol use disorders (COAs) (e.g., Merikangas et al., 1994; Schuckit and Smith, 1996), and there are few studies of children and adolescents of parents with other SUDs (Wilens and Biederman, 1993). Given that SUDs often have an adolescent onset (Anthony and Heizer, 1991), studies focusing exclusively on preadolescence are more applicable to the development of prevention and early intervention programs. Previous research suggests the importance of considering two broad classes of psychiatric disorders, i.e., externalizing disorders, particularly disruptive behavior disorders including conduct disorder (CD), oppositional defiant disorder (ODD), and attention-deficit hyperactivity disorder (ADHD), and internalizing disorders, particularly mood disorders and anxiety disorders.

Disruptive Behavior Disorders

Disruptive behavior disorders (DBDs) have been the psychiatric disorders most commonly noted in children of parents with SUDs. In a study comparing COAs (aged 6 through 17 years) with children of psychiatrically healthy medical patients, Earls and colleagues (1988) found that COAs had elevated rates of ADHD and ODD compared with comparison children. On the other hand, Hill and colleagues (Hill and Hruska, 1992; Hill and Muka, 1996) have not found differences in DBDs between children (aged 8 through 18 years) of families with multigenerational alcoholism and children of families without alcoholism. These studies did not have sufficient samples of preadolescent children to present results stratified by age.

Questionnaire scores indicating elevated externalizing behavior problems in children of parents with alcohol use disorders and other SUDs have been noted in several studies. Preadolescent COAs, compared with control children, have shown higher rates of externalizing behavior problems (Aronson and Gilbert, 1963; Zucker and Fitzgerald, 1991). Wilens and colleagues (1995) found that children of parents with opioid dependence, compared with control children, had higher Externalizing subscale scores on the Child Behavior Checklist (CBCL) (Achenbach and Edelbrock, 1983). Gabriel and Shindedecker (1993) found that children of parents with opioid dependence showed higher levels of aggressivity than children of parents with alcohol dependence. Thus, children of parents with SUDs involving drugs other than alcohol may show different characteristics than COAs. Recent analyses from the Center for Education and Drug Abuse Research (CEDAR) have shown that CBCL Externalizing subscale scores are elevated in sons of SUD fathers compared with sons of control fathers (Moss et al., 1994, 1995). However, elevated indices on questionnaires do not necessarily indicate that psychopathology is severe enough to justify intervention.

Mood and Anxiety Disorders

While less studied than DBDs, children of SUD parents have also been found to have increased depression and anxiety symptoms and related diagnoses. Earls and colleagues (1988) noted an increased rate of depression and anxiety disorders in COAs compared with control children. In a study comparing 50 COAs with 48 children of psychiatrically healthy parents, Rolf and colleagues (1988) found increased depression symptoms by maternal and child report in COAs. Hill and Muka (1996) have found an increase in the rate of internalizing disorders (i.e., mood and anxiety disorders combined) in children

(aged 8 through 18 years) of families with multigenerational alcoholism and children of families without alcoholism. Wilens and colleagues (1995) found that children of parents with opioid dependence, compared with control children, had higher Internalizing subscale scores on the CBCL. In the CEDAR sample (Moss et al., 1995), sons of SUD fathers have higher CBCL Internalizing subscale scores than sons of control fathers on mother and teacher ratings.

Transmission

In families with paternal SUD, the mothers also often have SUD (Vanyukov et al., 1994). Steinhausen and colleagues (1984) noted trends toward CD being associated with paternal alcoholism and internalizing disorders being associated with maternal alcoholism. In the CEDAR sample, problem behaviors and internalizing symptoms were found to be most increased in children with bilineal parental SUD (Moss et al., 1994). Parents with SUD typically also have comorbid psychiatric disorders. As children of parents with SUD may show psychopathology similar to children of parents with other psychiatric disorders (Jacob and Leonard, 1986), consideration of comorbid psychopathology in parents needs to be included in examining possible transmission patterns. In the CEDAR sample, Moss and colleagues (1995) found that paternal aggression indices contributed to aggression among boys. Consideration of SUDs and other psychiatric disorders in both parents is therefore critical.

Study Aims

While a few studies have investigated dimensional measures of psychopathology in the preadolescent children of parents with SUDs, none has reported psychiatric diagnoses in these at-risk children. The relationship between parent and child psychiatric diagnoses has also not been investigated in this population. The two aims of this study were (1) to determine the psychiatric disorders differentiating preadolescent boys of fathers with and without SUDs, and (2) to determine the direction and magnitude of the relationships between index case psychiatric disorders and both paternal and maternal psychiatric disorders. The hypotheses of the study were that the preadolescent boys of SUD fathers would have increased prevalence rates of psychiatric disorders in all areas and that offspring psychiatric disorders would be associated with similar disorders in their parents as well as with parental SUDs.

METHOD

Subjects

The subjects were 283 boys 10 through 12 years old and their biological parents. Boys were identified and recruited by contacting their biological fathers through multiple sources, including substance abuse and other psychiatric treatment programs, social service agencies, newspaper and radio advertisements, and a sampling frame purchased from a marketing firm. After a complete description of the study to the parents and children, written informed consent was obtained. The study was approved by the Institutional Review Board of the University of Pittsburgh Medical Center.

The 283 index cases were classified into two groups based on paternal SUD history: (1) boys of fathers with SUD histories (high risk or HR: $n = 113$) and (2) boys of fathers

without SUD histories (how average risk or LAR: $n = 170$). One boy in each family was identified as the index case. Fathers (i.e., probands) were considered to have SUD histories if they met lifetime DSM-III-R criteria (American Psychiatric Association, 1987) for any substance abuse or dependence for substances other than nicotine, caffeine, or alcohol. The presence of other psychiatric disorders in SUD fathers was not an exclusionary factor. The fathers of boys in the LAR group did not meet DSM-III-R criteria for a lifetime history of any SUD, or any other major adulthood Axis I psychiatric disorder. (An exception was made for four probands with alcohol abuse prior to the age of 21 without lifetime histories of any other SUDs.) As described under "Results," this selection process led fathers without SUDs to have relatively fewer other psychiatric diagnoses than would be expected from a random community sample. Probands and index cases were excluded if they had chronic physical or mental disabilities which precluded full participation in the protocol. This sample includes subjects described in other cited articles from CEDAR (i.e., Moss et al., 1994, 1995) and adds subsequently assessed subjects.

As seen in Table 1, 91 (81%) of the SUD fathers had a substance dependence disorder other than alcohol dependence. With regard to the specific substances involved in dependencies, SUD fathers were characterized by cocaine dependence ($n = 44$, 39%), marijuana dependence ($n = 42$, 37%), opioid dependence ($n = 25$, 22%), and dependence on other substances ($n = 26$, 23%). Including alcohol dependence, 26 (23%) of SUD fathers had one type of substance dependence, 40 (35%) two, 15 (13%) three, and 22 (20%) four or more.

Families of HR and LAR boys were compared on demographic variables, index IQ, and parental IQ. While not different on index age (10.8 [+ or -] 0.9 versus 11.0 [+ or -] 0.9 years, for HR and LAR, respectively; $t = 1.5$, $df = 281$, p [greater than] .05), the HR index cases showed lower educational attainment than LAR index cases (4.3 [+ or -] 1.1 versus 4.6 [+ or -] 1.1; $t = 2.7$, $df = 281$, p [less than] .01). HR fathers were younger (38.5 [+ or -] 4.7) than LAR fathers (40.0 [+ or -] 5.0; $F = 6.5$, p [less than] .05). Consistent with other studies documenting an association between socioeconomic status (SES) and SUD in adults (Dohrenwend et al., 1992), HR families had lower SES by Hollingshead two-factor index (Hollingshead, 1990) than LAR families (35 [+ or -] 12 versus 45.4 [+ or -] 13; $t = 6.2$, $df = 281$, p [less than] .001). The index case IQ by WISC-III (Wechsler, 1991) was lower in HR than LAR index cases (104 [+ or -] 15 versus 114 [+ or -] 15; $t = 5.7$, $df = 281$, p [less than] .001). The IQs for parents were prorated from the Vocabulary, Digit Span, and Block Design subscales of the WAIS-R (Wechsler, 1981). Parental IQs were lower in HR than in LAR families (father: 101 [+ or -] 16 versus 113 [+ or -] 18; $t = 5.9$, $df = 281$, p [less than] .001; mother: 95 [+ or -] 15 versus 109 [+ or -] 17; $t = 7.0$, $df = 281$, p [less than] .001).

While index boys were included according to age, they were also characterized by Tanner stage. By pubic hair development, most boys were stage 1 ($n = 57$, 52%; $n = 106$, 63% for HR and LAR, respectively), with the remainder distributed among stage 2 ($n = 42$, 39%; $n = 45$, 27%), stage 3 ($n = 9$, 8%; $n = 15$, 9%), and stage 4 ($n = 1$, 1%; $n = 3$, 2%). The HR and LAR boys did not differ significantly on this measure ($[\chi^2]_{sup.2} = 4.6$, $p =$ not significant).

Procedures

These assessments are components of a research protocol implemented at CEDAR. The primary objective of this ongoing study is to use a prospective paradigm to understand the etiological pathways to SUD. Index cases and their parents participated in a 26-hour protocol, which included interviews, questionnaires, and laboratory tasks.

Recruitment

SUD fathers were identified and recruited primarily through substance abuse and other psychiatric treatment programs. Men in treatment programs who were the fathers of boys aged 10 through 12 years were informed that they may be eligible for the research program, and interested men were further informed and screened for inclusion and exclusion criteria. Fathers without SUD were identified and recruited as volunteers responding to newspaper and radio advertisements or through a sampling frame purchased from a marketing firm. Fathers recruited through community sources and subsequently found to meet diagnostic criteria for SUD were included in the SUD group. Fathers without SUD but with other major Axis I disorders were excluded.

Diagnostic Instruments

Parents. Father and mother diagnoses were made according to DSM-III-R, using data collected by several instruments. (DSM-III-R diagnostic criteria were used because this research was initiated prior to the availability of DSM-IV.) Information concerning SUDs was gathered by a structured interview developed for CEDAR, using sections of the Structured Clinical Interview for DSM-III-R (SCID) (Spitzer et al., 1988) and the Lifetime Alcohol Use Interview (Skinner, 1982), which was modified and expanded to assess other substances. Screening information was gathered on all classes of psychoactive substances, and detailed information was gathered on the more frequently used substances. CD and antisocial personality disorder (ASPD) were assessed by administering the SCID Personality Disorders Questionnaire (SCID-II) (Spitzer et al., 1987) and confirming the positive endorsements by interview. The validity of this method has been documented (Nussbaum and Rogers, 1992). Other psychiatric disorders were assessed by the SCID (Spitzer et al., 1988).

[TABULAR DATA FOR TABLE 1 OMITTED]

Index Cases. The child and one parent, typically the mother, completed a modified Schedule for Affective Disorders and Schizophrenia for School-Age Children interview (Orvaschel et al., 1982) concerning the index child's psychiatric disorders. Mothers and teachers completed the CBCL and other questionnaires.

Diagnostic Procedure

The interviews were administered by graduate-level clinicians and were discussed in a consensus conference with two clinical psychologists or psychiatrists, the interviewers, and the evaluation coordinator. The consensus team reviewed all available information gathered in the assessment protocol, as well as psychiatric treatment records and teacher reports if available. Psychiatric diagnoses were then determined by the best-estimate diagnostic procedure (Leckman et al., 1982). Although data from each family member were gathered independently, discussions of subject characteristics with other family members and during case conferences resulted in the subject raters not being blind to the

recruitment and diagnostic characteristics of related family members.

Training of interviewers involved observation of several interviews with probands, index cases, and mothers, and joint interviews were practiced until greater than 90% agreement was reached with an experienced interviewer in all major areas. Interrater reliabilities for selected diagnoses by [Kappa] statistics for 22 probands were as follows: SUDs (other than alcohol), .94; alcohol use disorders, .96; DBDs, .88; separation anxiety disorder, .98; overanxious disorder, .87; major depression, .87.

Data Analyses

The HR and LAR groups were compared on index case and parental lifetime psychiatric disorders by Pearson [[Chi].sup.2] analyses. Test statistics were not completed for specific psychiatric diagnoses if the sample size was less than five in both cells. In cases in which the sample size in either cell was less than 12, the correction for continuity was used. For index cases, odds ratios were calculated with analyses controlled for differences between groups in index age, index education, SES, index IQ, mother IQ, and father IQ. Note that SES was calculated using raw scores of education and occupation for the head of household such that higher scores are interpreted as higher SES (Hollingshead, 1990).

Log-linear regression analyses were completed using parental psychiatric diagnoses to predict index case diagnoses. Regression equations were developed for the index case psychiatric diagnosis classes found to differ between groups. Parental psychiatric disorder variables included alcohol abuse, alcohol dependence, drug abuse, drug dependence, CD, ODD, ADHD, ASPD, mood disorders, childhood anxiety disorders, and adulthood anxiety disorders. For this procedure, SES, index IQ, father IQ, and mother IQ were forced to enter prior to parental psychiatric diagnoses. (The models were also examined with index age and index education entered as controlled variables. The results were not substantially changed with the addition of these variables.) A backward elimination method was used for other variables (Norusis, 1993). Backward elimination starts with all variables in the model, followed by evaluation of variables for entry and removal. The Wald statistic was used to select variables for removal. Variables were retained if their removal was associated with a significant (p [less than] .05) decrement in variance explained. The contributions of variables to the regression are represented by the partial correlations (R) between the dependent variable and each of the independent variables. If the Wald statistic is less than 2, R is set to 0. Using the derived formula, the percentages of index cases classified correctly on the presence or absence of diagnoses were calculated.

RESULTS

Psychiatric Disorders in Index Cases

HR index cases showed higher rates than LAR index cases of several psychiatric disorders (Table 2). Significantly higher rates of DBDs overall, as well as CD and ODD specifically, were noted in the HR compared with the LAR index cases. Mood disorders were infrequent, and the rates were not significantly different between groups. Anxiety disorders overall were significantly more prevalent in the HR than the LAR sample.

although neither overanxious disorder nor separation anxiety disorder separately showed significantly different rates. The proportion with any Axis I psychiatric disorder was higher in HR than in LAR index cases. The mean number of psychiatric diagnoses was [TABULAR DATA FOR TABLE 2 OMITTED] significantly higher in HR (1.60 [+ or -] 1.10) than in LAR index cases (1.27 [+ or -] 0.64; $F = 8.59$, $p = .004$).

Psychiatric Disorders in Parents

The psychiatric disorders identified in fathers and mothers are presented in Table 1. All diagnoses investigated were significantly more prevalent in the HR than in the LAR parents, with the exceptions of ADHD, ASPD, and major depression in mothers. As expected, the mean number of psychiatric diagnoses was significantly higher in the SUD fathers (5.40 [+ or -] 2.61) than in the fathers without SUD (1.14 [+ or -] 1.01; $F = 464.39$, p [less than] .001), as well as in the corresponding mothers (2.97 [+ or -] 2.26 versus 1.56 [+ or -] 0.36; $F = 32.35$, p [less than] .001).

Predicting Index Case Psychiatric Disorders From Parental Psychiatric Disorders

Logistic regression models were generated for index case DBDs and anxiety disorders. For index case DBDs, father childhood DBD was the most predictive variable (estimated coefficient = 1.22, p [less than] .001, $r = .17$, odds ratio = 3.4, 95% confidence interval = 1.7 to 6.9). Given the importance of these disorders, CD, ODD, and ADHD were used as separate predictors. Predictive parental psychiatric diagnoses included father CD, father ODD, mother drug dependence, and father alcohol abuse. The resulting equation (Table 3) correctly predicted 77% of cases (216/283), with a specificity of 94% (196/209) and a sensitivity of 31% (23/74), including 196 correct negative predictions, 23 correct positive predictions, 51 incorrect negative predictions, [TABULAR DATA FOR TABLE 3 OMITTED] and 13 incorrect positive predictions. Father DBD was highly associated with index DBD ($[\chi^2]_{sup.2} = 16.64$, p [less than] .001). In cases in which the father had a history of DBDs, 31 of 69 index cases also had DBDs. In cases in which the father did not have a history of DBDs, 171 of 214 index cases also did not have DBDs.



For index case anxiety disorders (Table 4), predictive parental psychiatric diagnoses included mother childhood anxiety disorders and mother adulthood anxiety disorders. The resulting equation correctly predicted 88% of cases (248/283), with a specificity of 99% (243/245) and a sensitivity of 11% (4/38), including 2.43 correct negative predictions, 4 correct positive predictions, 34 incorrect negative predictions, and 2 incorrect positive predictions.

DISCUSSION

Epidemiological, clinical, and adoption studies have suggested that there are several pathways leading to [TABULAR DATA FOR TABLE 4 OMITTED] SUD. Cadoret and colleagues (1995) have presented evidence for a pathway that begins with ASPD in the biological parent, proceeds through adoptee CD and ASPD, and results in SUD. These results are consistent with Cadoret's hypothesis in indicating that fathers with SUDs transmit an increased vulnerability to DBDs in their sons. The pathway to SUD may, however, begin with childhood DBDs in the biological father. The logistic regression results indicate that the risks transmitted were more closely associated with the

chronologically distal childhood characteristics of the parents than with the proximal characteristics of the parents as adults. Paternal childhood CD and ODD each independently contributed to the liability for index DBD. Although the genetic or environmental nature of this transmission is not explicitly investigated here, this pattern of results is consistent with a genetic interpretation. Behavioral genetics studies have suggested that there is substantial heritability for behavioral dimensions involved in DBDs (Edelbrock et al., 1995). Childhood DBDs are also highly relevant to the genetics of nonalcohol SUDs, as the genetic correlation between childhood DBD symptoms and drug use disorder symptoms has been found to be higher than that between adulthood antisocial symptoms and drug use disorder symptoms (Grove et al., 1990). Genetic influences on delinquent behaviors may be more relevant for these middle-age children than would be the case at younger ages, when environmental influences predominate (Schmitz et al., 1995). Assortative mating may also contribute to parent - offspring correlations (Vanyukov et al., 1996). The modest proportion of the variance in index case DBD accounted for by paternal DBD and the low sensitivity of predictions, however, suggests that factors other than parental psychopathology are influential in the development of DBD.

Anxiety disorders may be another pathway leading to SUD (Clark and Neighbors, 1996; Clark and Sayette, 1993). Anxiety disorders were more prevalent in HR than in LAR index cases, although the association was relatively weak. In a finding parallel to that with DBD, maternal childhood anxiety disorder was the parental disorder most associated with index case childhood anxiety disorder. While studies have yielded less consistent results than for delinquent behavior, anxiety symptoms show significant heritability (Todd and Heath, 1996). As with DBD, the modest proportion of the variance in index case anxiety disorders accounted for by maternal anxiety disorders and the low sensitivity of predictions suggests that factors other than parental psychopathology are influential in the development of anxiety disorders. The possibility that anxiety disorders may increase risk for SUD remains somewhat controversial, primarily because retrospective reports may be contaminated by anxiety symptoms produced by intoxication and withdrawal (Clark and Neighbors, 1996; Schuckit and Hesselbrock, 1994). Prospective follow-up of these index cases and other similar research will determine whether or not childhood anxiety disorders confer risk for SUD.



There are several limitations to this study, including a lack of systematic information regarding possible sampling bias, the possible contamination of child rating characteristics by parental bias, and the lack of blind evaluators for diagnoses. Fathers were self-selected from several sources. The extent to which these fathers and their families are representative of the programs and communities from which they were drawn is not known, and sampling bias may have influenced the results. As mothers reported on themselves and their child, bias in the direction of perceived similarities may have been introduced (Simonoff et al., 1995). As evaluators were not blind to the characteristics of family members, bias may have been introduced into the diagnostic procedure. These findings may also be limited by the focus on suprathreshold disorders, as well as the relatively young age of the index cases. Depressive symptoms may, for example, emerge during adolescence in the high-risk group prior to the development of SUD.



The presence of psychiatric disorders in these children justifies intervention. In addition to reducing the morbidity associated with these disorders in childhood, the early identification and treatment of psychiatric disorders in high-risk children may be an effective strategy for the prevention of later SUD. Prospective research reveals that violence and violation of social norms, key features of CD, predict consumption of marijuana and other illicit substances in late adolescence (Boyle et al., 1992). CD has been noted to be an ideal target for prevention programs, particularly those involving parent training (Reid, 1993). Externalizing behavior disorder characteristics have been shown to be evident in children of SUD parents as early as 3 through 5 years old (Zucker and Fitzgerald, 1991), suggesting the importance of very early intervention for CD prevention. In addition, as a relatively small proportion of sons of SUD fathers had CD (8%), interventions could feasibly be targeted to this affected group.

Given the limitations of parents with SUD, it may be unrealistic to expect that these parents would be able to participate successfully in parent-training programs. Limited education and low SES, characteristics disproportionately present in this population, predict poor outcome in parent-training programs (Clark and Baker, 1983). Interventions involving multiple settings including the school are more promising (Reid, 1993). These results indicate that, while paternal SUD confers increased vulnerability to DBDs and anxiety disorders in offspring, the childhood characteristics of parents themselves are also important to consider when identifying children at risk for SUDs and other psychiatric disorders.

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Childhood Education, Winter 1996 v73 n2 p66(4)



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.

Full Text: COPYRIGHT 1996 Association for Childhood Education International 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 through 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). Bellissimo (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" (Bellissimo, 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 (Bellissimo, 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), 35-37.

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Top of
Article



Previous
Article



Next
Article

Substance Abuse and Welfare Reform Policy

by Julie Strawn

Background

According to the U.S. Department of Health and Human Services, research studies have found that between 10 and 20% of welfare recipients have a substance abuse problem, with about 5% of recipients affected enough to substantially limit their day-to-day functioning. Anecdotal evidence suggests the problem may be larger among long-term recipients. States have begun to grapple with the question of what policies to adopt toward welfare recipients with substance abuse problems as a result of efforts to require most welfare recipients to work or participate in employment programs. A recent Urban Institute study concludes that substance abuse has emerged as one of the primary personal or family barriers to employment among welfare recipients, together with physical disabilities, mental health problems, children's health or behavioral problems, domestic violence, housing instability, and low basic skills or learning disabilities. (Low basic skills is by far the most common of these barriers, and the one most associated with a recipient not working.)

The new federal welfare reform law gives states the option of testing recipients for illegal drugs and sanctioning those who test positive. The law also prohibits states from providing cash aid or food stamps to those convicted after August 22, 1996, of drug-related felony offenses, unless the state chooses to pass a law modifying this requirement or opting out of it entirely. There are no provisions regarding alcohol abuse. Beyond the substance abuse provisions, the new law's stringent work requirements and five-year time limit—and shorter limits in many states—will necessitate that states find ways to help recipients with substance abuse problems become more employable. Some states are developing short-term, outpatient treatment options that aim simply to help substance abusers function well enough to begin working in combination with longer-term, outpatient treatment. Outpatient treatment may not be enough, however, for severely affected families. States are likely to find that they need to expand treatment options for single parents who need residential care. Such recipients may be unlikely to enter residential treatment if the facility cannot accommodate their children, if adequate child care is not available, or if doing so means giving their children up to foster care.

Policy Issues

The role of drug testing in welfare reform. There are four key policy reasons for drug testing welfare recipients: 1) to identify recipients who need substance abuse treatment; 2) to monitor compliance with treatment; 3) to screen recipients on behalf of employers; and, 4) to try to reduce drug use by sanctioning welfare recipients who test positive. Weighed against these programmatic objectives are: the high cost of testing all welfare recipients (at least \$20 per drug, rising to as much as \$70 with confirmatory testing); the questionable reliability of any one test; unresolved 4th Amendment legal issues around search and seizure; and, the shortage of treatment in many areas, especially for residential settings for families. These factors help explain why states generally have used testing to monitor compliance with treatment rather than as a general screening tool. In addition, such testing typically does not address alcohol abuse. There are alternative ways to screen for alcohol and drug abuse problems. States such as Oregon, Utah, and Ohio use client interview instruments to determine which recipients should be referred for further diagnosis and treatment.

Substance abuse as a barrier to steady work. According to a recent Urban Institute study, welfare recipients with substance abuse problems are as likely to work as other recipients — 63% worked at some point in the current or previous year, compared to 58% of recipients without a substance abuse problem. These

recipients do seem less likely to work steadily, however, with only 15% working full-time, year-round, as compared to 22% of all recipients. Because job retention has become a much higher priority for welfare-to-work programs in the wake of welfare time limits, this finding that substance abuse hurts job retention may give states and localities a powerful reason to address treatment needs. In addition, as employers themselves increasingly require job applicants to undergo drug tests, even substance abusers who function well enough to work may find themselves unemployable if they cannot pass a drug test.

Effectiveness of drug treatment. There is a consensus among researchers that drug treatment is cost-effective and results in reduced drug use, reduced criminal justice involvement, and increased employability. State-reported treatment data shows rather consistent results across states for client outcomes post-treatment as compared to pre-treatment: about a one-third drop in drug use, nearly a 60% increase in employment, and roughly \$6 in benefits for every dollar invested in treatment. Some states have also found a decreased need for foster care and child protective services as a result of treatment.

Many states do not have outcome data on welfare recipients specifically, but a few do. Minnesota found a 64% increase in employment among public aid recipients after treatment; a special Florida treatment program for pregnant or postpartum women and their children found a 76% increase in employment or school enrollment after treatment; and Ohio's data on welfare recipients who received treatment showed a substantial decline in the amount of work missed by recipients, a key finding given the need to improve job retention due to welfare time limits. Ohio also found a 15% reduction in welfare payments. The U.S. Department of Health and Human Services will soon release a study of treatment outcomes for welfare recipients in California showing that outcomes for them are comparable to outcomes found for all individuals in treatment.

Financing treatment for welfare recipients. States in the past have funded substance abuse treatment for welfare recipients in three ways: through the federal substance abuse block grant, through the Aid to Families With Dependent Children (AFDC) program, and through Medicaid. The block grant is by far the largest source of overall federal treatment funding, but anecdotal reports suggest that AFDC and Medicaid funds have played an important role in expanding residential treatment options for low-income, single parents with children. Medicaid funds can also support a range of outpatient services including screening services, counseling, detoxification, day treatment, and methadone maintenance.

It is unclear whether states can continue to fund substance abuse treatment under the new welfare program that replaced AFDC (the Temporary Assistance for Needy Families block grant or TANF), because TANF funds cannot be used to provide medical services. In addition, because federal TANF funds are capped, supporting treatment and other services through Medicaid is probably a better strategy because state treatment spending in that program will generate additional federal matching funds. Another advantage to funding treatment through Medicaid is that if a welfare recipient and her children are placed in a residential setting, states may be able to remove that family from the welfare rolls, deferring the parent from time limits and work requirements while treatment occurs. One key obstacle to funding residential treatment through Medicaid, however, is a federal regulation that prohibits Medicaid spending on services to individuals (between the ages of 21 and 65) in an "institution of mental diseases" (IMDs) with more than 16 beds. Medicaid treats nonhospital, residential treatment settings as IMDs. A 1992 survey of states by the Intergovernmental Health Policy Project (IHHP) found that states believe this IMD restriction prevents cost-effective provision of substance abuse treatment services under Medicaid. As a result, many states limit inpatient substance abuse coverage to short-term detoxification and emergency services provided by hospitals.

Requiring participation in welfare-to-work programs and the role of sanctions. State and local experience shows that it is feasible to require families with substance abuse problems to participate in welfare-to-work

programs but that participation often develops incrementally, beginning with small steps and becoming more intensive over time. A key issue in working with such families is the appropriate role of sanctions. While studies have shown that sanctions are important for increasing participation by recipients in welfare-to-work programs, the experience of several states with full family sanctions suggests that families with serious, unaddressed problems are more likely to be sanctioned.

In particular, Utah found that many of those being sanctioned for noncompliance in its work program had previously undetected problems, with mental health problems four times greater among sanctioned families and substance abuse problems twice as high. Utah decided that full family sanctions were not appropriate for such families and now requires that there be an extensive review process before full family sanctions are imposed, including an interdisciplinary team staff review and a home visit. Because of the possible negative impacts on children of denying all benefits to very troubled families, states with full family sanction policies may want to explore the use of protective payments to third parties as an alternative for some families. States have experience in using such third party payments with recipients of federal disability aid who have substance abuse problems.

Research Findings

Little research has been conducted on what types of welfare policies are effective for addressing substance abuse issues among recipients. Utah is one of four states (with Kansas, Oregon, and South Carolina) that has a waiver to require substance abuse treatment as a condition of welfare receipt. An independent, rigorous evaluation of Utah's overall welfare-to-work program shows large increases in family income, large reductions in public aid, and a strikingly high level of participation by families in self-sufficiency activities. No separate results are available, however, for families with substance abuse problems.

The Urban Institute recently conducted case studies of eight welfare-to-work programs that have substantial experience in working with families who face multiple personal or family barriers to self-sufficiency, including substance abuse. Researchers drew five broad lessons from the case studies:

- Programs must be flexible, with a broad range of strategies and services to respond to the diverse circumstances of individual families.
- Special services to families with various personal and family challenges are not incompatible with a "work first" program strategy. For some families, these services can be short-term; in other cases, employment or community service may help families to gain confidence that helps them overcome other problems.
- Welfare-to-work programs must form partnerships with community agencies that provide substance abuse treatment, mental health counseling and specialized services for women in abusive situations in order to help some families become self-sufficient.
- Clients must develop trust in program staff. It is very important to hire staff who are committed to helping families change their lives by celebrating small successes and pushing them toward further progress.
- Programs must set clear expectations for participation, reinforced by financial penalties.

Innovative Practices

Like Utah, Oregon has a federal waiver to require compliance with substance abuse treatment as a

condition of receiving aid. (All states are free to implement such policies under TANF.) Oregon provides local offices with considerable latitude for deciding how to provide substance abuse services to recipients. Local offices have the option to test recipients for drugs but most have not elected to do so. In most local welfare or JOBS offices, mental health and/or alcohol/drug abuse counselors are outstationed to identify recipients in need of treatment services and to provide counseling.

Initially, local offices in Oregon only addressed substance abuse issues when such problems interfered with participation in work-related activities. Over time, however, Portland and other localities have instituted a broader substance abuse education component as part of their upfront employability and job search process for all applicants and recipients. This change developed in response to staff concerns that some recipients successfully completed employment and training programs only to fail an employer's drug test. The substance abuse education component does include substance abuse screening using the Substance Abuse Subtle Screening Test (SASSI), a pen-and-paper test that can be administered in groups or individually and takes only 15-20 minutes to complete. Clients with substance abuse problems can be mandated to treatment, with the type of treatment varying in length and intensity. Treatment is usually combined with other self-sufficiency activities such as work, education, or training.

Utah has hired trained counselors (generally social workers) for its local welfare offices who are responsible for families with the severest problems, including substance abuse. These workers also supervise other staff working with difficult cases and train eligibility and self-sufficiency staff to be able to identify these problems. In addition, there are on-site mental health and alcohol/drug abuse counselors in some of the local offices. Like Oregon, Utah has found that substance abuse problems tend not to surface right away but rather become apparent when a recipient is failing to comply with program participation requirements. Utah tries to maintain its principal program focus on employment, so much of its substance abuse treatment is short-term to allow recipients to quickly move on to work.

Two other states, South Carolina and Kansas, have federal waivers to require treatment as a condition of eligibility. These waivers were approved more recently than those in Oregon and Utah, however, and are just now being implemented. In addition, Wisconsin's pending waiver request for its Wisconsin Works proposal includes substance abuse treatment as one of the activities that recipients can be required to participate in as a condition of eligibility. Other states and localities are also trying new ways of working with families who have substance abuse problems. Ohio is field testing a screening instrument to be used in alcohol and drug abuse assessment of all welfare recipients. Sacramento County, California, is training some child welfare, public health, and employment and training staff to identify and intervene with substance abusing clients. It is unclear yet what welfare policies states will choose to adopt toward substance abusers under TANF; the final decisions on this will probably be made by legislatures early in 1997. Some states, such as Maryland and New York, are considering whether to test all welfare recipients for drug use in order to identify those who need treatment.

For More Information . . .

RESOURCE CONTACTS

The Legal Action Center, Washington, DC. Contact Gwen Rubinstein, Deputy Director of National Policy, (202) 544-5478.

National Association of State Alcohol and Drug Abuse Directors, Washington, DC. Contact Kathleen Sheehan, Director of Public Policy, (202) 293-0090.

National Center on Addiction and Substance Abuse (CASA), Columbia University, New York, NY.

Contact Mary Nakashian, (212) 541-5200.

Oregon Department of Human Resources, Salem, OR. Contact April Lackey, Field Service Section, (503) 945-6122.

Portland, OR, Steps to Success Program. Contact Christa Sprinkle, Coordinator, Mental Health/Alcohol and Drug Treatment Services, Steps to Success, Mount Hood Community College, (503) 256-0432.

The SASSI Institute (publisher of the SASSI substance abuse screening instrument), 4403 Trailbridge Road, Bloomington, IN, 47408. Call 1-800-726-0526 for SASSI information.

The Urban Institute, Washington, DC. Contact LaDonna Pavetti, Research Associate, (202) 857-8660.

U.S. Department of Health and Human Services, Office of the Asst. Secretary for Planning and Evaluation (ASPE), Washington, DC. Contact Laura Feig, Senior Policy Analyst, (202) 690-5938.

Utah Department of Human Services, Salt Lake City, UT. Contact Connie Cowley, Program Specialist, (801) 538-4337.

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