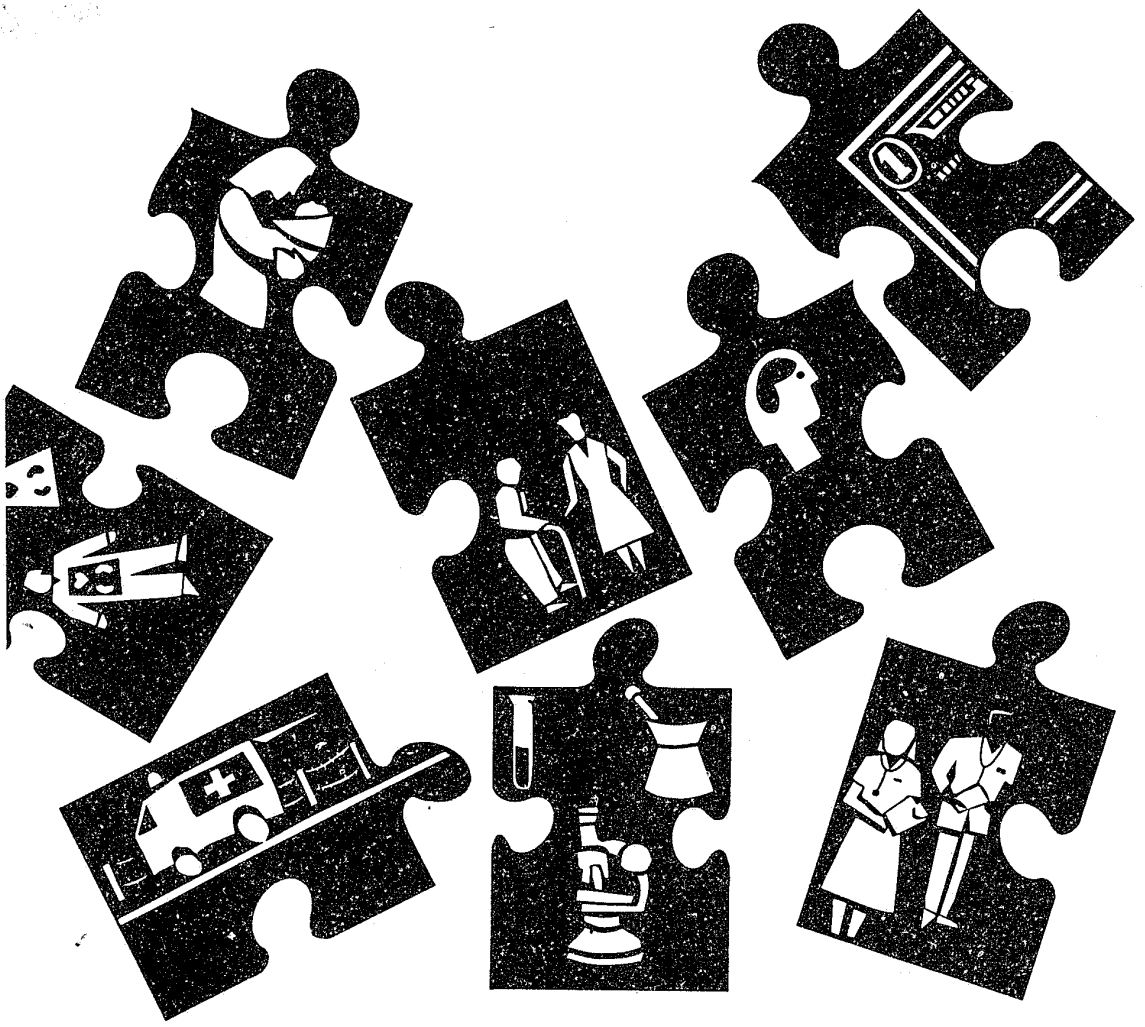
What Legislators Need to Know About Alcohol and Other Drug Abuse

National Conference of State Legislatures



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WHAT LEGISLATORS NEED TO KNOW ABOUT ALCOHOL AND OTHER DRUG ABUSE

by

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INTRODUCTION

Alcohol and other drug abuse are not new problems for Americans. Substance abuse issues have concerned public health workers and policymakers since the end of the nineteenth century. Abuse problems became most acute in the late 1940s and early 1950s with the increase in heroin use in many inner city communities. In the 1960s and 1970s, the focus of concern shifted to marijuana, hallucinogens, and the effects of alcohol. During the 1980s and early 1990s, the focus is on the problems of "crack" cocaine and designer or analog drugs like "ice" and "ecstasy," which are synthetic compounds created to copy the effects of illegal drugs.

The United States faces a major public health problem of epidemic proportions. The 1988 report from the White House Conference for a Drug-Free America states:

> Our forces are outmanned, outgunned and outspent. . .Our losses include children born addicted, and other children recruited to crime before their teens by drug lords who use them to build a business of terrible violence and tremendous profit. We have drug dealers on our street corners, in our offices, on our college campuses, and grade school playgrounds.[1]

Alcohol and other drug abuse are linked to the worst social, health, and economic problems that face the United States today, including: fetal alcohol syndrome, accidental death, suicide and homicide, 20,000 alcohol-related motor vehicle fatalities annually, AIDS, family violence and child abuse, diminished public safety, loss of individual freedom, losses in work productivity, and political corruption. The total annual cost of alcohol and other drug abuse is estimated to be more than $200 billion. Health and Human Services Secretary Louis W. Sullivan, M.D., estimates that the total cost of alcohol and alcoholism exceeds $136 billion a year.[2]

This publication focuses on prevention-and-treatment strategies for alcohol and other drug abuse problems. Issues of distribution-control efforts and other alcohol and drug abuse activities that affect the criminal justice system are not discussed. It is the intent of this publication to help state legislators understand the problems of alcohol and other drug abuse and to present viable strategies for state public policies that address these problems. In question-and-answer format, these topics are discussed:

- What is alcohol and other drug abuse?
- Who is most affected by alcohol and other drug abuse?
- Why should legislators be concerned about alcohol and other drug abuse?
- What prevention strategies are available for alcohol and other drug abuse?
- What treatment strategies are available for alcohol and other drug abuse?
- How are alcohol and other drug abuse programs and services funded?
- How are states responding to the problems of alcohol and other drug abuse?

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QUESTION ONE: WHAT IS ALCOHOL AND OTHER DRUG ABUSE?

Alcohol Abuse

Experts have studied the problems associated with the use of alcohol for years and have debated an appropriate definition of alcohol abuse. As recently as 1960, alcoholism was defined as "any drinking having harmful consequences."[3] Evidence now indicates that alcoholism is the interaction of environmental factors with specific biological mechanisms that exhibits itself in behavior. Experts usually identify three terms for problem drinking:

- *Alcohol abuse*--is characterized by heavy and frequent consumption of alcohol;
- *Alcohol-related disabilities*--defines problems in conducting the activities of daily life in the short-term or the long-term; and
- *Alcohol dependence*--also can be termed "alcoholism" or "alcohol dependence syndrome" and is distinguished from abuse by craving, tolerance, and physical dependence that changes the importance of drinking in one's life. People with an alcohol dependence may abuse alcohol or have alcohol-related disabilities.[4]

Although alcohol is not an illegal substance for adults, the abuse of alcohol has become a serious problem for the United States. Approximately 10.5 million adults in this country have symptoms of alcoholism or alcohol dependence, and an additional 7.2 million abuse alcohol with no apparent symptoms of dependency. According to the United States Public Health Service, there will be 11.2 million alcohol-dependent adults in this country by 1995.[5] The National Institute on Alcohol Abuse and Alcoholism estimates that at least 25 percent of people in general hospital beds suffer from complications of alcoholism in addition to another primary diagnosis.[6]

Alcohol consumption has leveled off in recent years and may even be declining. However, it remains the leading drug of abuse in the nation. Groups at greater risk of alcohol-related problems include adolescents, homeless people, Native Americans, and babies born to alcohol-dependent women. Motor vehicle deaths, injuries resulting from alcohol abuse, and fetal alcohol syndrome remain serious public policy concerns in the United States.

Other Drug Abuse

The diagnostic criteria of problem drug use are very similar to those used for alcohol and are based on "the level and pattern of consumption and the severity and persistence of functional problems."[7] An individual's drug history can be classified in three ways:

- *Use*, which is characterized by low or infrequent doses and can be considered experimental, occasional, or social; damaging consequences are rare or minor;
- *Abuse*, which describes higher doses or frequencies that are usually sporadically heavy and intensive; effects are unpredictable and sometimes severe; and
- *Dependence*, which defines the addiction to drugs and is associated with high or frequent doses, compulsion, craving, and withdrawal; severe consequences are likely.

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Although the character of addiction in general is controversial, recent studies indicate that psychosocial and biological factors play a role in drug addiction similar to that found in alcoholism.[8] In addition, polydrug use is a prevalent condition that complicates diagnosis and treatment. Many people with a diagnosis of alcohol or drug abuse use more than one substance for a variety of reasons, including: access, prolonged experience, reduction of deleterious side effects of the primary drug, and sociability. Especially with cocaine, a person may smoke marijuana, imbibe alcohol, or combine a number of drugs to lessen the negative effects experienced as the drug wears off. The polydrug user is the most common type of user, and alcohol is most generally used in combination with other substances.[9] (See Table A for a classification of psychoactive drugs.)

According to the National Institute of Drug Abuse (NIDA) 1988 National Household Survey, 37 percent of the population (72 million Americans) have used an illicit drug in their lifetime.[10] Given any month in the last 20 years, approximately 14 million people in the United States used some illicit drug.[11] Although casual drug use has declined significantly since the 1985 edition of the survey, there has been an increase in the number of heavy cocaine and crack users. The number of people using cocaine at least once a week rose by 33 percent, and the number of daily users increased by 19 percent.[12]

The FY 1988 State Alcohol and Drug Abuse Profile Report indicated that admissions for cocaine treatment tripled between FY 1985 and FY 1988. Medical emergencies due to cocaine abuse increased about five times in that same period. Most disturbing is survey evidence that nearly 60 million women in child-bearing years had used an illicit drug in the past month.[13]

Drug abuse causes problems for society and affects the quality of life for the addicted individual. Legislators are deliberating policies on cocaine- and substance-affected babies, intravenous drug users, AIDS, driving while impaired, and the link of illicit drug use to crime.

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QUESTION TWO: WHO IS MOST AFFECTED BY ALCOHOL AND OTHER DRUG ABUSE?

Alcohol and other drug abuse affects all sectors of society. This section outlines the adverse effects of use and abuse in the general population and in specific groups, such as women, adolescents and young adults, older adults, the homeless, and racial and ethnic minorities.

Men and Women

Heavy drinking and drinking-related problems are associated most often with young, single males in this culture; the problems seem to decline with age. Women at highest risk for alcohol problems are in their late twenties or early thirties, unmarried, and living with a partner who is a heavy drinker. Depression and reproductive problems may occur before and actually contribute to a woman's alcohol problems, as well as after alcohol dependence becomes evident.[14] Men are five times more likely to be diagnosed with alcohol dependence, but women have a greater association of alcoholism with other medical diagnoses.[15] However, it should be noted that studies of male/female alcohol consumption do not account for differences in body weight, which may indicate that differences in consumption amounts are exaggerated.

A majority of people receiving drug treatment are men 20 to 40 years old.[16] Information about drug use by women is scanty, although one early recognition of addictive behavior focused on morphine addiction among women in the late 19th century.[17] Experts agree that adolescents and women, especially child-bearing women, have special problems and need different treatment than men. For example, women who abuse drugs or are drug dependent have lower self-esteem and suffer greater anxiety, depression, and detachment than men.[18]

Women, especially pregnant women, have a difficult time obtaining treatment for alcohol and other drug abuse. Very few public treatment programs even accept pregnant women or mothers with children, largely because these facilities are not equipped to deal with the health, housing, and education needs of mothers and their families.

Adolescents and Young Adults

The Institute for Social Research at the University of Michigan has conducted an annual national survey of approximately 17,000 high school seniors on drug and alcohol use and attitudes since 1975. Most of these studies included follow-up work, and data are now available for people between the ages of 18 and 30.

According to the survey results, the number of seniors who had tried alcohol remained stable at 92 percent between 1975 and 1988. However, actual usage decreased for most major indicators of alcohol use. A little more than 4 percent of seniors said that they drank daily in 1988, a 13 percent decline from the previous year. The mutual decline in both alcohol and drug use indicates that there was no displacement effect with students replacing one substance for another.[19] The follow-up study of graduates indicated similar patterns of alcohol use, with some increase in the amount consumed per incident for about four years after high school, before decreasing to below the level of the seniors' consumption in high school.

The study of high school seniors reflected that use of all drug types increased from 1975 to 1978. However, drug use declined by 1984. For example, 6 percent of seniors reported daily marijuana use in

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1975. This increased to 11 percent in 1978 but declined to 5 percent in 1984.[20] Marijuana use peaked in 1979; illicit drug use (other than marijuana) peaked in 1982; and there has been a decided decrease in the use of tranquilizers, barbiturates, methaqualone, LSD, and PCP. Cocaine use, which continued to increase in the late 1980s, is now declining as well.

Older Adults

Research consistently shows that, as people get older, consumption of alcohol decreases and there is less alcohol abuse. However, longitudinal studies indicate that a person's drinking behavior remains fairly stable as he or she ages, with a change more often exhibited in abstinence and a decrease in consumption.[21] A new phenomenon is the late-onset of heavy drinking in older adults. Although most heavy drinkers begin early in youth and middle-age, a small percentage of older people appear to begin heavy drinking as a possible response to grieving, poor health, economic changes, and the stress of retirement. This is a phenomenon that seems to occur in higher socioeconomic classes.

Underreporting also may be a factor in the understanding of abuse in older folks, since much of the information depends upon self-reporting. Indicators of alcohol abuse include housing problems, falls or accidents, poor nutrition, inadequate self-care, lack of physical exercise, and social isolation. A study of hospital discharge data by age group from 1979 to 1985 indicates that the 65-and-older age group had the highest proportion of alcohol-related diagnoses. This has disturbing implications for an aging population, where the people 65 and older in the United States will represent 25 percent of the population in 2030.

Among the elderly, over-use and misuse of prescription drugs--sometimes in combination with alcohol--has been identified as a widespread problem. Typically, this is not related to recreational abuse of medications but to misdiagnoses by doctors, faulty prescriptions, and improper use of drugs by patients.[22]

The Homeless

The problems of the homeless are difficult to assess. The proportion of homeless people who abuse alcohol or are alcohol dependent ranges between 10 and 33.5 percent of the estimated 2 million homeless people.[23] Estimates of lifetime incidence of alcohol dependence among homeless persons may be as high as 63 percent.[24] Alcohol abuse among this population is most prevalent among the middle-aged group, which may be the result of coping with the situation of homelessness itself. The cause and effect relationship is not clearly understood, and it may be that alcohol dependence in middle-age contributes to homelessness.

Homeless people are at risk for health problems, which are exacerbated by alcohol abuse. Health Care for the Homeless (HCH) funded a study of 30,000 homeless clients for health problems, finding that 45 percent of men and 15 percent of women wanting health care were alcohol abusers or alcohol-dependent people.[25] The occurrence of alcohol abuse with drug abuse and mental illness among homeless persons is very significant. Drugs in addition to alcohol were used by more than 25 percent of alcohol-abusing homeless women and almost 20 percent of alcohol-abusing homeless men. More than one-half of the women and one-fourth of the men were diagnosed with mental illness.[26]

Racial and Ethnic Minorities

Black and white men have similar alcohol consumption levels. However, black men experience higher rates of social and health complications as a result of their drinking than white men. These problems are concentrated among the socioeconomically disadvantaged. Some studies indicate that this higher vulnerability of blacks to the effects of alcohol may be due to social and economic problems, including unemployment, poverty, poor health care, and racial discrimination. Biological predisposition to this trauma needs further study.[27]

Hispanic people show a great diversity of alcohol consumption, depending on their country of origin. More Mexican-American people reported drinking problems than Puerto Ricans or Cubans. There is also some correlation to immigration status and alcohol behavior. Generally, alcohol-related problems are higher among Hispanic men than among black or white men. Eighteen percent of Hispanic men and 6 percent of women had at least one problem related to alcohol in the year preceding a 1984 survey. The alcohol consumption and behavior of adolescent Hispanics has not been studied.[28]

Asian-Americans, although displaying a wide diversity of alcohol consumption patterns, have the lowest alcohol consumption and related problems of all racial and ethnic groups in the United States. Although Asian-Americans are more likely to abstain from using alcohol than other racial groups, the frequency and consumption levels seem to be increasing, according to a 1987 study.[29] The study stressed the importance of factors such as ethnic group, place of birth, generational status, and degree of acculturation in analyzing the results of the study.

Diversity also characterizes the different tribes among Native Americans and Alaskan Natives, with members of some tribes being mostly abstinent and others exhibiting a high level of abuse. The severity and extent of alcohol-related problems among Native Americans are reflected in mortality rates associated with alcohol, such as accidents, chronic liver disease and cirrhosis, homicide, and suicide. Accidents, which occur at more than twice the rate as in the general population, are the second leading cause of death among Native Americans. Homicides and suicides are more than half again as prevalent in the Native American community, with almost 75 percent of all traumatic deaths and suicides being alcohol related. Deaths attributed to alcohol are most acute in the 25 to 44 age group. Accidents in this group were nine times higher than the national average in 1985, and the death rate for cirrhosis was more than five times greater.[30]

Although Native American women drink much less than Native American men, they seem to be very susceptible to alcohol-related health problems. They account for nearly one-half of the cirrhosis deaths of Native Americans in the country, although their consumption level is relatively low. Fetal alcohol syndrome (FAS) is of particular concern to many Native American groups.[31] Most identified cases of FAS have come from studies of black and Native American women who are poor. The rate in these communities is 2.6 per 1000 births as compared to 0.6 per 1000 births from studies of white, middle-income mothers.[32]

QUESTION THREE: WHY SHOULD LEGISLATORS BE CONCERNED ABOUT ALCOHOL AND OTHER DRUG ABUSE?

Policymakers are extremely concerned about the misuse and illicit use of alcohol and other drugs. State governments spend nearly $1 billion each year on alcohol and drug related treatment.[33] Additional billions are spent on alcohol and drug abuse-related crimes, accidents, and social problems that arise in the workplace, the community, and the home. Problems include lost worker productivity, increased health and social services demands, high-risk pregnancy, AIDS, unsafe highways, increased crime, homelessness, mental health problems, and disrupted families. This section addresses the economic, health, and social consequences of alcohol and other drug abuse, which legislators need to know in order to make cost-effective public policy decisions.

Economic Consequences of Alcohol and Other Drug Abuse

According to a study by the national Institute of Medicine, the estimated total annual cost of drug abuse is more than $72 billion.[34] This figure represents the total costs associated with decreased economic productivity, unemployment, increased health and social welfare costs, law enforcement, and associated costs of criminal trafficking in drugs. The costs of alcohol abuse were estimated by the U.S. Department of Health and Human Services to be more than $136 billion a year in 1989. These costs are expected to increase to $150 billion by 1995--61 percent attributed to lost employment and a reduction in productivity and 13 percent to health care and treatment costs.[35] A report released in January 1990 by the Institute for Health and Aging, which used the latest complete figures available in 1985 to analyze the economic impact of alcohol, drug abuse, and mental health (ADM) disorders, concluded that:

- Direct core costs represented 24 percent of the total expenditures;
- Morbidity costs were 37 percent of total;
- Mortality costs were 16 percent; and
- Other costs, including the cost of AIDS and fetal alcohol syndrome, represented 23 percent.[36]

Between 10 and 23 percent of all workers in the United States use drugs on the job, and many more come to work already impaired.[37] More comparative and timely statistics need to be gathered on the costs of alcohol and drug abuse, since the most recent studies often use statistics that are more than five years old. To better plan cost-effective programs addressing the serious problems of addiction, state policymakers need information about current costs incurred in the workplace, the criminal justice system, the health and social services systems, and on the highways.

Health Effects of Alcohol and Other Drug Abuse

Officially, alcohol is directly responsible for 3 percent of the deaths in this country.[38] However, the true correlation between alcohol and mortality is difficult to measure, because little account is made of deaths in incidents where alcohol is a contributing factor. Although alcohol has been implicated in deaths caused by motor vehicle crashes, drownings, falls, fires, and suicides, the connection has not been well reported.

Alcohol is harmful to almost every part of the human body. However, due to the limitations in measuring alcohol consumption and other contributing factors in a person's health, a cause and effect relationship cannot be proven. The National Hospital Discharge Survey provides an annual summary of data on short-term stay discharges at community hospitals that comprises up to six diagnoses, including the primary one. These studies have confirmed that 4 percent--1.1 million of 27.4 million--of short-stay hospital discharges among persons 14 years and older involve an alcohol-related diagnosis, of which 54 percent had an alcohol-related problem as the primary diagnosis.[39] Experts suspect that this actually represents an under-reporting of the actual incidence of alcohol-related conditions. A survey of psychiatric disorders in the general population in 1988 indicated that 13 percent of those surveyed had a problem with alcohol abuse or dependence at some time.[40] Again, suspicions exist that this may be under-reported.

Diseases and medical disorders associated with the consumption of alcohol include: liver problems (ranked as the ninth leading cause of death in 1986 with 26,000 deaths reported); gastrointestinal disorders; cardiovascular system problems; nutritional and metabolic disorders; immune system problems; cancer; endocrine and reproductive problems; and neurologic disorders.[41]

The actual effects of other drug abuse are not as well researched as are the effects of alcohol. However, the National Institute on Drug Abuse estimates that 6.5 million people use drugs, which damages their health and impedes their ability to function. Intravenous drug users account for 1.2 million of these people. The Presidential Commission on the HIV Epidemic has reported that only 250,000 drug abusers and 148,000 intravenous drug abusers are in treatment at any one time in this country, which means that only approximately 10 percent of the nation's IV drug users are being treated.[42] This has serious implications for the spread of AIDS, especially to newborns, and the occurrence of substance-affected and addicted babies.

Health-related drug and alcohol issues that are of increasing concern to state lawmakers include fetal alcohol syndrome, drug-affected babies, and AIDS.

Fetal Alcohol Syndrome (FAS). Alcohol produces defects in fetuses. Characteristics of FAS include: prenatal and postnatal growth retardation, evidence of craniofacial anomalies, central nervous system dysfunction, and malformations in the major organ systems. Fetal Alcohol Effects (FAE) refers to a situation where some, but not all, fetal alcohol syndrome criteria are confirmed. FAS and FAE are two of the leading known causes of mental retardation in the Western world. Treatment of FAS in the United States was estimated to cost one-third of a billion dollars a year in 1988. The incidence of FAE has been estimated to be approximately three times as high as that of FAS.[43]

Studies have assessed babies born with FAS at later developmental stages to determine the long-term effects. Overall improvement could be seen in some areas: the appearance of the children, their clumsiness, impaired concentration, difficulties with siblings, tantrums, negativity, and phobias. However, other factors persisted, including hyperactivity, speech defects, and anxiety. There was a greater incidence of special education for these children as they reached school age. And, the more retarded the children were at birth, the less improvement they had as they grew older. Most of these children continued to need special health, education, and social services as they got older. Some studies also have shown that black infants are at greater risk of developing FAS when their mothers abuse alcohol during pregnancy.

AIDS. Although homosexual men account for 62 percent of the one million cases of AIDS in this country, the incidence of reported cases among IV drug users is accelerating at an alarming rate, especially in urban areas. The Centers for Disease Control reports IV drug users account for almost one-third of people infected with AIDS.[44] Concurrently, the National Institute on Drug Abuse reports that 80 percent of heterosexual people infected with human immunodeficiency virus (HIV) have contracted the disease through sex with an IV drug user.

Intravenous drug use is also the primary cause of transmission of the AIDS virus to newborn babies. The Centers for Disease Control states that approximately 75 percent of perinatal AIDS cases are the result of

births to mothers using IV drugs or having sex with IV drug users.[45] In New York, 77 percent of babies with AIDS have at least one parent who is an IV drug user.

AIDS and pediatric AIDS have staggering consequences for the health and child welfare systems in this country. Care for AIDS victims can cost as much as $100,000 per year; and many people with AIDS are poor, homeless, and lack traditional family and community supports, leaving them to rely upon public services for assistance.[46]

Drug-Affected Babies. Drug and alcohol use by pregnant women is gaining national attention. A 1988 survey of 36 private and public hospitals nationwide found that 11 percent of new mothers admitted to using illegal drugs while they were pregnant.[47]

Experts estimate that approximately 105,000 pregnant women need drug treatment annually.[48] When a pregnant woman uses drugs, alcohol, or cigarettes, the substances cross the placenta and affect the developing fetus. Cocaine use can cause miscarriage, fetal stroke, premature delivery, and maternal and infant hemorrhaging. Narcotics use can cause fetal addiction, which can lead to infant withdrawal, respiratory distress, and convulsions. By age two to five years, these children may have speech and cognitive/dexterity delays, and difficulties with learning and social skills.[49] In addition to costly medical services, drug-exposed children often require special education and a variety of support services.

Some recent research suggests that marijuana may have the same effect on the fetus as alcohol. This has particular implications for public health and the high incidence of teen pregnancy. Alcohol and marijuana use is high among adolescents, and sexually active adolescent women are more likely to be using alcohol and drugs. They are also less likely to receive prenatal care once they become pregnant. Drug-using pregnant adolescents have a higher incidence of premature babies, underweight babies, and babies that require intensive care during the first months of life.[50]

Social Consequences of Alcohol and Other Drug Abuse

Families, friends, associates, and communities--the entire fabric of our society--are affected by the problems associated with alcohol and other drug abuse. People who misuse drugs and alcohol are often less productive on their jobs than others. In addition to motor vehicle accidents, alcohol and other drug abuse contributes to accidental injuries and fatalities, traumas, suicide, homelessness, mental health problems, crime and family violence, and dysfunctional families.

Accidents. Alcohol and drugs have been implicated in the four leading causes of accidents: motor vehicle collisions, falls, drownings, and burns and fires.

Automobile accidents are the leading cause of death by injury in the United States, especially for people between the ages of four and 34. Although the number of people dying in traffic accidents related to alcohol or drug abuse has been declining since 1982, more than 46,000 people were killed in 1987 in traffic accidents in this country. Of that number, almost one-half were alcohol related.[51] A California study of 440 male drivers killed in automobile accidents showed that four-fifths of the drivers were under the influence of alcohol or drugs at the time of their accidents.[52]

Nationally, in 1988, 41 percent of all fatally injured drivers of passenger vehicles had illegal blood alcohol concentrations.[53] Approximately 40 percent of teenage deaths occur in traffic accidents, and drivers not using seat belts were three times more likely to be intoxicated as those using seat belts.[54]

Research confirms that use and abuse of alcohol increases the chances of falling, starting fires, and being burned. However, a similar relationship remains unsubstantiated for drowning.[55] Two studies report that approximately 40 percent of people take alcohol on boat outings and 35 percent drink while out in the boat. Although between 17 and 31 percent of boaters who drown were proved to be drinking, the association between alcohol and drowning is weak.[56] A number of studies associating drinking with fires

suggest that alcohol exposure was more frequent among victims of cigarette fires.[57] Data collection needs to be improved with regard to the relationship between drug and alcohol use and accidents, such as: (1) routine blood alcohol testing in emergency rooms; (2) better recording of "acute" alcohol involvement in injuries; and (3) better use of accident codes in care settings to provide information on circumstances surrounding injuries.

Suicide. Recent studies in 1987 and 1988 indicate an association between alcohol, suicide, and firearms.[58] This is particularly true among youth suicides. In one Pennsylvania county, the suicide rate of residents between the ages of 10 and 19 doubled from 1960 to 1987. Positive blood alcohol levels were found in 12.9 percent of these victims between 1968 and 1972, and in 46 percent between 1978 and 1983. No changes were seen in the percentage of young victims under the influence of other drugs.[59] Suicide by guns increased significantly; victims with a detectable blood alcohol level were five times more likely to use guns than those not under the influence of alcohol.[60]

Trauma. Twenty to 37 percent of all emergency room trauma cases involve alcohol. In fact, a history of trauma is one of the early signals of alcohol abuse.[61] Independent studies and data from insurance claims indicate that there is greater risk for broken bones among the alcohol dependent. Alcohol reduces the number of blood platelets and contributes to reduced bone density, incidence of bacterial infections, lower blood pressure, and retarded ability to recover from trauma. Interestingly, motorcyclists were more likely to be drunk than drivers of other vehicles, and head injuries were twice as likely to be fatal.[62] Thirty percent of pedestrians involved in car accidents and taken to trauma centers during 1982 and 1983 were found to be intoxicated, according to a 1988 study.[63] These patients had more severe injuries, their hospital stays were longer, and they had more injuries to the spine and chest than similar uninebriated patients. Conflicting studies exist regarding the mortality rate of intoxicated and nonintoxicated trauma victims. Again, better data collection and routine blood alcohol testing are needed.

Homelessness. Alcohol and drug abuse also contributes to a community's homelessness problem. Between 20 and 45 percent of homeless people suffer from alcohol- and drug-related disorders.[64] While alcohol and drug abuse is a result of homelessness for many people, many others are homeless because of their alcohol and drug abuse. For example, in one study of homeless male alcoholics, 59 percent reported that their alcoholism caused them to become homeless.[65] Homeless alcohol and drug abusers are at increased risk of trauma, victimization, hypothermia, frostbite, and infection.[66]

Mental Health Problems. A close relationship exists between mental disorders and alcohol and drug abuse. For example, one study showed that one in three adults with a mental disorder will have an alcohol or drug abuse problem at some point.[67] Alcoholics have a 50 percent chance of suffering from a mental disorder or a drug problem in their lifetimes, and drug abusers have a 70 percent chance of having a mental disorder or alcohol problem.[68] People having more than one disorder create special treatment challenges.

Crime and Family Violence. Drug and alcohol abuse is one of the most common factors seen in perpetrators of serious crimes.[69] Of the current total prison population, approximately 62 percent used drugs regularly prior to arrest, and 22 percent were under the influence of a drug at the time of their offense.[70] Nonetheless, a direct causal relationship between alcohol and other drugs and crime has not been proved.

While more research needs to be done, alcohol may be linked to physical violence in the family. Alcohol use also may provide short-term solutions to family problems and actually encourage heavy drinking in some situations.[71] Other factors play a role in violence, even when alcohol is present. Cultural, environmental, and personal circumstances and characteristics can influence the effects of alcohol on aggressive behavior. Studies often are hampered by varying definitions of abuse, reliance on data collected from families under court order for treatment, lack of comparison groups, and lack of control for contributing variables, such as socioeconomic status.[72]

Dysfunctional Families. Besides creating community problems, alcohol and drug abuse can disrupt families. Not only can it create or contribute to marital problems, but it can be damaging to the healthy development of children, by increasing the likelihood that they will abuse alcohol or drugs, and by contributing to family instability. Children with an alcoholic parent are four times more likely than other children to become alcoholics.[73]

A genetic link to alcohol abuse may increase the chances of children of alcoholics becoming alcoholics themselves.[74] However, negative environmental influences associated with a parent's alcohol and drug abuse also must be considered. For example, children of alcohol and drug abusers, in general, are more likely to be abandoned or physically, emotionally, or sexually abused.[75] When their family lives are chaotic and inconsistent, many children experience low self-esteem, depression, isolation, guilt, and difficulties in maintaining personal relationships. Many have learning and behavior problems at school, are in trouble with the law, and are in need of mental health services. Many grow up in homeless families, while others run away from home.

While these problems are damaging to children in and of themselves, they also can lead to a child's abuse of alcohol and drugs. In turn, young people who abuse alcohol and drugs are more likely to drop out of school, get pregnant, or become delinquent.[76]

Teens who do poorly in school and have no other way to distinguish themselves may use drugs as a substitute for enhancing their self-esteem or social status. Smoking cigarettes, drinking alcohol, and using other drugs may be a coping mechanism for tension or anxiety, especially in social situations. Parents, siblings, and other esteemed role models may play an important part in the decision to use drugs and alcohol, depending on the person's self-concept, confidence, and sense of personal autonomy.[77] Prevention strategies must give teens and other people with an alcohol or drug problem the skills to resist pressures to smoke, drink, or take drugs, as well as reduce their motivation to do so.

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QUESTION FOUR: WHAT PREVENTION STRATEGIES ARE AVAILABLE FOR ALCOHOL AND OTHER DRUG ABUSE?

Prevention of alcohol and drug abuse, like prevention of most social problems, is easier and less expensive than treating the problem once it arises. However, it is difficult to estimate the savings to the public of prevention programs, and research in this area is very new. Unfortunately, in the present situation of scarcity of resources, lawmakers often cut prevention and evaluation programs to provide needed services to the growing number of victims of alcohol and other drug abuse.

This section discusses prevention efforts, including community prevention, education in the schools, and state regulation to curb the use of alcohol and drugs.

Community Prevention

Public policymakers increasingly are looking at early intervention and prevention in the community to address major human services problems, including alcohol and other drug abuse. Prevention usually does not result from the efforts of one community-based program or under the auspices of a single prevention activity. Successful community-based prevention can best be defined as "community-wide" prevention, which is:

> . . . a systematic application of prevention strategies throughout the community in a sustained, highly integrated approach that simultaneously targets and involves diverse social systems such as families, schools, workplaces, media, governmental institutions, and community organizations.[78]

Successful community-wide prevention strategies include involving and training significant role models in the community; designing information carefully for specifically targeted audiences; emphasizing life skills training; creating alternatives to drug and alcohol use; and presenting consistent messages by society's major institutions about alcohol and other drug use. A program development process also is very important to successful prevention. This process includes the identification of important community leaders and organizational structures; a needs assessment; the development of realistic and measurable long-term goals and short-term objectives; coordinated implementation of activities and tasks; and program management, including evaluation and fine-tuning.[79] Cooperation and collaboration among various stakeholders in the prevention of alcohol and other drug use contribute to success by ensuring that all pertinent players "buy in" to the prevention effort.

Community-wide prevention attempts to address the underlying variables that have a high correlation to problem behaviors throughout life, such as social alienation, loneliness, and a feeling of impotence. By empowering people to take charge of their own lives in physically and psychologically healthy communities, many of the problems associated with alcohol and other drug use appear to subside. To build strong communities, lawmakers can facilitate the development of bridges and intersystem linkages among families, schools, business, and government social services. Three examples of programs that promise to be models for alcohol and other drug abuse prevention are described below.

The University of Southern California's (USC) Comprehensive Drug Abuse Program. The USC model implements a state-of-the-art resistance skills strategy in middle schools. This is coupled with a planning process that involves the family, media, work, local government, and other community organizations. The model was developed from successful community-wide heart disease and adolescent smoking prevention programs begun in the 1970s. Program components that contributed to successful

outcomes included: family involvement, specific skills development, multiple prevention strategies, process and impact evaluations, and a program duration of three to five years. The model has been implemented as Project Star in Kansas City, Missouri, school districts and as Project I-Star in Indianapolis, Indiana. Project Star involves the collaborative effort of a university research team, a business, a philanthropic foundation, a federal agency, the schools, families, the media, health agencies, and even a baseball team.[80]

The Minnesota Heart Health Program (MHHP). The MHHP is part of a 10-year education program in three communities to change the smoking habits, eating patterns, physical exercise, and hypertension management in all members of the communities--children, teens, adults, and the elderly. The three main strategies are built around health behavior campaigns, educational interventions, and community organization programs. However, youth are considered a special target group. Each intervention activity focuses on a set of risk factors for problem behaviors and has as its goal to "delay the onset, minimize the consequences, and prevent the abuse of drugs as well as promote the adoption of health-enhancing alternatives to drug use."[81] Consequently, this model stresses good health practices as well as the need to change bad health behavior. It also stresses the need for healthy lifestyles among all age groups.

The Techniques of Effective Alcohol Management (TEAM) Project. The TEAM Project is a collaborative effort of the National Highway Traffic Safety Administration, the National Basketball Association, GEICO Insurance Company, the National Automobile Dealers Association, the National Safety Council, the Motor Vehicle Manufacturers Association, and CBS Television. The TEAM project focuses on sports events with effective crowd control to reduce the number of drunk- and drugged-driving incidents after the events. TEAM disseminates information about responsible sales, service, promotion, and consumption of alcohol. Beverage and food services, indoor security, ushering, parking lot security, and ticket handling workers are trained to recognize and intervene with individuals showing signs of alcohol impairment. Traffic safety messages also are flashed from scoreboards. Forty-four sports facilities in 1987 used the TEAM approach, but the project has not been evaluated for outcomes.[82]

Although prevention efforts require a sizeable commitment of time and money, states can utilize federal programs to help defray the costs. States are required to spend 20 percent of the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant funds on prevention. Monies from the Drug-Free Schools and Communities Program also can be used for early intervention and prevention efforts. (See Page 24.)

Education

Many schools, state and local agencies, and community groups have prevention programs that attempt to educate the public about the dangers of alcohol and drug abuse, promote anti-drug attitudes, help people make better personal decisions, and train people to resist pressures to use drugs. Professional associations in the fields of medicine, psychology, social work, and the public education system are active in alcohol and drug abuse prevention through education.

Youth Education Efforts. Frequently, these youth education efforts are school-based, but they also may be conducted by youth organizations found in Boys' Clubs, YMCAs, YWCAs, recreation centers, and housing developments.[83] These efforts include traditional, didactic education modes, but they also employ discussions of practical alternatives to alcohol and drug use and personal decision-making skills to help young people resist social pressures to imbibe alcohol and use other drugs. Alcohol and drug education programs may focus on abstinence and emphasize the importance of not drinking or using drugs while driving. Delay of onset of alcohol and drug use is encouraged through:

- Increasing knowledge and changing attitudes;
- Teaching values, self-esteem and decision-making skills; and
- Developing peer refusal and social competency skills.

Most approaches improve knowledge about the problem, but evaluation studies in 1988 of school education strategies do not indicate a change in attitudes or delay or prevention of alcohol use.[84] Factors that do affect the use of alcohol include demographic characteristics, such as religion, and the students' relationship with parents and peers. As a result, recent development of education programs use a social learning theory model based on assumptions that people learn through personal experiences and observations of other people. Children seem to copy the behavior of others whose behavior receives society's support. Often, these social learning theory programs are lead by peer groups. These programs stress peer refusal skills, correct normative expectations about alcohol and other drug use, sensitize young people to inaccurate messages about drinking found in the media, and provide information about parental and adult influences. Studies of social learning theory program results are conflicting, and more study needs to be done on their effectiveness.

Every state has incorporated alcohol education into its driver education programs after the establishment of the Alcohol Safety Action Projects of the 1970s.[85] Other driver education efforts include attempts to offer alcohol-free events for students; transportation alternatives for intoxicated young drivers; incentives for reducing alcohol consumption; and regulations of the places, hours, and conditions under which alcohol will be served. These efforts need to be evaluated to determine their effect on alcohol behavior.

A program developed in the northwest for Native American students in 1987 focused on decision-making and skills to resist overt and covert pressures to use alcohol and other substances. The program had a strong cultural component to discuss myths about Native American drinking, factors that exacerbate the use of alcohol and drugs among this population, and cognitive skills to maintain the "Indian" way while resisting alcohol and drugs. A six-month follow-up evaluation showed that participants reported lower rates of alcohol, marijuana, and inhalant use than the control group.[86] Peer involvement in the instruction may have had a strong bearing on the success of this program.

Research indicates that social learning and affective strategies are effective in reducing drug abuse in the short term. However, it is still questionable whether they are effective in producing enduring reductions in alcohol and other drug abuse.[87] Questions also remain about what components of these programs make the difference and how they actually work. Some experts contend that successful alcohol and drug education curricula should be part of a comprehensive community prevention effort that addresses all social influences that affect American youth.[88]

Regulation

Regulation of the advertising and pricing of alcohol and efforts to reduce the availability of other drugs is another prevention strategy. In addition, prevention efforts include increasing the minimum drinking age, toughening drinking-while-driving laws, developing transportation alternatives, requiring warning labels on substances, and testing in schools and the workplace.

Advertising. As previously mentioned, research has yet to confirm a relationship between advertising and alcohol consumption. Peer associations appear to have a greater impact on consumption than any other factor. A 1987 study concluded that advertising may have a moderate effect on alcohol consumption and may contribute to reinforcing adverse alcohol use patterns once they have been established.[89]

It is commonly believed that the realistic portrayal of the negative effects of consumption is a useful prevention strategy. Once again, the results of studies are conflicting. Research in 1983 indicated that

seeing drinking on television influences young children's beliefs about alcohol. However, a 1986 study found no effect of televised drinking scenes on alcohol consumption of male college students.[90]

Pricing. Taxes on alcohol by federal, state, and local authorities affect the price. Research on alcohol consumption in states with varying tax rates and data from econometric models indicate that price affects the alcohol consumption patterns of people and may even reduce the number of traffic accidents.[91] According to 1987 studies that controlled for contributing factors (such as age, sex, and family income), heavy drinking, especially among young people, could be reduced by increasing the price of beer.[92] The same researchers contend that if the tax on beer were increased 100 percent ($1.50 for a 24-unit case of 12-ounce beer), traffic fatalities of 15- to 17-year olds would be reduced by 18 percent; of 18- to 21-year olds by 27 percent; and 21- to 24-year olds by 19 percent.[93]

Higher prices also are associated with a reduction in heavy drinking. A 1981 study indicated that, in the 30 states that had raised the tax on distilled spirits, the mortality rates of individuals with cirrhosis of the liver was lower. A 1989 study estimated that current alcohol excise taxes pay for approximately one-half of the lifetime costs that drinkers impose on society through health insurance, pensions, disability, group life insurance, motor vehicle accidents, and criminal justice.[94]

Minimum Drinking Age. Many states reduced the minimum drinking age from 21 to 18 in the early 1970s. With the increase in traffic fatalities among 18- to 21-year-olds, most of these states increased their minimum age back to 21 by 1984. Federal highway legislation in 1984 withheld money from the other states until they enforced a minimum drinking age of 21. All states had passed this legislation by 1988. Results from studies conducted by the Fatal Accident Reporting System of the National Highway Traffic Safety Administration reflect that the greatest reduction in traffic fatalities between 1982 and 1986 was among 16- to 20-year olds in states that had raised their minimum drinking age.[95] During the period in which state laws changed, the percentage of university students who drank decreased, but there seemed to be no change in the number of heavy drinkers (more than six drinks at one sitting), according to a 1988 study.[96] Understanding these differences more clearly may help policymakers design better strategies to affect the behavior of those who drink and drive.

Drinking and Driving Laws. These laws aim to deter driving while drinking through fines, imprisonment, or revocation of drivers' licenses. In 1985, researchers studied the effects of deterrence programs that stress severity and certainty of punishment, such as strengthened enforcement efforts, sobriety checkpoints, and mandatory jail sentences. The study also looked at speedy punishment through administrative license suspension. The researchers concluded that increased perception of the certainty of punishment had short-term effectiveness in deterring drinking and driving. However, severity and swiftness in punishment were found ineffective in changing a person's drinking and driving behavior. In addition, the severe punishments seemed to cause delays, postponement, and avoidance of punishment within the criminal justice system.[97]

Server Training. Most states have laws that make it illegal for drinking establishments to serve minors or persons who are visibly intoxicated. However, much of the enforcement of these laws focuses on serving minors.[98] As of January 1990, 35 states had "dram shop" laws that enable an individual injured by a driver who was served alcohol illegally while drunk to sue the server for damages. The restaurant and bar industry consequently has begun to offer training to servers, managers, and owners of establishments to reduce liability and prevent drunk driving. Trainees are given information about the physiological effects of alcohol on the body, signs of overindulgence, and tactics for handling customers who are intoxicated. The results of this training are positive. A 1987 study indicated that a customer's chances of becoming drunk were reduced by one-half if a server had been trained, although per capita consumption was not affected.[99] As with other studies, servers' performance may be associated with the support of managers and owners.[100]

Because of the direct involvement of servers with the drinking public at or before the point of intoxication, server training may have greater impact than more didactic prevention programs on alcohol consumption and drunk driving.

Motor Vehicle and Roadway Design. Although ignition interlock devices have received much attention, there is no evidence to establish their effectiveness to deter drunk driving.[101] These devices, which are used primarily with driving-while-intoxicated (DWI) offenders, require the driver to self-administer a breath test before the car will start.

Other vehicle modifications to reduce injuries resulting from alcohol-related traffic accidents include: elevated rear brake lights, passive restraints such as self-fastening seat belts and air bags, penetration-resistant windshields, padded dashboards, and other energy- and injury-absorbing features. Roads also can be designed to reduce the occurrence of accidents when people have been drinking, especially with respect to grades and curves and the rate of changing traffic lights.[102] A 1982 study found that even a greater width of road stripe could keep impaired drivers from crossing the center line as frequently.[103]

Transportation Alternatives. Designated driver and ride-service programs are alternatives to driving while drunk. Designated driver programs usually are voluntary, and no tests are available to determine their effectiveness in reducing drunk driving or traffic accidents and fatalities. Ride-service programs--also known as safe-ride or dial-a-ride programs--aim to provide intoxicated drivers with alternative transportation. In 1988 there were 325 ride service programs in the United States run by taxi companies, bus companies, charitable organizations, trade associations, hospitals, and police and other government agencies.[104] Most provide rides by taxi and 95 percent are free. Surprisingly, a small opposition to these programs contends that they actually encourage drinking. Evaluations of their effectiveness in reducing drunk driving are needed.

Warning Labels. As of November 1989, federal law makes it unlawful to manufacture, import, or bottle any alcoholic beverage unless it has a warning about the risks of drinking while pregnant. This policy has not been evaluated for its effect on reducing consumption or its effect on fetal alcohol syndrome.

Testing. Testing an employee's urine for drugs or alcohol can serve as a deterrent. Testing also may be used to facilitate referral for treatment to employee assistance programs (EAPs) that provide counseling and information about other services for employees and their families. When used, drug testing is conducted for a variety of purposes, including: pre-employment screening of job applicants; testing persons who are suspected alcohol or drug abusers; testing workers whose jobs involve the safety of others; testing employees who are returning to work after treatment or at the time of a promotion; and for deterrence, through random or universal testing.

Drug testing is controversial and raises issues of accuracy, privacy, fairness, and confidentiality. With regard to accuracy, even laboratories that conduct medical tests have been shown to have very high error rates.[105] Stricter state licensing requirements for labs that conduct drug testing, periodic testing of the labs to ensure accuracy, new methods of testing, and second or confirmatory tests may lead to lower error rates. In addition, lawmakers may wish to regulate confidentiality of test results to protect the individuals involved.

QUESTION FIVE: WHAT TREATMENT STRATEGIES ARE AVAILABLE FOR ALCOHOL AND OTHER DRUG ABUSE?

> Treatment refers to the broad range of services, including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, and follow-up, for persons with alcohol problems. The overall goal of treatment is to reduce or eliminate the use of alcohol as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems.[106] *Institute of Medicine*

A study of alcohol and other drug abuse treatment programs shows that for every dollar spent for a treatment service, $11.54 of social costs are saved.[107] Fewer than 40 years ago, only one rehabilitation center in the United States specialized in drug treatment, helping people overcome their dependency on alcohol or other drugs.[108] Today, there are 9,000 public and private drug and alcohol treatment facilities.[109] In FY 1988, over 1.2 million people were treated for alcoholism at state-supported facilities alone, and over one-half million people were treated for drug problems.[110]

The Treatment Outcome Prospective Study (TOPS) is the largest, most comprehensive study of the effectiveness of drug abuse treatment. TOPS represented a study of 10,000 individuals admitted to 37 programs in 10 cities across the nation between 1979 and 1981. Participants were tracked for five years in methadone maintenance, residential therapeutic, and out-patient drug-free treatment programs. No significant differences were found in these types of treatment. In addition, the study indicated that treatment is effective in reducing drug abuse up to five years after a single treatment episode.[111]

This section describes types of treatment strategies, treatment for special needs populations, treatment settings, and treatment programs.

Treatment Strategies

Treatment strategies can be classified into three stages: acute intervention, rehabilitation, and maintenance.[112]

Acute Intervention. This term refers to emergency treatment designed to address an acute physical, social, or psychological emergency caused by excessive use of alcohol or other drugs; detoxification and the services required to help a person safely through symptoms caused by the drop of blood alcohol or drug levels during withdrawal; and assessment and screening, which includes a person seeking treatment for himself or herself and efforts on behalf of another to resolve an alcohol or drug problem.

Detoxification is not considered a treatment modality by clinicians, largely because of the specific and short-term focus of the procedures and the poor outcomes in terms of relapse to drug dependence. However, it often precedes other treatment choices and is essential in emergency drug or alcohol overdose situations. The goal of detoxification is to break the cycle of addiction to enable a person to enter longer-term treatment and rehabilitation. Detoxification is therapeutically supervised "withdrawal to abstinence" for a period up to 21 days but usually no more than five to seven. Other drugs often are used to reduce a person's discomfort or medical complications.[113]

An estimated 100,000 people are admitted annually for drug detoxification, most of which occurs in hospitals.[114] Hospitalization longer than two days for drug or alcohol detoxification is only necessary for

infants born with a drug or alcohol dependence, persons with a serious sedative dependence, and individuals who have concurrent medical or severe psychiatric problems.

Assessment services provide a professional determination of the nature of an individual's problem, contributing factors, and the assets and resources available to resolve the problem. A thorough assessment can expedite the placement of an individual with an alcohol or drug problem into the best program to ensure successful treatment outcomes. This is especially true with special populations, such as pregnant women, the elderly, and homeless people for whom services may be scarce.

Studies of treatment modalities indicate that no one approach works for all people with alcohol and other drug abuse problems. Consequently, "matching" the client to appropriate treatment has become a major focus of attention and research. Individuals and their problems need comprehensive assessment. Treatments prescribed must be explicitly detailed in writing. Common sense dictates that outcomes to treatments with unspecified content are difficult to gauge. This specificity of treatment also enables a successful program to be analyzed and used with another similar client.[115]

Rehabilitation. Evaluation and assessment, primary care, and extended care for stabilization are part of the rehabilitation effort. The development of an individualized treatment plan to reduce alcohol consumption includes an assessment of a person's physical, psychological, and social status. A thorough assessment also includes an analysis of the environmental factors that contribute to a person's drinking or drug problem. Successful treatment plans include ongoing assessment and evaluation to tailor activities to the changing needs of the client.

Primary care, the core of the rehabilitation program, includes the assignment of activities designed to help the individual reduce his or her dependence on alcohol or drugs and attain a higher level of physical, psychological, and social functioning. Primary care embraces both intensive and brief intervention strategies that often include counseling. A study of methadone maintenance patients showed that those individuals with moderate to severe psychiatric problems displayed more improvement with their drug problems when they had professional psychological counseling than those who had nonprofessional drug counseling.[116]

Maintenance. Success of the rehabilitation effort often is predicated on the maintenance or stabilization of the person with a drinking or drug problem. During this phase of treatment, individuals are given treatment and supportive activities as they make a transition to a fully active, more normal life.

Maintenance comprises aftercare, relapse prevention, and domiciliary care services. To maintain the gains of rehabilitation, a plan of therapeutic services to help a person stabilize is critical to full recovery. Continued contact and therapeutic activities are essential to avoid a return to negative patterns of drinking and other substance abuse. In some instances, people who are too disabled by alcohol or other drug abuse to live independently can be provided with domiciliary care to ensure the continuance of necessary supportive services. This prevents dangerous relapses to addictive behavior.

Treatment for Special Needs

Most alcohol-dependent behavior and drug abuse is multidimensional, and an individual may be a member of several special population groups, which makes the identification of an appropriate treatment group very difficult. Some experts recommend developing treatment by considering factors such as gender, racial and ethnic group identification of the patient and the staff, service locations, structure and programs of the service delivery system, source of financing, and the racial and academic backgrounds of administrators of special population programs.

For staff working with mainstream programs, training should include skills needed to identify and work with people in special populations. Programs for special populations are important as a means to increase access to treatment. Because evidence is weak in supporting the contention that culturally specialized

approaches are important to the successful treatment of special populations, more extensive evaluations of these programs need to be conducted.[117] Following is a brief description of several populations that may require special consideration for treatment, including: pregnant and parenting women, persons who are mentally disabled, homeless persons, and prison inmates.

Pregnant women and children. Many alcohol and other drug treatment programs do not accept pregnant women or provide child care for children while their mothers are in treatment. In New York, the proposed Family Support Communities model for treating pregnant drug or alcohol abusers and women with young children is a comprehensive response to the health, housing, and educational needs of this population. It includes a progression of intensive residential treatment, communal housing, and independent housing; remedial education; job training and placement services; day care, medical care, and preschool programs for the children; and referrals, follow-up care, and outpatient services.

Mentally disabled persons. Many alcohol and drug abuse problems are closely linked to mental health problems. Many people with long-standing mental and emotional problems take drugs or alcohol to relieve their symptoms. Education and counseling can encourage these people to give up their dependency or reduce their use of alcohol or drugs. In some cases, providing early identification and treatment of mental health problems may prevent alcohol and drug abuse.

Homelessness. Homeless people with alcohol or drug abuse problems can benefit from residential treatment, since living on the streets may exacerbate their alcohol or drug abuse problems. Moreover, homeless persons may need to have medical and psychological care before alcohol or drug abuse treatment can be attempted. New York implemented cooperative efforts to provide services to homeless people, including aggressive outreach and special programs for homeless women, pregnant women, and adolescents.(See Question 7, New York.)

Prison Inmates. Alcohol and drug abusers who are in prison may benefit from being placed in a separate, drug-free living area for the period of their alcohol and drug abuse treatment. States that embrace this philosophy often treat inmates with milieu therapy, a comprehensive drug treatment program that combines drug education, individual counseling, and group therapy. For example, Florida has implemented a comprehensive statewide treatment strategy within its correctional system. (See Question 7, Florida.)

In the case of inmates with alcohol or drug abuse problems who have been convicted of certain minor drug misdemeanors, some states have placed them back in the community for treatment. In Treatment Alternatives to Street Crime (TASC) programs, nonviolent offenders are referred to residential treatment programs in lieu of a prison sentence, or offenders are given mandated treatment in addition to prison terms. TASC was initiated in Illinois in 1976 as a bridge between the justice system and the treatment community. Twenty-four states currently have TASC programs.[118] (See Question 7, Illinois.)

Other strategies. These include intensive-supervision probation and parole, whereby nonviolent offenders are confined to their homes, monitored for illegal movement, tested for drugs and alcohol, counseled, and trained as appropriate; and intermittent sentencing, whereby offenders spend part of their time in prison, perhaps on weekends or in the evening, and part of it in the community. Release is tied to remaining drug-free, attending treatment sessions, reimbursing victims, and providing evidence of positive behavior.

Treatment Settings

The Institute of Medicine proposes that four levels of care be used in defining alcohol and other drug treatment settings:

- *Inpatient*--medical, nursing, and supportive services, including counseling, board, laundry, and housekeeping on a 24-hour basis in a hospital or equipped, licensed medical setting;

- *Residential*--medical, nursing, and supportive services, including counseling, board, laundry and housekeeping on a 24-hour basis in a residential facility or other licensed special setting;

- *Intermediate*--the previously-described services for persons requiring care or support in a treatment or recovery setting for less than 24 hours; this generally means more intensive care, treatment, and support during the day in a special setting; and

- *Outpatient*--the provision of treatment services, as needed, including medical services, nursing services, counseling, and supportive services for those who can live independently and benefit from ambulatory care settings.[119]

Inpatient hospitalization is the most expensive, closely supervised, restrictive service and the one with the highest percentage of medical staff. It usually is reserved for extreme situations, such as short-term treatment and crisis stabilization for individuals in acute distress, comprehensive evaluations, and long-term treatment for people with multiple disorders.

Because of the inconsistencies that have arisen in the classifications of treatment locales, some states have developed their own definitions of treatment settings. For instance, in 1978 the Colorado Alcohol and Drug Abuse Division introduced its own Treatment Needs Model. This model identified four distinct settings of treatment: outpatient, partial (day) care, residential, and hospital inpatient. These terms were developed based on the amount of time per day in treatment activities with professional staff supervision and the relationship of the setting to a hospital. Individuals requiring more intensive treatment and care were assigned to hospital-based programs. Residential and outpatient programs have different licensing requirements regarding physical structure, safety, staffing ratios, and medical control and supervision.[120]

The medical component in the definitions of treatment settings has implications for funding. For instance, health insurance procedures require medical control. Funding from community service agencies does not require this medical involvement.[121] In order to increase accessibility and broaden the range of reimbursement mechanisms, some states have developed new licensing standards to permit reimbursement for detoxification and rehabilitation services for ambulatory patients in nonhospital settings.

Colorado developed a licenser category for nonhospital, community-based, intensive residential treatment programs in both the public and private sectors; as well as program standards for alcohol detoxification and rehabilitation provided in licensed hospitals. Oregon developed a similar licenser category. In an effort to capture third-party payer funds, California developed a chemical dependency rehabilitation hospital licenser category for private-sector programs and recovery home standards for public-sector programs. Recovery homes offer a mix of different models of treatment, including social supports, vocational rehabilitation, and medical services, in addition to primary treatment efforts.[122]

Treatment Programs

This section describes various treatment models that have been used for alcohol and other drug abuse treatment, including the Minnesota Model, pharmacologic treatment, methadone maintenance, therapeutic communities, outpatient non-methadone programs, chemical dependency programs, and employee assistance programs.

The Minnesota Model. The Minnesota model is an abstinence-oriented, comprehensive, multiprofessional approach that considers alcohol and other drug dependency a disease for which there is the promise of recovery--if not a cure. The program is patterned after Minnesota alcohol treatment centers developed in the 1940s and 1950s. Treatment includes a three- to six-week admission to a residential facility for lectures, group therapy, and family programs. At the completion of the program, a

patient usually is referred to Alcoholics Anonymous. Studies of the Minnesota Model indicate that two-thirds of the participants were abstinent or had reduced their alcohol consumption after one year.[123]

Pharmacologic Treatment. Although many doctors prescribe certain drugs to support alcohol treatment, they are not very effective in reducing drinking consumption in the long run.[124] Drugs are used to manage withdrawal, foster sobriety, decrease drinking by managing the effects of associated psychological disorders, and weaken problem drinking behavior. For example, benzodiazepines, like librium and valium, are used to counter the effects of withdrawal, including seizures, hypertension, and delirium tremens. Antabuse (disulfiram) is widely used to treat alcohol dependence by inhibiting one of the major alcohol-metabolizing enzymes. If a person on antabuse takes a drink, he or she has a toxic physiological response that acts as an inducement to sobriety.[125] Although still being studied, pharmacologic agents like naloxone and naltrexone have shown to reduce the craving for alcohol in rodents and primates.[126]

Methadone Maintenance. Methadone often is prescribed for people as an alternative to heroin addiction. The patient receives a daily dose of methadone hydrochloride, a long-lasting narcotic analgesic that suppresses drug craving and prevents withdrawal. Methadone does not produce sedation or euphoria and seems to have no long-term toxic effects. Once stabilized, the methadone user is amenable to counseling, changing his or her environment, and using other social services to counter criminal and addictive behavior. When administered under careful control and monitoring, methadone does reduce or eliminate the use of some street drugs, so that a person can lead a more productive life.

Methadone maintenance is the most studied form of drug treatment. It also is highly controversial. Opposition to methadone treatment generally is based on the grounds that it is substituting one addiction for another and that many clients continue to use drugs and to commit crimes. However, studies have shown that 65 to 85 percent of people on methadone maintenance for heroin stay in treatment for a year or more and that, during this time, there is a dramatic decrease in criminal behavior and an increase in gainful employment.[127] Methadone treatment exhibits significantly higher retention rates for opiate-dependent people than other forms of treatment. However, methadone does not block cocaine, alcohol, and other drugs as effectively as it does heroin, and people on methadone maintenance sometimes use other drugs.[128]

Outpatient Nonmethadone Programs. Outpatient nonmethadone programs vary in treatment processes, philosophies, and staffing. Clients are treated in these programs for all types of chemical dependence problems, but generally not opiate dependence. These programs also serve less dependent individuals and people with less serious criminal records than people served by methadone treatment or a therapeutic community program. Outpatient nonmethadone programs usually consist of one or two visits per week for an average of six months.[129]

Therapeutic communities (TCs). TCs are a popular form of rehabilitation in residential settings for individuals with major social and behavioral problems. The traditional TC provides a residential setting for drug abusers, criminal offenders, and the socially dislocated, usually from nine to 12 months before phasing into independent residence and day programs.[130] The basic goal is to offer a complete change in lifestyle to include: drug abstinence; elimination of antisocial behavior; development of employment skills; and development of positive attitudes, values, and behaviors.

The TC model is based on the assumption that successful rehabilitation is best achieved in a "community," where socially acceptable behaviors will be learned to replace the deviant criminal or antisocial behavior. This support often includes:

- Self-help through learning stages and gradual assumption of responsibility;
- A self-help network that replaces the old gangs and anti-social peers with a new community of peers;
- Prescribed rewards and punishments to reinforce socially acceptable behavior;

- Individual commitment to the community, whereby members accept the idea that their individual problems are in relation to others;

- Role modeling accomplished through the clinical and custodial staff, who might include ex-offenders or ex-drug addicts successfully rehabilitated; and

- Links with support agencies for aftercare treatment and employment as a means of establishing a continuity of care for the released individual.[131]

TC clients demonstrate less drug use and criminal activity during treatment and after discharge. Length of stay in the program remains the strongest predictor of success. Attrition is high, and rates are below participation rates in outpatient, nonmethadone programs but are higher than methadone programs. However, TC clients demonstrate more positive outcomes than those people who did not enter the programs, and TC graduates have better outcomes than those individuals who dropped out of the program.[132]

Chemical Dependency Programs. Chemical dependency (CD) programs can be either residential or inpatient and usually span a three- to six-week period, with a two-year period of attendance at self-help groups or outpatient group therapy. These programs are based on the 12-step Alcoholics Anonymous model of personal change and the commitment to controlling one's vulnerability to dependence. People in CD programs set goals of total abstinence and lifestyle alteration. These programs have been most prevalent for the treatment of primary alcoholism, and careful evaluation of their effectiveness with other drug problems has not been done. Initial studies comparing effectiveness with various populations indicate that CD programs are less successful with drug dependency than with alcohol dependency.[133]

Employee Assistance Programs (EAPs). Employee Assistance Programs (EAPs) provide business management and labor another way to improve job performance and worker health for employees and their families who have a problem with alcoholism, other drug abuse, and behavioral problems. Participation in EAPs can occur because of a supervisor's referral or through voluntary worker initiation. These programs may be staffed by company employees, contracted to outside consultants, offered through labor organizations, or exist through professional associations linked to the business.

Business and industry are more aware than ever that EAPs are a cost-effective means of reducing financial losses due to decreased productivity, escalating health care costs, absenteeism, and on-the-job accidents. Effective rehabilitation of employees whose work may have declined in quantity or quality due to an alcohol or drug abuse problem also saves business the costs of firing employees and retraining new ones. Originally, EAPs were occupational alcoholism programs that helped alcoholic employees achieve and sustain sobriety. Today, these programs aim to help employees with any behavioral problem that adversely affects their work.

A 1985 Public Health Service survey of worksite health promotion activities discovered that 24 percent of businesses with 50 or more workers offered EAPs.[134] An adequate assessment of the effectiveness of EAPs has not been done, due to problems such as poor documentation, lack of control groups, and inaccessibility of company records.

QUESTION SIX: WHAT FUNDING IS AVAILABLE TO PROVIDE SERVICES TO PEOPLE WHO ABUSE ALCOHOL OR DRUGS?

Sources for funding of alcohol and drug abuse prevention and treatment services include the federal, state and local governments and the private sector.

In 1988 the federal government contributed only 23 percent of the $2.1 billion spent on alcohol and drug treatment and prevention in the states. The states contributed 48 percent; local government provided 9 percent; and the private sector accounted for 20 percent.[135] (See Figure 1 and Table B for expenditures for state-supported alcohol and drug abuse services by funding source for FY 1988.)

Federal Sources of Funding

The General Accounting Office reports that total federal funds budgeted for drug enforcement and treatment programs increased nearly 500 percent from $1.5 billion in FY 1980 to $5.669 billion in FY 1989.[136] After the release of the National Drug Control Strategy in September 1989, Congress authorized $9.48 billion in FY 1990, including $800 million for education, prevention and treatment and $100 million for state and local law enforcement.[137] The President has recommended additional increases to $10.6 billion for FY 1991. As already stated, 75 percent of federal investment is allocated to law enforcement and only 25 percent for education, prevention, and treatment.

According to a 1988 survey, of the 23 percent invested by the federal government in alcohol and drug abuse programs and services, 17 percent came from the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant.[138] Six percent of the total funding came from a variety of other federal grants and entitlement programs.

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) State Alcohol and Drug Abuse Profile (SADAP) of data for FY 1987 suggests the following about funding for state alcohol and drug abuse programs:

- 79 percent of the total funds available for alcohol problems comes from state, local, or federal sources;
- 46 percent of the funds comes from state alcohol and drug abuse agencies, with 15 percent coming from the ADMS block grant;
- Other state agencies provide 6 percent;
- County agencies provide 9 percent;
- Other federal agencies provide 3 percent; and
- 21 percent comes from private health insurance, fees, and court assessments imposed on drinking drivers.[139]

Although states exhibited growth in all categories of funding, in comparing studies over the last three years, there appears to be a decline in the proportion of federal block grant funds and state funds spent on alcohol- and drug-related treatment, while county and local funds have increased.[140]

This section discusses the block grants, entitlement programs, and other federal funding for alcohol and drug abuse prevention and treatment services.

Block Grant Programs. State government is the largest single purchaser of treatment services for alcohol problems through the block grants in most states.[141] The three major federal block grants are the Alcohol, Drug Abuse, and Mental Health Services block grant, the Alcohol and Drug Abuse Treatment and Rehabilitation block grant, and the Community Services Block Grant.

- *Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant.* Nearly 74 percent of federal funds utilized by state-supported alcohol and drug abuse programs and services comes from the ADMS block grant, which is administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).[142] This block grant provides financial assistance to states and territories to support prevention, treatment, and rehabilitation programs and activities related to alcohol, drug abuse, and mental health services. Currently, states are required to allocate these funds as follows:

  * At least 50 percent allocated for drug abuse purposes to improve the treatment of IV-drug users, with the goal of preventing the spread of AIDS (States with small populations of IV-drug users can obtain waivers for this requirement.);

  * 20 percent for prevention of alcohol and drug abuse; and

  * At least 10 percent to improve services to women, especially pregnant women and their children.

In FY 1989, $765 million were available for ADMS block grants to states.[143] The funds are allocated based on population characteristics, program factors, and the taxable resources of a state.

Most of the block grants are passed on by state agencies to local governments or to nonprofit contract agencies that provide direct services. The federal law limits the amount of money that can be used on administration.[144]

- *Alcohol and Drug Abuse Treatment and Rehabilitation (ADTR) Block Grant.* The ADTR block grant was authorized in 1986 as a limited, two-year emergency measure to increase access to alcohol and drug abuse treatment and rehabilitation programs and to provide access to vocational training, job counseling, and educational programs for persons receiving treatment for these problems.[145] The Anti-Drug Abuse Act of 1988 (P.L. 100-690) consolidated funds previously provided to the states through the ADMS block grant and the ADTR block grant and added $125 million in new funding for drug and alcohol abuse services.

- *Community Services Block Grant.* Funds for treatment of low-income and disabled persons with drug and alcohol problems were authorized through the Title XX social services grant-in-aid program, whereby states had increased flexibility in administering and allocating funds for social services. In 1981 the program was changed into a block grant program, now known as the Community Services block grant, with funds determined by population with no matching requirement. The current program gives states authority to define social services and who receives them. Some states, including South Carolina, Minnesota, and Massachusetts, use Title XX funds to finance alcohol abuse treatment programs and services that do not meet the federal or private health insurance definitions for medical services. The crucial community services block grant funds are reported in the public welfare budget.[146]

Entitlement Programs. Medicaid, Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) are entitlement programs that enable eligible recipients to receive income support maintenance

and health care. All of these programs have services that can be used for alcohol and other drug abuse treatment and services. In fact, in 1987 Medicaid, Medicare, CHAMPUS, and SSI accounted for 8 percent of the total funding for programs that provided special treatment for alcohol problems. Each program has different eligibility criteria and its own benefit plan for treatment of these problems. The total percentage of funding for treatment of alcohol problems by these entitlement programs varied from zero percent in Delaware, District of Columbia, and Puerto Rico, to 18 percent in Pennsylvania, 19 percent in Maryland, and 22 percent in New York. The national median was 5.6 percent.[147]

- *Medicaid.* Medicaid is jointly financed by the federal and state governments to provide required and optional health care services to millions of low-income Americans. Grants are given to the states on an open-ended formula basis and provide a minimum of 50 percent federal share in the cost of medical services covered and part of administrative costs. All states, with the exception of Arizona, have Medicaid programs.[148] All persons who receive Aid to Families with Dependent Children (AFDC) and most people who receive SSI are eligible for Medicaid. Medicaid serves 24 million children and adults who are aged, blind, or disabled, a group which represents 41 percent of all people below the federal poverty line.

  Federal Medicaid guidelines require a core of basic services, including: hospital inpatient and outpatient care; early and periodic screening, diagnosis, and treatment of physical and mental defects for individuals under the age of 21; rural health clinic services; physicians' services; and nurse-midwife services. States have discretion to cover additional services, such as alcohol and drug abuse treatment programs, inpatient hospital care in mental institutions for individuals under age 21; services of state-licensed practitioners, such as psychologists, alcohol and drug counselors, and medical social workers; clinic services, such as those offered by outpatient alcohol and drug clinics; prescription drugs; and transportation and emergency hospital services.

  Although Medicaid still defines alcohol and substance abuse as a mental disorder, treatment services can be provided by outpatient care in the state's optional services plan. However, these treatment services, even if included in the optional state plan, do not automatically provide coverage for the educational, vocational, and psychosocial services often found in good rehabilitation and maintenance alcohol and drug abuse programs.[149]

  According to a recent memorandum from the U.S. Health Care Financing Administration:

  > Although payment restrictions relating to institutions for mental diseases (IMDs) can affect some inpatient programs for treating chemical dependency, it is important to remember that these restrictions do not apply to any facility that has less than 17 beds. For this reason, it may be advantageous to set up this type program in smaller facilities, even though room and board payment would not be made unless it is a participating facility. Optional IMD benefits are also available in psychiatric facilities for individuals under age 21 and for individuals age 65 and over regardless of the size of the facility.[150]

  In addition, the memo encourages states interested in providing substance abuse treatment to contact other funding agencies, such as the Office of Substance Abuse Prevention, the National Institute on Drug Abuse, and the Health Resources and Services Administration.

- *Medicare.* Medicare is a public health insurance program that covers most elderly Americans age 65 and older and some disabled individuals under age 65 who meet specific criteria or have chronic kidney disease.[151] The purpose of Medicare is to protect these individuals from the cost of health care for acute and chronic illness. Like Medicaid, Medicare includes alcohol and drug dependence and intoxication as mental disorders.

To qualify for Medicare, a disabled person must be over age 18 and have incurred the disability prior to age 22. Since these individuals must first qualify for Social Security Disability Insurance (SSDI), and SSDI is not awarded on the basis of alcoholism or drug abuse alone, only drug and alcohol abusers with physical or mental impairments are eligible for Medicare on the basis of disability. Even then, SSDI beneficiaries must receive 24 months of SSDI payments before they become eligible for Medicare.

- *Supplemental Security Income (SSI).* SSI provides income support at subsistence levels to indigent, aged, blind, and disabled persons who meet standard income and asset criteria. If alcohol or drug abuse is a significant factor in determining an individual's eligibility, he or she must agree to cooperate with a state-approved treatment plan in order to receive benefits. Moreover, if a person who abuses drugs or alcohol is awarded SSI and is determined to be incapable of managing money, payments will be made to a trustee. In most states, recipients of SSI are automatically entitled to Medicaid benefits. In other states, SSI recipients must meet other state-specific criteria.

- *Social Security Disability Insurance (SSDI).* SSDI provides income support for persons who are forced to retire from employment prematurely due to a disability. Benefits are based on a person's history of payroll deductions into the program. A person cannot receive benefits solely because of a diagnosis of an alcohol or drug abuse problem. The individual also must demonstrate physical or mental impairments, such as organic mental disorders, depressive syndrome, anxiety disorders, personality disorders, liver damage, gastritis, pancreatitis, or seizures.[152] As with SSI, if an individual awarded SSDI is determined to be incapable of managing money, the money is managed by a trustee.

- Other federal income supports include: Aid to Families with Dependent Children, which assists low-income single-parent families or two-parent households with an unemployed parent; and food stamps, which are vouchers that eligible low-income persons can exchange for food.

Other Federal Programs. Many other grants are available from the federal government through various federal agencies, including the military, the Office of Substance Abuse Prevention (OSAP), the Department of Education, and the Administration on Children, Youth, and Families. Some of the larger ones include:

- *CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)* is perhaps the largest federal program outside the block grants and entitlement programs. It provides health insurance coverage for military personnel and their dependents. Recently, CHAMPUS has experimented with alternative delivery systems to contain costs through a specific benefit package, including hospital care for detoxification, inpatient rehabilitation, and partial and outpatient care. This package is being reevaluated.

- *The Drug-Free Schools and Communities Program*, through the Department of Education, provides funds primarily to the state education agency and the governor's office for anti-drug abuse education, prevention, early intervention, and rehabilitation referral programs.

- *The Public Housing Drug Elimination Pilot Project Program*, through the Department of Housing and Urban Development, provides grants to public housing agencies to use in eliminating drug-related crime in public housing projects.

- *The Drug Control and System Improvement Grant Program*, through the Department of Justice, provides funds to assist states and localities in carrying out programs designed to enhance state and local drug control efforts and to improve the functioning of the criminal justice system.

State and Local Funding

According to a recent survey, of the more than $2.1 billion spent for state-supported alcohol and drug abuse services in FY 1988, 48 percent--approximately $1 billion--came from state sources.[153] In 40 states and jurisdictions, state government constituted the largest source of funding for state-supported alcohol and drug abuse programs.[154](See Figure 1.) These state government sources included:

(1) State general fund revenues;

(2) The state share of Medicaid funds used for drug and alcohol services;

(3) Earmarked taxes, which are taxes on products or services designated for use by particular programs;

(4) Seized assets, which is money or property derived from drug crimes that is specifically appropriated for support of alcohol and drug treatment, prevention, or other related services; and

(5) Fines, fees, and assessments that are earmarked for alcohol or drug treatment services.

In that same year, approximately 9 percent of funding for alcohol and drug abuse programs and services came from local government. The majority of local government revenues come from property taxes.[155] Other local sources of funds for alcohol and drug abuse programs and services are sales taxes, local government fees for service, and court fines or assessments for treatment imposed on intoxicated drivers. Often, these fees and fines are deposited in state or local trust funds to be used for specific programs or services.

According to a 1987 survey, hospital units received 34 percent of the total of state and local government funds available, which represents 20 percent of their revenue. Residential facilities received 33 percent of the state and local government funds, representing 52 percent of their total revenue, and outpatient facilities received 43 percent--48 percent of their revenue--of the state and local government dollars.[156] More studies need to be conducted on funding of provider type, setting, and services, with special attention to the fact that variations in provider eligibility in public and private insurance plans contribute greatly to the variation in funding sources.[157]

States do not break down reports of expenditures into those receiving treatment for alcohol-related problems and those related to other drug problems. Since 1982, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) has been conducting annual surveys to determine state expenditures for programs receiving at least some funds administered by the state alcohol and drug abuse agency. Unfortunately, although these surveys provide valuable data, they do not include programs operated by the Department of Defense; the Veterans Administration; the Indian Health Services; most private, for-profit, hospital-based and freestanding detoxification and rehabilitation facilities; and detoxification and rehabilitation units in general hospitals that receive Medicaid and Medicare funds. The state expenditure data is incomplete and most figures represent only a partial look at the funding picture.

The following sections describe specific strategies that states and localities are using to fund alcohol and other drug treatment programs.

State Initiatives. In 1984, 17 states--Alabama, Illinois, Indiana, Iowa, Kansas, Maine, Mississippi, Montana, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oregon, South Carolina, South Dakota, and Washington--earmarked taxes from alcoholic beverages, tobacco products, liquor licenses or bingo to be used for alcohol, drug treatment, or mental health services.[158] California is one of several states that provide a mechanism for distributing funds from the sale of property seized in controlled substances cases to drug and alcohol prevention programs.

Several states earmark fines from drunk-driving convictions for treatment or education programs. Illinois charges a driver's license reinstatement fee to persons who have lost their licenses due to an alcohol- or drug-related offense. The state uses these fees to reimburse programs for costs of providing indigent persons with free or reduced-cost court-ordered drug or alcohol education classes. Florida car rental agencies must now assess a 50 cent per day fee on rental cars, which is expected to collect $11 to $12 million per year for prevention and adolescent treatment services. In 1988, approximately 77 percent of state government funds for alcohol and drug abuse services were expended for treatment; 15 percent for prevention services; and 8 percent for other related activities, such as training, research, and administration.[159]

States are responsible for the health care of the medically indigent. Consequently, they provide more than 50 percent of the funds available to nonprofit specialty programs.[160] It is not surprising that state programs and funding for the treatment of alcohol and drug abuse are vastly different. Funding decisions continue to be decentralized, and more states are requiring local matching funds as a condition for receiving state and federal money. All but four states have combined alcohol and drug abuse state agencies.[161] Some states, like California, Colorado, and New York, with combined agencies, still separate funding mechanisms for alcohol and other drug treatment programs. Connecticut, Minnesota, and Michigan are examples of states that have an addictions, chemical dependency, or substance abuse orientation. Virginia's Community Services Boards and Alabama's integrated community services are examples of states that administer their funds for treatment of alcohol problems as part of a combined funding strategy for alcohol, drug, and mental health treatment.[162]

Private Sector Funding

While numerous private funding sources exist, private insurers are the most significant source. In 1988, nearly one-third of funding for private and public alcohol and drug abuse programs and services came from private insurers and independent plans, such as employer- or employee-sponsored programs, health maintenance organizations (HMOs), and private group clinics.[163] Although insurance plans are a major funding source, as many as one-third of American employees who have health insurance do not have coverage for drug treatment.[164]

In 1987, a study was conducted of patients in treatment centers participating in the Chemical Abuse/Addiction Treatment Outcome Register (CATOR). In that study, a sample of Minnesota programs revealed that 75 percent of adults admitted for alcohol-related problems and treatment were covered by private health insurance.[165] Commercial insurance, Blue Cross, or coverage through a health maintenance organization (HMO) was available to 77 percent of the patients, while Medicare- and Medicaid-eligible patients totaled only 16 percent of the group. Six percent of the sample were self-payers, and the rest constituted patients receiving money from state, federal, or local government grants or contracts. A 1988 survey of adolescent programs disclosed that 63 percent of those admitted for treatment had private insurance, while only 9 percent received public funding.[166] Insurance contracts for specific coverage of alcohol and other drug abuse treatment, mandated benefits, and client fees play significant roles in private sector funding of alcohol and other drug treatment programs.

Insurance Coverage. One important gain in the last several years has been the inclusion of alcohol-related illness as a physical illness or trauma reimbursable in a general hospital setting under private insurance.[167] Rehabilitation is still an option on many private health policies. Resistance in the insurance community revolves around questions about the lack of medical supervision in many rehabilitation and maintenance programs. Private insurers also question the overinclusiveness of the definition of alcohol- and drug-related illnesses, and they suspect that practitioners overtreat patients, which contributes to the belief that the treatment industry is becoming an entrepreneurial interest.[168]

Mandated Benefits. Mandated benefits for alcohol and drug treatment are very controversial. Employers and insurers are opposed to mandates on the basis of added costs and restricted flexibility.

Thirty-seven states and the District of Columbia now mandate that alcohol treatment be offered in private health insurance plans; 25 states and D.C. require benefits for alcohol-related services; and the remaining 12 states have laws that require insurance companies to offer these benefits for purchase.[169]

Mandated benefits vary from state to state. Some establish a maximum number of days for treatment or a monetary ceiling, whereas others just require that a benefit be offered for sale. In addition, while most private insurers reimburse for drug and alcohol treatment in medically oriented inpatient settings for a limited period of time, few provide comparable benefits in the less costly and more widely utilized outpatient settings or those staffed by nonmedical personnel.[170]

Mandates do not cover all third-party payers. Medicare and Medicaid are exempt from state mandates, as are employers who are self-insured under the federal Employee Retirement Income and Security Act (ERISA). According to a Bureau of Labor Statistics Survey of Employee Benefits in 1985, 65 percent of the self-insured companies participating had some coverage for the treatment of alcohol problems, and coverage grew faster among self-insured employers from 1981 to 1985 than among employers who purchased insurance coverage.[171] Although there is some concern that self-insurers will not provide alcohol and drug treatment, state mandates in this area seem less important to insurance coverage than the industry, the company size, and the character of the workforce.

Client Fees. Another source of private funds is client fees paid directly to a program or facility in return for services received. These fees may be apportioned on a sliding scale based on the client's income. Fees accounted for 13 percent of funding for private and public programs in 1987.[172] Other funding sources include grants from foundations, cash donations, cash value of donated goods, and contributions from United Way and other charitable institutions.

QUESTION SEVEN: HOW ARE STATES RESPONDING TO THE PROBLEMS OF ALCOHOL AND OTHER DRUG ABUSE?

State legislatures are responding in a variety of ways to the problems stemming from the abuse of alcohol and other drugs. Some states are emphasizing prevention and treatment, with a focus on particular populations such as pregnant women and youth. Other states are concentrating resources in the enforcement area, expanding their criminal justice systems, and building more prisons. A few states, including Illinois, Pennsylvania, and Washington, recently have adopted more comprehensive initiatives to address all three areas: prevention, treatment, and enforcement.

The following examples illustrate a variety of approaches that states are implementing to address the problems of alcohol and other drug abuse. The examples were chosen to highlight a range of state activities and are not a description of any state's total alcohol or drug abuse efforts. These examples do represent a survey of all states' activities or programs.

Washington: A Comprehensive Approach

Profile: The Washington Legislature enacted the Omnibus Alcohol and Controlled Substance Act of 1989 (1989 Wash. Laws, Chap. 271) to attack drug and alcohol abuse in several areas, including law enforcement, treatment, and prevention. The $80 million plan to fight alcohol and other drug abuse mandates tougher sentences, promotes school education programs, provides state grants for community prevention programs, and calls for revocation of a juvenile's driver's license for specified alcohol- or drug-related offenses. The treatment component emphasizes drug and alcohol abuse by adolescents, low-income parents, and pregnant women.

The act increases penalties for drug-related crimes and establishes drug-free school zones, a designation that doubles all penalties for drug-related crimes occurring within 1,000 feet of a school or school bus stop. Principals are authorized to search a student's person, property, or locker if they believe that the search will yield evidence of a violation of the law or school rules.

The legislation also provides grants to implement alcohol and other drug abuse prevention and intervention programs in grades kindergarten through 12. These programs, under the supervision of substance abuse intervention specialists, provide counseling and assessment; referrals for treatment, aftercare, and student mentor programs; and training for staff, parents, students, and members of the community. In addition, the act addresses the treatment of alcoholism and other drug addiction by adding a program of involuntary detention and detoxification for drug addicts (to complement the existing program of alcoholism detention and detoxification); by expanding residential and outpatient treatment services for adolescents; and by establishing a program of identification, referral, assessment, and treatment of pregnant or postpartum women addicted to alcohol and other drugs.

Under the law, the state is to support the development of community mobilization efforts through the following activities: providing financial support for prevention, treatment, and enforcement programs; extending technical assistance to help communities develop

and carry out effective activities; and listening and responding to the suggestions of community members in developing state program and budget decisions.

Funding: The Omnibus Alcohol and Controlled Substance Act of 1989 created the Drug Enforcement and Education Account, with funding from increased taxes on alcohol and cigarettes and proceeds from forfeiture of real property, including land used in drug transactions. The account is expected to collect $80.7 million during the 1990-91 biennium. The act allocates the following monies:

- o $5 million for maternity care support services for pregnant women who abuse alcohol or other drugs;
- o $10 million to the Alcohol and Drug Addiction Treatment and Support Act program established in 1987;
- o $4.9 million to provide 72-hour detention and detoxification for persons addicted to drugs;
- o $3.6 million to develop community-wide mobilization strategies against substance abuse;
- o $10 million to support school district substance abuse awareness programs;
- o $12.2 million for youth assessment and treatment programs to serve youth and their families;
- o $8.4 million for additional security in schools, enforcement, treatment, and training services; and
- o $25.4 million to renovate and operate correctional facilities, to improve detection and treatment services for offenders who abuse alcohol or other drugs, and to support alternatives to incarceration.

Program Highlight: **Chemically Dependent Pregnant Women Program.** The Omnibus Alcohol and Controlled Substance Act of 1989 appropriated $5 million for treatment and support services for low-income, chemically dependent, pregnant or postpartum women. The Department of Social and Health Services, through the Division of Alcohol and Substance Abuse (DASA), responded to this legislative directive by developing a comprehensive intervention program to address needs of chemically dependent pregnant women. DASA works cooperatively with the Division of Parent/Child Health and the Division of Medical Assistance to ensure early identification and treatment intervention through the program. Women who abuse alcohol or other drugs may enter treatment in any stage of their pregnancy and up to one year after delivery. Service providers who have contact with pregnant women are given information and tools to identify chemical use and abuse. These service providers refer women to the program. The Community Services Office screens pregnant women to determine eligibility for Medicaid and other social services. Once eligibility is determined, case managers assist pregnant women to identify their particular needs, develop a service plan, and obtain needed services through private physicians, community health clinics, and public health departments.

Clients. The program serves Medicaid-eligible pregnant or postpartum women who abuse alcohol or other drugs. Washington's income eligibility threshold for these women is 185 percent of the federal poverty level.

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Services. Assessment Centers, created by Washington's 1987 Alcoholism and Drug Addiction Treatment and Support Act, evaluate chemical dependency, provide treatment planning, refer clients to appropriate treatment intervention programs, and monitor the treatment. Available services include intensive inpatient and outpatient treatment; long-term residential/recovery treatment programs, including accommodations for infants and children up to age six; transitional housing with accommodations for infants and children up to age one; and child care services, which include both therapeutic and family child care throughout the parents' treatment.

Results. Because the Chemically Dependent Pregnant Women Program and other efforts initiated in 1989 are so new, results are not available.

South Carolina: Coordination, Prevention, And Treatment

Profile:

In 1974, the General Assembly merged the state's separate alcohol and drug control authorities to form the South Carolina Commission on Alcohol and Drug Abuse (SCCADA). The commission is responsible for developing and administering the State Plan on Alcohol and Drug Abuse. In 1989, SCCADA initiated an Interagency Planning Committee on Alcohol and Other Drug Abuse, which includes members from the Health and Human Services Finance Commission and the Departments of Mental Health, Social Services, Mental Retardation, Education, and Vocational Rehabilitation. All of these agencies play vital roles in coordinating statewide substance abuse prevention and treatment strategies.

SCCADA contracts with 37 county and multicounty alcohol and drug abuse authorities to provide primary prevention, intervention, and treatment services in all 46 counties of the state. Statewide primary prevention activities foster cooperative efforts among SCCADA, county alcohol and drug abuse authorities, schools, religious organizations, and other individuals and groups at the state and local levels.

County alcohol and drug abuse authorities collaborate with existing health and social service systems to implement intervention programs. Credentialed intervention specialists conduct assessments of all referred clients and develop appropriate treatment responses. Clients are referred to education, outpatient, and inpatient treatment services offered by the county authority or other public or private resources.

Program Highlight:

School Intervention Program (ScIP). In the mid-1970s, a survey conducted by SCCADA indicated that 13 percent of South Carolina's high school population had a problem with alcohol, and 50 percent had experimented with illicit drugs. In response, SCCADA initiated a student assistance program in 1978 as a five-county project to prevent or reduce inappropriate use of alcohol and other drugs among students in South Carolina. Today, the program is available in every county in the state.

Clients. Students in grades seven through 12 who exhibit high-risk behaviors, such as inappropriate use of alcohol or other drugs, truancy, or vandalism, are referred to an intervention specialist at the county alcohol and drug abuse authority for an assessment to determine the nature and extent of their problems.

Services. ScIP services, provided through county alcohol and drug abuse authorities in cooperation with local school districts, include the following:

- o Substance abuse training for key school personnel;
- o Individual substance abuse assessment with referral to education and treatment services;
- o Structured group counseling sessions that provide information on alcohol and other drugs and address issues such as decision-making and social resistance skills;
- o Individual and family counseling;
- o Family and parent education; and
- o Final client assessment with referral to appropriate aftercare services.

Funding. In 1984, as part of an educational reform package, the General Assembly gave ScIP statutory authority through the Education Improvement Act. In 1989, ScIP received $1.9 million through a combination of state general funds, federal funds from the Drug-Free Schools and Communities Act, local appropriations, and state appropriations designated through the South Carolina Education Improvement Act.

Results. Participation in ScIP is associated with a reduction in student suspensions, days absent, days tardy, and official disciplinary visits to the school office, as well as an increase in grade point average.

Other Programs:

South Carolina Teen Institute for Alcohol and Drug Abuse Prevention. The institute encourages teens to help other teens through peer-initiated prevention activities. This program began in 1984 and was modeled after a similar effort in Ohio. Teams consisting of four high school students and one adult advisor participate in one of several week-long leadership training sessions each summer designed to involve students in prevention activities in their schools. Between 1984 and 1989, approximately 500 teams from throughout the state participated in the teen institute. As a result, these youths have reached thousands of other students, teachers, and parents through their respective prevention initiatives.

Alcohol and Drug Safety Action Programs. These programs, which are available statewide through county alcohol and drug abuse authorities, provide education, intervention, and treatment services to persons convicted of driving under the influence (DUI) to reduce their risk of committing another DUI offense. Since 1982, South Carolina has required all convicted DUI offenders to complete an Alcohol and Drug Safety Action Program as a condition for driver's license reinstatement.

Employee Assistance Program (EAP). Assistance to any person employed in South Carolina whose productivity has deteriorated as a result of alcohol or other drug abuse is available through a local Employee Assistance Program. These programs are offered throughout the state through county alcohol and drug abuse authorities. Employers refer employees in an effort to restore them to an acceptable level of job performance. EAP services must be purchased, either by employers or individuals. The programs offer an alternative to employment termination.

Offender Based Intervention (OBI). OBI programs provide services to individuals referred to the county authorities by the criminal justice system after an alcohol- or other drug-related arrest, excluding DUI. These programs provide education, intervention, and treatment services in lieu of criminal prosecution.

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Illinois: A Statewide Initiative And An Alternative To Incarceration

Profile: In 1989, the governor and Illinois legislators enhanced state efforts to combat widespread abuse of alcohol and other drugs by approving a $44.3 million plan, titled Drug Free Illinois. More than a dozen bills were passed, which established a three-pronged attack on substance abuse and allocated $20.8 million for treatment and prevention, $4.6 million for education, and $18.9 million for enforcement activities. Highlights of the initiative include the following:

Prevention. The Drug Free Illinois initiative provides $2.3 million in new general fund dollars to initiate or expand community-based programs in unfunded or underfunded prevention service areas. Funds will enhance efforts by the Department of Alcoholism and Substance Abuse (DASA). DASA's Division of Prevention and Education funds the following types of programs:

- o InTouch, the Illinois Network to Organize the Understanding of Community Health, which coordinates school-focused prevention programs statewide;
- o Comprehensive prevention programs, which are community-based programs that provide an array of services to meet the needs of local communities;
- o Innovative and minority services, which provide unique or model services for high-risk target populations. For example, a Rock Island program delivers comprehensive services to high-risk youths and their families through outreach efforts to community leaders, who are assisted through training and education. In Chicago, the Polish Welfare Association supplies culturally specific information and materials to Polish-speaking individuals; and
- o Statewide public awareness and education.

In addition, federal dollars from the Drug Free Schools and Communities Act have been allocated to place prevention workers in 22 communities with high infant mortality rates and high prevalence of alcohol and other drug use.

Women's services. Women consistently have been under-represented in the state's drug services programs. Drug Free Illinois combines $1.9 million in general fund money with $2.5 million in federal block grant funds to provide enhanced treatment and outreach services to women. Of special concern are the increased incidence of AIDS, pregnant women using drugs and alcohol, and child abuse and neglect related to parental addiction. An estimated 2,500 additional women will receive services through expansions supported by the Drug Free Illinois initiative. Major components of the women's service expansion include the following: creation of a comprehensive women's service center in Chicago; statewide expansion of specialized women's services; and statewide expansion of Project Safe, a joint project of DASA and the Department of Children and Family Services, which combines intensive outpatient alcohol treatment with parent training for mothers who have neglected their children.

Intravenous drug users' programs. Illinois currently ranks sixth nationwide in the number of diagnosed AIDS cases, with persons who use intravenous drugs emerging as the fastest-growing group. African-Americans and Hispanics are disproportionately represented among HIV-infected persons, female IV-drug users, and partners of IV-drug users. Of the pediatric AIDS cases in Illinois, about 75 percent are children born to women who used IV-drugs or were the sex partners of IV-drug users. Drug Free Illinois

targets $5.1 million in state general funds to expand treatment service capacity for IV-drug users by 16 percent, enabling 1,410 additional IV-drug users to receive outpatient and residential services. Groups targeted for increased services include minorities and women with children.

Youth. Consequences of youth alcohol and drug abuse include poor health status, car accidents, personal violence, increased criminality, and missed school or work. Of the 1.5 million Illinois youth aged 10-17 years, 70 percent are considered at risk for alcohol or other drug use. Drug Free Illinois pools $4.8 million in general funds with federal block grant monies to expand outpatient and residential substance abuse services for youth by 3,161 new admissions annually. Homeless adolescents and those within the juvenile justice system are targeted for increased services.

Criminal justice programs. According to the National Institute of Justice, 87 percent of persons arrested in Chicago in 1988 tested positive for drugs, and 75 percent of inmates surveyed reported illegal drug use at some point in their lives. The Drug Free Illinois initiative allocated $5.2 million to the criminal justice system to expand substance abuse services for individuals within the Department of Corrections and criminal justice system; fund a pilot home confinement program for substance-abusing offenders; support new night court programs to handle increased drug offense arrests; and increase service capacity for the Treatment Alternatives to Street Crime (TASC) program.

Funding: The $44.3 million legislative appropriation for "Drug Free Illinois" efforts is funded through an increased cigarette tax of ten cents per package.

Program Highlight:

Treatment Alternatives to Street Crime. TASC was initiated in Cook County in 1976 in response to a documented link between alcohol and other drug abuse and criminal behavior. By 1980, state government officials recognized the program's success and contracted with TASC to provide services statewide. The program acts as a liaison between the criminal justice system and the treatment system, and identifies substance-abusing offenders who desire treatment and demonstrate potential for rehabilitation. TASC assists the judiciary in making decisions about treatment alternatives to standard sentencing options. Based on state law and agency criteria, TASC implements court mandates and informs courts about treatment progress.

Clients. Under state law, TASC receives juvenile and adult court-referred offenders who have committed nonviolent crimes, including DUI. TASC attempts to intervene to prevent further alcohol or other drug abuse or criminal justice involvement.

Services. The TASC program screens court-referred offenders to determine their potential for rehabilitation, places clients in an appropriate residential or outpatient treatment setting, tracks the progress of clients in treatment, and communicates with the courts.

Funding. In 1989 TASC received $5 million in state general funds.

Results. TASC is a cost-effective treatment alternative to incarceration. In 1988, 679 offenders were deferred from incarceration and placed in a TASC program. The total cost of TASC treatment was $4.1 million as opposed to the potential cost of $21.7 million for incarcerating these offenders for two years. By opting for treatment over incarceration, the state saved more than $17.6 million in 1988. Based on Illinois' success, 25 states have implemented TASC programs. The Illinois TASC program recently expanded its scope to serve other populations, such as persons who receive general assistance, students, and persons who receive Supplemental Security Income due to an

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alcohol- or drug-related disability. With its expanded scope, the Illinois program's name was changed to Treatment Alternatives to Special Clients.

New York: Focus On Special Populations

Profile: New York's Division of Substance Abuse Services (DSAS) and the Division of Alcoholism and Alcohol Abuse fund and regulate numerous agencies and programs that offer prevention, treatment, and rehabilitation services to chemically dependent individuals throughout the state. Although most of the state-supported treatment programs are designed to serve a wide range of persons with alcohol and other drug abuse problems, several populations in New York are targeted for special services, including persons with AIDS and HIV infection, polydrug users of all ages, mentally ill substance abusers, the criminal justice population, youth and children of substance abusers, pregnant women and postpartum women, and homeless persons.

Program Highlight:

Homeless Services (HEART/SHARP) Project. More than 30 percent of the 40,000 to 50,000 homeless persons in New York City are estimated to abuse alcohol or other drugs. The Homeless Services Project is comprised of the Homeless Emergency Assistance Referral and Treatment (HEART) Program and the Shelter Assessment and Referral Program (SHARP).

HEART, sponsored by DSAS, conducts outreach in the streets of New York City. HEART began in 1985, under the Governor's Statewide Homeless Initiative, with 60 beds. The program now has 623 treatment slots, which are utilized at 96 percent capacity. HEART gives special attention to women, pregnant women, and adolescents.

SHARP is a cooperative effort that targets individuals in New York City's municipal shelters. Coordinating agencies include DSAS, the Division of Alcoholism and Alcohol Abuse, and the Office of Mental Health. The project offers crisis intervention, screening, and residential treatment program referrals to homeless substance abusers throughout New York City.

More recently, DSAS teamed up with the Metropolitan Transit Authority (MTA) and New York City's Human Resource Administration to expand SHARP to provide services to homeless persons with substance abuse problems who congregate in New York City's transit system and terminals. An MTA-Outreach Unit was established at Grand Central Terminal to provide on-site screening, assessment, and treatment for persons in need of such services.

Clients. The Homeless Services (HEART/SHARP) Project supports services in New York City and six targeted areas outside of the city for homeless persons with alcohol and other drug abuse problems who are found in shelters, hospitals, transit centers, or on the streets.

Services. The following services are provided in New York City by DSAS staff members and community-based agencies supported by DSAS and the Division of Alcoholism and Alcohol Abuse:

- Client outreach and screening in areas known to have significant numbers of homeless persons, using two mobile units;

- o Information and education to increase community awareness about alcohol and other drug abuse and prevention;
- o Assessment for alcohol and drug abuse and direct placement into drug-free and detoxification programs upon client request;
- o Referral to community agencies for medical, psychiatric, detoxification, housing, employment, legal aid, public assistance, and other services as needed;
- o Follow-up to determine that services were actually delivered;
- o Emergency food and shelter; and
- o Assistance in obtaining permanent housing upon completion of a treatment program.

Funding. 1989 funding for the project included $6.2 million in state general revenues and $4.7 million in federal dollars.

Results. In 1988 and 1989, HEART/SHARP outreach units interviewed 9,773 homeless persons who abused alcohol or drugs. Of those, 4,635 sought referrals to a variety of social service and substance abuse agencies.

Other Programs:

The Task Force on Integrated Projects (TFIP). TFIP was created in 1987 to ensure state agency coordination of prevention programs and services for persons who have multiple disabilities. The task force is a cooperative effort of the Division of Alcoholism and Alcohol Abuse, the Division of Substance Abuse Services, the Office of Mental Health, and the Education Department. TFIP disburses federal funds for innovative prevention and treatment services for high-risk youth. Currently, TFIP sponsors 62 demonstration prevention programs that serve a variety of client populations, such as youth with psychiatric disorders who are also substance abusers, underserved minority youth, adolescents who live in "welfare" hotels, and high-risk gay and lesbian youth.

Key Extended Entry Program (KEEP). An estimated 60 percent of New York's IV-drug users are thought to be infected with the human immunodeficiency virus, which causes AIDS. The Division of Substance Abuse Services developed the KEEP program to facilitate the entry of IV-drug users into long-term treatment, with an emphasis on difficult-to-reach persons who are at a high risk for AIDS. During an initial orientation and evaluation period, which may last up to six months, clients are maintained on methadone, educated about AIDS, and assessed for medical and social services needs. Upon completion of the KEEP process, individuals are referred to chemotherapy, drug-free treatment, or other health care agencies.

Women and children. The Division of Alcoholism and Alcohol Abuse has initiated a comprehensive program for women with young children and pregnant women who abuse alcohol and other drugs, principally cocaine and crack. Based on the eight-year statewide Fetal Alcohol Syndrome Program, the new effort includes the Department of Social Services, the Department of Health, and the Division of Substance Abuse Services. The approach includes outpatient alcohol and substance abuse outreach, prevention, treatment, case management, child care, follow-up pediatric services for a minimum of two years, and program evaluation. The program targets community health centers, WIC centers, Head Start programs, domestic violence shelters, and child protective services to reach pregnant women and women with young children.

Persons with multiple disabilities. The Division of Alcoholism and Alcohol Abuse is cooperating with the Division of Substance Abuse Services and the Office of Mental Health to develop innovative treatment models for special populations, including the following: persons with multi-substance abuse problems, especially those who are dependent on both alcohol and cocaine, as are more than one-half of the patients in "downstate" outpatient alcoholism programs; alcohol-dependent persons who have moderate psychiatric disorders, as do more than one-third of the patients in New York City's hospital-based alcoholism outpatient programs; and Vietnam veterans who have multi-substance abuse problems combined with Post-Traumatic Stress Disorder.

The Safe Summer Campaign. The Safe Summer Campaign is a statewide annual public information effort to discourage intoxication and promote safety in all family summer activities. This educational and media campaign, which is sponsored by the Division of Alcoholism and Alcohol Abuse, provides local councils on alcoholism and youth agencies with a prevention approach for organizing a variety of community-based activities.

New Jersey: Focus On Law Enforcement

Profile: In 1986, the governor of New Jersey identified drug abuse as the greatest single danger to the health and safety of the state's citizens and announced a long-range program to attack simultaneously both the supply and demand sides of drug abuse. A member of the Middle Atlantic Governors' Compact on Alcohol and Drug Abuse, New Jersey has one of the nation's toughest criminal justice systems for drug offenders. The compact commits states to coordinate their drug and alcohol laws and to share information and training sessions.

In response to the governor's call for action, the New Jersey Legislature unanimously adopted the Comprehensive Drug Reform Act of 1987 (1987 N.J. Laws, Chap. 106). This legislation implements strict punishment, deterrence, and incarceration of serious drug offenders. It also facilitates rehabilitation of drug-dependent persons to reduce the incidence of drug-related crimes and the demand for controlled substances. The act mandates the following penalties:

- First degree crime charges for persons who distribute drugs that lead to a death;
- Twenty-five years without parole for the kingpins of drug distribution networks;
- Five years for involving a juvenile in drug dealing; and
- Three years without parole for selling drugs within 1,000 feet of a school.

The act also mandates that persons convicted of any drug offense automatically lose their driver's licenses for a period of six months to two years, whether or not an automobile was involved. When a drug offender is younger than the minimum driving age, the loss of driving privileges goes into effect when the offender reaches the minimum age to apply for a driver's license. It is believed that this will be a significant deterrent for young people.

Funding: In addition to providing stern punishment for drug dealers, the 1987 legislation established the Drug Enforcement and Demand Reduction Fund, which ensures a funding base for substance abuse initiatives by assessing cash penalties against all drug offenders. Mandatory penalties start at $500 for possession of a single marijuana cigarette and range

up to $3,000 for more serious drug offenses. In 1988 New Jersey collected $3.5 million in mandatory cash penalties. In the first six months of 1989, an additional $2.5 million was collected. All monies collected are earmarked to provide a stable funding source for community-based drug prevention, education, and community awareness initiatives.

Before the new law could go into effect, the Legislature had to ensure funding for expanded prison space. This was accomplished through passage of a $198 million bond issue.

Results: Armed with the new law, New Jersey police arrested 65,000 suspected drug offenders in 1988, an increase of 25,000 over 1986. Arrests for distributing drugs in school zones accounted for 6,500 of these arrests. The state Division of Motor Vehicles suspended the licenses of more than 9,500 drug offenders in 1988 for at least six months. The number of suspended licenses jumped to 16,960 in 1989, and the number continues to increase in 1990. In a 1989 survey of New Jersey high school students, 41 percent reported that the risk of losing (or postponing the acquisition of) their driver's license "strongly influences" their decision to use an illicit drug; 18 percent said the new law influences them "a little;" 25 percent reported that the law makes no difference to them (which includes those who would not use drugs regardless of the law); and 16 percent said they did not know about the law.

Other Programs: In 1989 the Legislature established a Governor's Council on Alcoholism. The council is mandated to submit a Comprehensive Statewide Alcoholism and Drug Abuse Master Plan to the governor and the Legislature annually. The council will review state agency budgets for alcohol and drug abuse initiatives and make recommendations for expenditures. Additionally, the council will develop regulations and procedures for expenditures of the Drug Enforcement and Demand Reduction Fund.

Pennsylvania: Assessing The Need And Launching A Statewide Initiative

Profile: Pennsylvania made a concerted effort to determine its alcohol and other drug abuse problems and needs. To identify areas of greatest need, the Governor's Drug Policy Council sponsored public forums and invited police, teachers, students, parents, community leaders, treatment professionals, and persons recovering from drug and alcohol addiction to describe anti-drug efforts and areas of need.
Pennsylvania policymakers learned that an estimated 1.2 million men, women, and children are addicted to crack, cocaine, alcohol, or other drugs. More than one-third of all Pennsylvania families are directly affected by these addictions. Between 1985 and 1989, admissions to drug treatment centers for cocaine addiction increased nearly 1,000 percent. Over the past decade, arrests for drugs and drug-related offenses increased 97 percent, with an 858 percent increase in cocaine arrests during the same period. The estimated cost to the state's economy through government human services, health care, and lost productivity is more than $10 billion a year.

In response to these findings, the governor launched a statewide substance abuse enforcement, prevention, and treatment initiative called "PENNFREE." The governor and the General Assembly agreed to earmark $90 million in 1989 to support the plan over a two-year period.

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Services: PENNFREE's monies will be used for the following purposes:

- o $37.6 million will go to law enforcement agencies to accelerate investigation and prosecution of drug-related cases and expand drug and alcohol services to offenders in state prisons, on probation, or parole.

- o $20 million earmarked for education and prevention efforts in schools and communities will finance the following: school-based prevention education in kindergarten through grade 12, community and grass-roots drug prevention efforts, student assistance programs in junior and senior high schools, and outreach and treatment for IV-drug users and their children.

- o Drug and alcohol treatment services will receive an additional $32.6 million to expand local programs for the following PENNFREE treatment priority groups: substance-abusing women with young children; substance-abusing pregnant women and addicted newborns; prison inmates; low-income individuals in need of long-term residential treatment; and other victims of drug and alcohol abuse, including children, families, and homeless persons.

Funding: Reserves from an earlier surplus of state monies were dedicated to fund PENNFREE. When added to more than $170 million of existing state and federal funds targeted for drug and alcohol programs, PENNFREE provides Pennsylvania with $260 million to combat alcohol and drug abuse.

Virginia: Focus On Prevention For Youth

Profile: Virginia requires local governments to have a Community Services Board responsible for substance abuse, mental health, and mental retardation services. The boards are to ensure a continuum of substance abuse services, including inpatient, residential, outpatient, day support, and emergency services. Local services are funded by a combination of federal block grants, state general funds, local funds, and third-party payments for services.

The Department of Mental Health, Mental Retardation and Substance Abuse Services is responsible for planning, coordinating, and evaluating a state plan for substance abuse. The 1989 Interagency Comprehensive Substance Abuse Plan documented substance abuse-related activities from 17 state agencies and their plans for the coming biennium. The plan established an interagency process that produced major goals, objectives, and strategies to form a base for future planning initiatives.

Program Highlight: **The Commonwealth Alliance for Drug Rehabilitation and Education (CADRE).** CADRE actively involves citizens at both state and local levels to create, develop, and maintain a coordinated interagency effort focused on decreasing juvenile substance abuse. CADRE is a public/private partnership divided into three operating bodies: the state CADRE, local CADREs, and the CADRE Foundation.

At the state level, CADRE brings together eight state departments to combat substance abuse through interagency efforts, including the Office of the Attorney General; the Departments of Education; Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Motor Vehicles; State Police; Alcoholic Beverage Control; and Criminal Justice Services. State CADRE helps stretch existing resources and guarantees that state experts are available to assist local drug education, prevention, intervention, treatment, and enforcement efforts. The alliance operates a statewide hotline, conducts

media campaigns to foster parental involvement, encourages local CADRE organizations to develop community awareness and interagency networking, and hosts an annual conference.

At the local level, businesses, residents, and public agencies cooperatively identify community needs through local CADRE chapters. Local CADREs are encouraged to include members of community services boards in their planning efforts.

Services. Local CADRE programs mobilize communities and can provide a variety of services, including education, prevention, early intervention, treatment, and rehabilitation. Following are examples of local programs and the services they provide:

- The Bland County CADRE works extensively with the Prisoners Assisting Youth Program at the Bland Correctional Center to educate youth and parents about drug use and abuse.

- The Hampton CADRE focuses on improving educational services to parents by: developing and distributing a booklet to parents of fourth, sixth, and ninth grade students; developing and presenting programs to parents of sixth through eighth graders at four middle schools; developing and implementing an intervention program for high-risk students; and developing and implementing the Life Force Program to tackle teen drinking and keg parties.

- The Norfolk CADRE trained coaches and Drug Abuse Resistance Education (DARE) officers to implement alcohol and drug prevention components for athletes at all five high schools, developed and implemented drug prevention clubs in all schools, and administered a drug education survey and distributed results to all middle and senior high schools.

- The Roanoke Area CADRE combats substance abuse through the following activities: parent awareness seminars, monthly drug-free recreational events for youths age 10 to 19, and a letter campaign to law enforcement officials informing them of after-prom parties and urging serious treatment of any young person driving and using alcohol or other drugs.

Funding. State CADRE is funded by the federal Drug Free Schools and Community Act and the CADRE Foundation. The foundation, the fundraising arm of CADRE, seeks resources from private businesses to combat alcohol and other drug abuse among youth. In 1988 the General Assembly increased funding for community-based substance abuse treatment by $13.2 million for the biennium to enhance or expand substance abuse services.

Other Programs:

The Governor's Council on Alcohol and Drug Abuse Problems. The council is comprised of state agency representatives, private citizens, and public sector service providers. The council coordinates both public and private efforts to control alcohol and drug abuse and makes broad policy recommendations to the governor. Additionally, the council awards funds from the federal Drug Free Schools and Community Act to programs that target high-risk youth.

Florida: Treatment For Offenders

Profile: The Alcohol and Drug Abuse Program was created as part of the Florida Department of Health and Rehabilitative Services (HRS) to oversee the state's substance abuse prevention, intervention, and treatment efforts; to facilitate effective use of state resources; and to foster the development of new resources. The program provides funds to the 11 HRS districts, which contract with approximately 94 community-based alcohol and drug abuse agencies to deliver prevention, intervention, and treatment services statewide.

In 1989, of the more than 38,000 offenders sentenced to Florida's prisons, approximately 53 percent had drug and alcohol problems. The Florida Legislature responded to the drug programming needs within correctional institutions by allocating an additional $1.5 million to fund 60 substance abuse counseling positions and to assist with outside contractors' services.

Program Highlight: **Substance Abuse Programs.** These programs comprise a comprehensive statewide treatment strategy within the Florida correctional system.

Clients. The programs serve inmates with addictions to alcohol or other drugs.

Services. Inmates receive substance abuse assessments at all reception locations and are assigned to a prison with appropriate treatment services based on severity of addiction, length of sentence, and receptivity to treatment. The substance abuse programs provide a continuum of services identified by the following tiers:

- Tier I: Drug Education. This 40-hour program provides drug information and education, with an introduction to group counseling techniques to offenders who do not have a severe substance abuse history or who have very short sentences. Participants are encouraged to follow up with continued group counseling in community support groups or are referred to appropriate treatment services.

- Tier II: Modified Therapeutic Community. This intensive eight-week program is designed for inmates with serious substance abuse problems who will not be in the correctional system long enough to participate in a more extensive program. Offenders receive frequent individual and group counseling with referrals to other levels of treatment within the correctional institution or to community-based programs.

- Tier III: Therapeutic Community. This nine- to 12-month full-service residential therapeutic community program places inmates in an isolated unit, separated from the general prison population, to establish psychological and physical safety. Staff members include ex-offenders and ex-addicts. Clients are given progressively higher-level positions as they prove themselves through involvement in confrontation and support groups, individual counseling, community and relationship training, and a variety of other therapeutic activities.

- Tier IV: Community Aftercare. This program provides 10 weeks of outpatient/aftercare treatment stressing relapse prevention and supportive therapy. Individual, group, and family counseling sessions focus on preparing participants to re-enter the community. Participants are encouraged to make connections with community-based drug treatment programs, self-help support groups, and other aftercare services.

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- o Tier V: Tracking System. This program ensures proper assessment of an inmate and links all components of an inmate's treatment while in the correctional system. When an inmate exits the system, Tier V assists the individual to connect with appropriate community resources that may aid the individual's continuing abstinence.

The correctional system also supports a Drug Abuse Treatment Resource Center, which produces and distributes materials on substance abuse for counseling staff and inmates.

Funding. The Legislature allocated a total of $3.6 million in 1989-90 for alcohol and other drug abuse treatment within the correctional system from the following sources: general revenue, $290,000; block grant trust fund, $270,000; probation and parole line item, $645,000; and law enforcement trust fund, $2.4 million. An additional vehicle registration fee of $30 provides the funding base for the law enforcement trust fund.

Results. In FY 1989, available treatment slots in the correctional system totaled 6,276; the number is expected to more than double in FY 1990, to 15,915. The Department of Corrections is completing an evaluation of substance abuse programs within the correctional system. The department is using a pre-test/post-test design to measure educational and psychological outcomes of treatment.

Other Programs:

ALPHA Programs. ALPHA programs were created to prevent future alcohol or other drug abuse by high-risk elementary school children. High-risk individuals are identified by their aggressive behavior, reading difficulties, or family adjustment problems. Through collaborative efforts among community-based treatment providers, local school systems, and the state, ALPHA programs provide assessment, student and family counseling, parent education, teacher training, and referral to health and welfare services. Children who participate in ALPHA programs exhibit improved math and reading skills and better behavior at home and in school. Fifteen to 20 children and their families are served in each ALPHA unit for 10- to 15-week cycles.

In 1989 there were 26 ALPHA programs throughout the state. Each program received approximately $65,000 from the Florida Department of Health and Rehabilitative Services and $50,000 from the local school district.

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VII. CONCLUSION

State legislatures increasingly are asked to make policy decisions about alcohol and other drug abuse in their states. Through the legislative process, state legislators pass laws that regulate alcohol and other drugs; appropriate funds for prevention and treatment programs; provide oversight to health and human services agencies that administer alcohol and drug abuse programs; approve rules and regulations for the administration of these programs; authorize the transfer of federal funds to state and local programs; conduct studies and hold statewide forums; and act as advocates at the federal level for the people directly affected by alcohol and other drug abuse problems.

Alcohol and drug abuse is related to many issues on state legislative agendas, including state economics, worker safety, increased state services, infant morbidity, AIDS, highway safety, crime, homelessness, mental illness, and at-risk youth. Such a complex set of problems requires a comprehensive policy approach of education, prevention, treatment, and law enforcement strategies. Since alcohol and drug abuse affects people of all ages and racial and ethnic backgrounds from diverse socioeconomic classes, legislators will be asked to fund strategies that meet the needs of various populations. In devising appropriate public service, state legislators would be well advised to consider a community-wide approach that incorporates diverse social systems, such as the family, the education system, workplaces, the media, government agencies, and community-based organizations.

This publication discusses various federal, state, local and private strategies to fund alcohol and other drug abuse prevention and treatment programs. Much can be learned from the successes and mistakes of other states that have addressed the alcohol and other drug abuse problem. State legislator will want to examine the strategies developed by other states and to examine the evaluations of costs and results in developing the most cost-effective programs. In addition to funding, states will need to examine ways to coordinate various agencies that receive separate federal funding. For example, alcohol and other drug prevention money appropriated by Congress is separate from money appropriated for AIDS, and states may administer services for persons with HIV and those for persons with drug problems separately. Although the connection between intravenous drug users and AIDS has been well documented, many state services have not been coordinated sufficiently to provide needed treatment to persons with substance abuse problems, especially pregnant women who may risk transmitting AIDS to their unborn children.

As with any public policy problem, the development of effective solutions for alcohol and other drug abuse will take time and careful deliberation by policymakers. NCSL hopes that the contents of this publication will serve as a valuable resource to state policymakers, as well as a catalyst for discussion and debate.

APPENDIX A

State Agencies for Alcohol and Other Drug Abuse

Alabama
Division of Substance Abuse Services
Department of Mental Health and Mental Retardation
205/270-4650

Alaska
Division of Alcoholism and Drug Abuse
Department of Health and Social Services
907/586-6201

Arizona
Division of Behavioral Health
Department of Health Services
602/255-1030

Arkansas
Office on Alcohol and Drug Abuse Prevention
501/682-6650

California
Department of Alcohol and Drug Programs
916/445-0834

Colorado
Alcohol and Drug Abuse Division
Department of Health
303/331-8201

Connecticut
Alcohol and Drug Abuse Commission
203/566-4145

Delaware
Division of Alcoholism, Drug Abuse and Mental Health
302/421-6101

District of Columbia
Health Planning and Development
202/673-7481

Florida
Alcohol and Drug Abuse Program
Department of Health and Rehabilitative Services
904/488-0900

Georgia
Alcohol and Drug Services Section
404/894-6352

Hawaii
Alcohol and Drug Abuse Division
Department of Health
808/548-4280

Idaho
Division of Family and Children Services
Department of Health and Welfare
208/334-5935

Illinois
Department of Alcoholism and Substance Abuse
312/814-3840

Indiana
Division of Addiction Services
Department of Mental Health
317/232-7816

Iowa
Division of Substance Abuse and Health Promotion
Department of Public Health
515/281-3641

Kansas
Alcohol and Drug Abuse Services
913/296-3925

Kentucky
Division of Substance Abuse
Department for Mental Health and Mental Retardation Services
502/564-2880

Louisiana
Division of Alcohol and Drug Abuse
Department of Health and Hospitals
504/342-9354

Maine
Office of Substance Abuse
207/289-2595

Maryland
State Alcohol and Drug Abuse Administration
301/225-6925

Massachusetts
Division of Substance Abuse Services
617/727-8614

Michigan
Office of Substance Abuse Services
Department of Public Health
517/335-8809

Minnesota
Chemical Dependency Program Division
Department of Human Services
612/296-4610

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Mississippi
Division of Alcohol and Drug Abuse
Department of Mental Health
601/359-1288

Missouri
Division of Alcohol and Drug Abuse
Department of Mental Health
314/751-4942

Montana
Alcohol and Drug Abuse Division
Department of Institutions
406/444-2827

Nebraska
Division of Alcoholism and Drug Abuse
Department of Public Institutions
402/471-2851, ext. 5583

Nevada
Bureau of Alcohol and Drug Abuse
Department of Human Resources
702/687-4790

New Hampshire
Office of Alcohol and Drug Abuse Prevention
603/271-6104

New Jersey
Division of Alcoholism and Drug Abuse
Department of Health
609/292-7836

New Mexico
Behavioral Health Services Division
505/827-2601

New York
Division of Alcoholism and Alcohol Abuse
518/474-5417

Division of Substance Abuse Services
518/457-7629

North Carolina
Alcohol and Drug Abuse Section
Division of Mental Health and Mental Retardation Services
919/733-4670

North Dakota
Division of Alcoholism and Drug Abuse
Department of Human Services
701/224-2769

Ohio
Department of Alcohol and Drug Addiction Services
614/466-3445

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Oklahoma
Department of Mental Health and Substance Abuse Services
405/271-8777

Oregon
Office of Alcohol and Drug Abuse Programs
503/378-2163

Pennsylvania
Deputy Secretary for Drug and Alcohol Programs
Department of Health
717/787-9857

Rhode Island
Division of Substance Abuse
Department of Mental Health, Retardation and Hospitals
401/464-2091

South Carolina
Commission on Alcohol and Drug Abuse
803/734-9520

South Dakota
Division of Alcohol and Drug Abuse
605/773-3123

Tennessee
Division of Alcohol and Drug Abuse Services
Department of Mental Health and Mental Retardation
615/741-1921

Texas
Commission on Alcohol and Drug Abuse
512/867-8700

Utah
Division of Substance Abuse
Department of Social Services
801/538-3939

Vermont
Office of Alcohol and Drug Abuse Programs
802/241-2170, 241-2175

Virginia
Office of Substance Abuse Services
Department of Mental Health, Mental Retardation and Substance Services
804/786-3906

Washington
Division of Alcoholism and Substance Abuse
Department of Social and Health Services
206/753-5866

West Virginia
Division of Alcohol and Drug Abuse
304/348-2276

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Wisconsin
Office of Alcohol and Other Drug Abuse
608/266-3442

Wyoming
Alcohol and Drug Abuse Programs
307/777-7115, ext. 7118

Guam
Department of Mental Health and Substance Abuse
671/646-9262

Puerto Rico
Department of Anti-Addiction Services
809/764-3795

Virgin Islands
Division of Mental Health, Alcoholism and Drug
Dependency Services
809/773-1992

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Table A

Classification of Psychoactive Drugs

Class	Examples	Effects for Which Used	Other Possible Effects
Opiates	Heroin, morphine, methadone, codeine	Euphoria, relaxation, mood elevation (reduction of pain, anxiety, aggressive or sexual drives	Drowsiness, Respiratory depression, nausea
Depressants	Barbiturates, methaqualone (Quaalude), diazepam (Valium)	Like alcohol: euphoria, relaxation, mood elevation	Drowsiness, mood volatility, respiratory depression, nausea, impaired coordination
Stimulants	Cocaine, amphetamine, nicotine methylphenidate	Euphoria, alertness, sense of well-being, suppression of fatigue and hunger, increased sexual arousal	Increased pules and blood pressure, tremor, insomnia, paranoia, psychosis, cardiac arrest
Hallucinogens	LSD, mescaline, psilocybin, MDA	Vividly altered perception, detachment from self	Increased blood pressure, tremor, impaired judgment and perceptions of time and distance, panic reaction
Phencyclidines	PCP, ketamine	Detachment from surroundings, numbness, distorted perceptions, illusions of strength	Anxiety, paranoid delusions, impaired coordination
Cannabinoids	Marijuana, hashish	Euphoria, relaxation, altered perceptions, increased sexual arousal	Increased appetite, impaired judgment and coordination, disorientation, paranoia, headaches
Inhalants	Acetone, benzene, nitrous oxide, butyl nitrate	Euphoria, giddiness, illusions of strength, distortions of visual perceptions	Hallucinations, slurred speech, drowsiness, headache, nausea, respiratory depression, cardiac arrest

Note: The effects of different compounds within each drug class differ in duration and in the specific combination of effects. In addition, the responses to a drug vary according to the dose level, the drug taker's prior experience with the drug, including current tolerance, the drug taker's prior mental and physical condition, and the situation. The effects of a drug change from immediate reaction across time to the clearing of extended responses, which may involve withdrawal symptoms after chronic use.

Source: Treating Drug Problems, Volume 1, Institute of Medicine; National Academy Press; (Washington, D.C., 1990), p. 63.

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Table B

Expenditures for State-Supported Alcohol and Drug Abuse Services By State and By Funding Source for Fiscal Year 1988

STATE	State Alcohol/ Drug Agency	Other State Agency	Alcohol Drug Abuse Block Grant	Other Federal Government	County or Local Agencies	Other Sources	GRAND TOTAL	
Alabama	2,178,625	91,798	5,679,658	304,679	449,287	1,295,004	9,999,051	
Alaska	13,356,800	1,307,965	2,245,900	1,947,691	4,351,482	1,988,209	25,198,047	
Arizona	10,217,844	600,000	5,191,678	N/A	N/A	7,872,020	23,881,047	ab
Arkansas	2,794,180	0	3,636,951	984,279	613,972	0	8,029,382	
California	81,300,000	5,421,000	34,961,000	29,362,000	37,102,465	73,328,205	261,474,670	a
Colorado	8,570,736	3,928,136	4,866,043	944,338	4,278,164	4,930,922	27,518,339	
Connecticut	32,323,405	90,000	6,785,755	2,723,204	0	16,029,459	57,951,823	
Delaware	3,017,991	60,477	1,387,285	45,756	0	9,930	4,521,439	
District of Columbia	115,437	26,401,256	2,847,030	140,346	0	1,267,218	30,771,287	c
Florida	34,091,580	1,095,000	20,966,923	195,995	18,783,166	0	75,132,664	
Georgia	26,921,692	0	6,599,822	1,205,472	1,142,093	3,350,884	39,319,963	
Guam	N/A	N/A	50,000	N/A	1,755,801	432,777	2,238,578	
Hawaii	1,305,632	429,863	2,111,746	279,877	9,000	973,665	5,109,783	
Idaho	1,812,762	3,500	1,493,432	238,651	0	0	3,548,345	
Illinois	50,624,900	250,000	15,817,000	1,365,000	N/A	N/A	68,056,900	
Indiana	3,212,073	10,803,146	3,614,095	3,049,562	1,426,469	N/A	22,105,345	
Iowa	7,598,499	940,865	4,237,214	194,178	2,117,779	2,595,744	17,684,279	
Kansas	5,771,552	381,408	2,582,561	401,084	1,831,112	3,151,165	14,118,882	
Kentucky	6,964,221	458,817	5,172,666	766,202	366,961	592,810	14,321,677	
Louisiana	3,430,962	0	8,131,299	333,562	0	337,331	12,233,154	
Maine	5,868,238	1,373,363	2,076,382	N/A	N/A	N/A	9,371,983	
Maryland	28,723,191	0	7,128,087	707,935	1,193,895	9,786,834	47,539,942	
Massachusetts	37,027,000	0	9,123,000	4,370,000	0	0	50,520,000	
Michigan	29,380,278	0	16,943,388	2,725,250	10,294,791	22,057,834	81,401,541	
Minnesota	25,376,233	N/A	7,557,468	2,823,500	10,295,424	N/A	46,052,625	
Mississippi	2,459,546	637,535	2,336,329	1,000,000	N/A	N/A	6,433,410	
Missouri	9,659,448	N/A	6,281,567	1,006,273	N/A	N/A	16,947,288	
Montana	525,071	2,075,250	1,415,447	849,801	1,280,180	6,239,852	12,386,601	
Nebraska	4,585,040	0	2,597,903	56,503	570,090	846,593	8,656,129	
Nevada	2,355,706	0	2,038,813	144,450	150,000	2,905,977	7,594,946	d
New Hampshire	1,778,954	0	1,264,073	9,683	0	14,350	3,067,060	
New Jersey	23,483,667	0	8,936,162	4,126,163	2,728,000	6,037,578	45,311,570	
New Mexico	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
New York	234,708,000	4,384,434	44,154,800	336,458	32,225,346	188,399,752	504,208,790	aefg
North Carolina	13,375,319	N/A	7,929,193	418,425	18,442,516	N/A	40,165,453	
North Dakota	1,272,859	N/A	1,069,173	196,828	N/A	N/A	2,538,860	
Ohio	16,824,275	9,298,292	14,129,867	6,820,720	4,916,003	11,783,068	63,772,225	
Oklahoma	5,828,536	0	3,030,522	651,000	0	0	9,510,058	
Oregon	7,355,621	20,125,396	5,058,083	20,938,578	5,131,311	1,991,929	60,600,918	
Pennsylvania	31,441,249	9,243,489	15,575,217	296,120	6,295,616	23,398,662	86,250,353	
Puerto Rico	16,161,425	2,588,824	4,459,584	1,289,880	N/A	N/A	24,499,713	h
Rhode Island	8,715,799	0	1,815,533	764,000	0	0	11,295,332	ij
South Carolina	8,672,905	5,138,621	3,486,509	1,666,430	4,045,518	6,458,469	29,468,452	
South Dakota	556,961	497,189	879,006	191,874	605,097	1,384,782	4,114,909	
Tennessee	7,348,068	1,274,701	4,287,392	1,298,958	3,816,970	3,018,560	21,044,649	
Texas	4,739,368	0	17,130,335	2,914,941	0	0	24,784,644	
Utah	5,769,767	1,208,828	2,763,304	699,287	2,825,171	3,219,236	16,485,593	
Vermont	2,122,549	327,645	1,431,446	115,700	0	422,433	4,419,773	
Virgin Islands	259,071	0	377,483	79,000	0	0	715,554	
Virginia	14,136,163	N/A	6,437,879	811,488	10,008,127	5,305,782	36,699,439	
Washington	29,355,372	0	6,150,849	1,057,777	0	0	36,563,998	
West Virginia	2,807,452	857,313	1,393,425	698,730	108,425	2,643,671	8,509,016	
Wisconsin	31,851,900	0	7,389,154	20,379,900	2,181,740	8,962,618	70,765,312	
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TOTALS	910,134,922	111,294,111	355,025,431	123,927,528	191,341,971	423,133,323	2,114,857,286	
PERCENT OF TOTAL	43.0%	5.3%	16.8%	5.9%	9.0%	20.0%	100.0%	

a Figures represent allocated funds rather than expenditures.

b Alcohol/Drug Abuse Block Grant includes $1,374,972 Alcohol and Drug Treatment and Rehabilitation (ADTR) Block Grant monies.

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Table B (Continued)

c Figures based on provisional year and expenditure report.
d County or Local Agencies category includes required matching funds.
e Other State Agency category includes lab revenues, methadone registry, capital construction, Medicaid MIS and suballocations from the Department of Social Services.
f Other Federal Government category includes the Federal Crime Control and Safe Street Act, Adolescent Detainee Project, and Western New York Prevention Project through the Division of Criminal Justice Services.
g Other Sources category includes Medicaid, client fees, and Juvenile Justice Prevention Funds.
h Other State Agency category funds are assigned by the State's Legislature for private programs and are not used in the Agency's operations.
i Figures represent an estimate of expenditures.
j State Alcohol/Drug Agency category includes substance abuse detox facility, DUI program and Treatment Alternatives to Street Crime (TASC) Program.

N/A Information not available.

Cautionary Note: In a number of states complete information is not available on all funding sources for state-supported programs. In most instances where such information is not presented, the amount of such funding, if any, is probably minimal. Since in some instances such funding may be substantial, the percents presented at the bottom of this table should be used only as gross estimates of the overall levels of funding from various sources. It is likely that the "Other State," "Other Federal," "County or Local," and "Other Sources" categories actually contribute more monies and higher percents than the figures shown.

Source: State Alcohol and Drug Abuse Profile, FY 1988; data are included for "only those programs that received at least some funds administered by the State Alcohol/Drug Agency during the state's fiscal year 1988."

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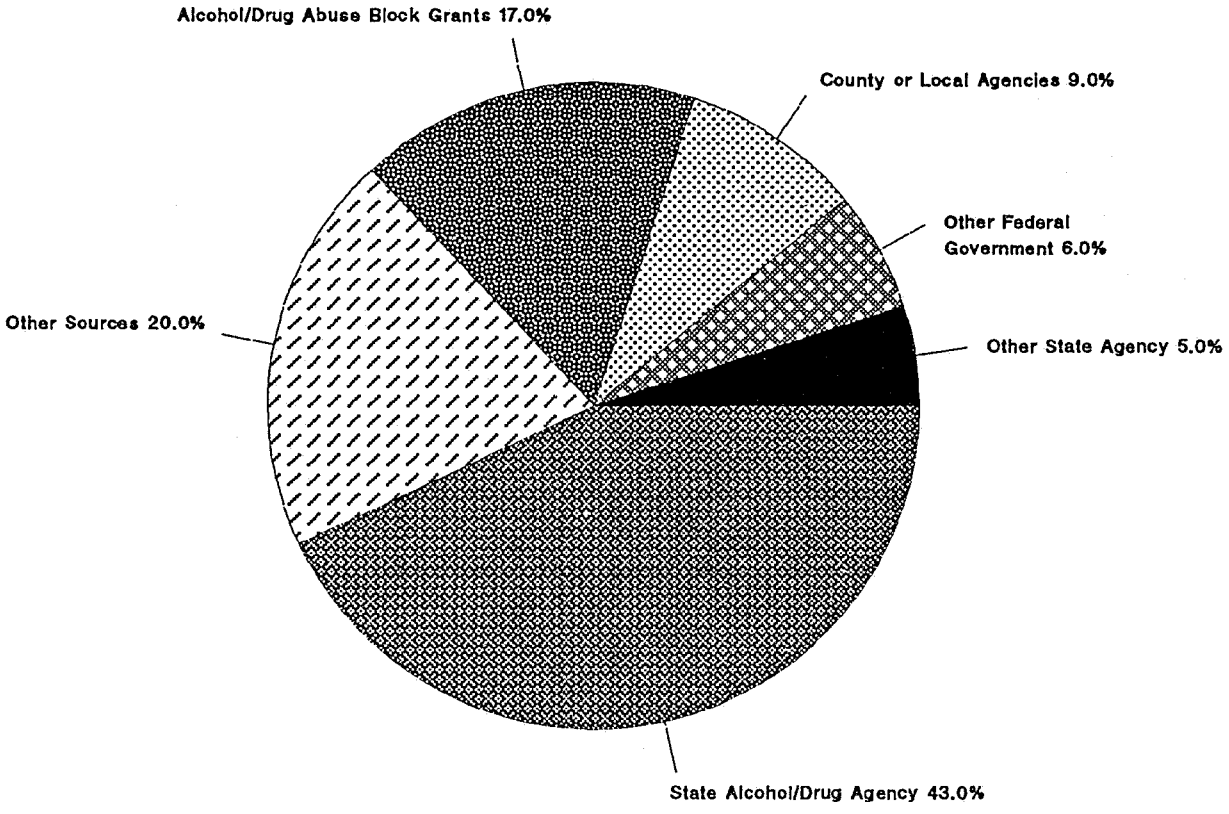
Figure 1

Expenditures for State Supported Alcohol and Drug Abuse Services by Funding Source for Fiscal Year 1988



Total alcohol and drug expenditures for FY 1988 were $2,114,857,286.

NOTE: The Other Sources category includes funding from sources such as client fees, court fines and reimbursements from private health insurance.

SOURCE: State Alcohol and Drug Abuse Profile, FY 1988; data are included for "only those programs that received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year 1988."

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