

# Substance Abuse

## BACKGROUND

Problems associated with using alcohol and other drugs (AOD) affect millions of Americans and have enormous financial and human costs. In financial terms, each year, AOD-related problems—including absenteeism, health and welfare expenses, property damage, accidents, and medical expenses—conservatively cost Michigan more than \$2 billion; lost productivity alone costs business and industry around \$700 million. Nationally, the statistics are staggering.

- AOD is the key factor in many violent crimes: manslaughter (as many as 68 percent), parental child abuse cases (64 percent), assaults (62 percent), murders/attempted murders (54 percent), robberies (48 percent), burglaries (44 percent), and rapes (42 percent).
- AOD use is a factor in more than 45 percent of all fatal automobile crashes (annually claiming almost 20,000 lives, one-third of whom were aged under 25) and 20 percent of all crashes involving injury (to more than one million people).
- The federal Centers for Disease Control and Prevention reports that almost half of all new HIV/AIDS cases are related to drug use.
- Annually, 20–35 percent of the nation’s almost 30,000 suicide victims have a history of alcohol abuse or were drinking shortly before they died.
- As many as three of every 1,000 babies are born with fetal alcohol syndrome, which is characterized by a variety of physical and behavioral traits, including prenatal or postnatal growth deficiency, abnormal facial features, and central nervous system deficiencies; fetal alcohol syndrome is the leading known environmental (and preventable) cause of mental retardation in the western world.
- At both two- and four-year colleges and universities, drinking has a negative effect on student grades: surveys reveal that “A” students average about 4 drinks a week, “B” students about 6 drinks, “C” students about 8, and “D or F” students about 11.

## Alcohol

By a substantial margin, alcohol is the most widely abused drug in every age group—including children. The 1997 Michigan Youth Risk Behavior Survey (MYRBS), reveals that many Michigan youths are exposed to alcohol use at a very young age, even before they graduate from high school. The survey of 9–12th graders reveals that

## GLOSSARY

### AOD

Acronym for “alcohol and other drugs.”

### Substance abuse

Patterns of alcohol and other drug use that impair one’s health or social, psychological, or occupational functioning.

### Substance dependence

Physical dependence occurs when the body adapts to alcohol or another drug and needs more to achieve the same effect or function; psychological dependence occurs when the user needs the substance to feel good or normal.

- 82 percent have had one or more alcoholic drinks;
- 32 percent have had five or more alcoholic drinks in a row; and
- 37 percent have ridden in a vehicle driven by someone who had been drinking.

Alcohol use also is substantial among Michigan's adult population. Studies reveal that

- 94 percent have consumed alcohol;
- in a given month, 52 percent consume alcohol; and
- in a given month, an estimated 5 percent are heavy drinkers (consuming 60 or more drinks), and another 19 percent are binge drinkers (consuming five or more drinks in a row on at least one occasion).

### Other Drugs

Marijuana is the most widely used illicit substance among all age groups. The 1997 MYRBS finds that among Michigan high schoolers

- 7 percent have used cocaine (including powder crack, or freebase) one or more times;
- 20 percent have used another type of illegal drug (e.g., LSD, PCP, heroin) one or more times;
- in a given month, 28 percent use marijuana one or more times; and
- in a given year, 36 percent have had someone offer, sell, or give them an illegal drug on school property.

The MYRBS statistics do not include the 15–20 percent of students who drop out of high school and are more likely to use alcohol and other drugs than those who stay in school.

Among adults, the 1995 Michigan Drug and Alcohol Population Survey—published in fall 1997—reveals that

- nearly 40 percent have used marijuana (in a given month, 4 percent use it);

- close to 7 percent have used cocaine (in a given month, less than one percent use it); and
- almost 25 percent have used another type of illegal drug—e.g., hallucinogen, stimulant, heroin, other opiate, sedative, inhalant (in a given month, the figure is about one percent).

### Combating AOD Use

Surveys reveal that almost 10 percent of Michigan's population—more than one million people—either are dependent on or abuse one or more substances. From 1992 to 1994, more than 3,000 state residents died because of their substance abuse/dependence problem. Major state government initiatives to combat substance abuse fall into three categories: treatment, law enforcement, and prevention.

The Center for Substance Abuse Services in the Michigan Department of Community Health (MDCH) is responsible for carrying out state and federal substance abuse mandates. The center's key responsibility is to develop, administer, and coordinate public and private funding and other resources for substance-abuse prevention and other services. The center contracts with 15 regional coordinating agencies, which, in turn, identify local needs and priorities and subcontract with local programs that provide necessary services.

The Office of Drug Control Policy, also under the MDCH, focuses mainly on enforcing drug laws and monitoring the state's Safe and Drug-Free Schools and Communities initiative—a state and federal government effort to curb drug use among teens. The office also oversees the Drug Abuse Resistance Education (DARE) program, which entails uniformed law enforcement officers teaching substance-abuse and violence prevention to children.

The Michigan Department of Education is responsible for one of the state's most comprehensive drug- and alcohol-use prevention efforts: The Michigan Model for Comprehensive School Health Education has been taught to almost one million K–8 Michigan students annually since its inception in 1983; it now is offered in 95 percent of Michigan public schools.

## SUBSTANCE ABUSE

State and federal funding for treatment and prevention is directed particularly to cocaine/crack abusers, pregnant female addicts, people with mental illness who use drugs, and substance-abusing women and adolescents in general. Intravenous drug users, because they are at very high risk for HIV/AIDS, also are targeted for treatment.

### DISCUSSION

Although people agree that AOD use has enormous economic and social consequences, they are uncertain about the best policy for alleviating the problem. As with any government program, the financial and other resources available for combating substance abuse are limited. As a result, policymakers must determine how those resources will be balanced among the three methods to combat the problem—prevention, treatment, and law enforcement.

Many argue for targeting a majority of resources toward prevention, because such initiatives often are the least expensive, reach the most people, and, in the long run, yield savings. Others argue for allocating more resources on treating those who currently have AOD problems, because this population is contributing to government's law-enforcement and corrections, health care, and other costs and setting a bad example for children. Finally, some contend that the funding priority should be law enforcement, because the rest of society deserves to be protected from those who engage in AOD use and drug trafficking.

Over the years, the state has invested heavily in all three approaches, and general substance abuse has declined. Although public programming gets considerable credit, some observers point out that the economy's role cannot be overlooked: When people are able to get a decent job, they are more likely to feel that they are economically secure and productive members of society and less likely to abuse alcohol and drugs.

The statistics presented at the beginning of this piece illustrate that despite improvement, the war on AOD dependence/abuse is far from over. There are many issues relating to AOD dependence/abuse, and the

discussion that follows presents three that are particularly contentious: whether the prevention focus should shift more toward families and women and away from single males; whether funding for treatment should be limited or have conditions attached; and the extent to which criminals directly or indirectly involved in AOD use/abuse should be punished/treated.

#### Women and Families

Although the proportion of AOD dependent/abusing women is rising, the majority of AOD abusers are single males. For several reasons, however, public policy's focus with regard to substance abuse prevention is shifting from single men to women with young children. This is impelled in part by research that suggests that there may be genetic predisposition toward alcoholism and also that addicts' children are much more likely than others to experiment with alcohol and drugs. In addition, drug-using mothers can pass their addiction on to their baby even before the child is born. The shift also is driven by studies that reveal that AOD use by pregnant women is a leading cause of birth defects, spontaneous abortion, fetal death, fetal alcohol syndrome, and low birth weight.

In Michigan, concern about mothers who abuse certain substances led to Public Act 581 of 1996, which classifies fetal addiction to AOD as potential child abuse/neglect that must be reported to the state. Under the law, health care providers, social workers, and certain others must report any reasonable suspicion that alcohol or any controlled substance is present in a newborn.

Legislation has been introduced to require mothers of addicted newborns to attend parenting classes; the objective is to reduce the likelihood of child abuse. Other legislation would require the state to notify the local prosecuting attorney when a newborn is found to have alcohol or another controlled substance in his/her blood; the objective is to permit prosecution for child abuse.

Supporters of such legislation argue that knowing that there will be serious legal or other consequences

will deter women from abusing substances while they are pregnant. They also believe such policies are necessary to safeguard children from future harm resulting from their mother's AOD abuse. Furthermore, they contend, mothers do much to shape their children's values in regard to AOD, and a child, if his/her mother is an abuser, may perceive that such behavior is appropriate and acceptable. Opponents argue that such legislation unfairly and unwisely places the onus of substance abuse prevention on women. They argue that unless society as a whole, rather than only half (women), takes responsibility for substance abuse, efforts to reduce it will fail.

In 1993 children's protective services workers (employees who investigate suspected abuse/neglect) confirmed that 273 infants were known to be victims of congenital drug addiction. In 1994 (the latest year in which such data were compiled) the number rose to 289. Such victims currently comprise 1.3 percent of all confirmed child abuse/neglect cases in Michigan.

### Spending for Treatment

Through the years the predominant view has been that abuse and dependency are diseases or manifestations of disease. Abuse/dependency has been viewed as a health issue, and Michigan policymakers have provided substantial public funds for treatment.

In FY 1995–96 the state spent nearly \$81 million (roughly three-quarters of the Center for Substance Abuse Services's \$108 million budget) on substance abuse treatment. That year, admissions to state-funded substance abuse treatment programs (outpatient, intensive outpatient, and residential and detoxification services) exceeded 86,000.

In FY 1996–97 state spending for substance abuse treatment is believed to have fallen (at this writing the expenditure figure is not available), and the number who received the services fell to just over 82,000 (officials believe the dip may be attributable to stricter standards being imposed for admission to treatment programs). Despite the decline, the state expects its substance abuse treatment costs to continue rising over time; the trend is upward—since FY 1989–90

such spending has risen more than 19 percent, mainly due to demand.

A substantial portion of state AOD-treatment spending is for Medicaid recipients, and these and most state health services to this population are being shifted to a capitated managed-care system. Under this scenario, Michigan's 15 substance abuse coordinating agencies will receive a fixed price per recipient per month to provide necessary care. Supporters of this step argue that if the per person treatment expenditure is capped, the money will go further, serving more people. The alternative, they assert, is to reduce the number of people who are served and/or eliminate/reduce certain treatment programs.

Opponents of the decision argue that it is not good economic or social policy to place a per-person cap on how much Michigan will spend: They point out that for every dollar the state spends on treating AOD dependents/abusers, it saves hundreds of dollars in other health care costs, spending for law enforcement and corrections, and other areas. They believe that a spending cap will cause the number of people with AOD problems to rise, resulting in higher costs elsewhere.

Another viewpoint is that the state should reduce its spending on all treatment because there is no conclusive evidence that such programs are successful. Many who argue this point suggest that AOD dependence/abuse is not a disease but rather a lifestyle choice; that is, people choose to use addictive substances and also whether they will stop. They assert that unless a person chooses to overcome an addiction, treatment will not work. Supporters of public spending for treatment programs counter that to overcome addiction, most people need emotional, physical, and other support; they may want to quit but do not know how and/or cannot deal on their own with withdrawal and the temptation to resume use.

Some policymakers, while believing that substance abuse is a disease or a manifestation of one, do not entirely discount the element of choice, and they support certain policies that provide consequences for making the wrong choice. For example, federal

## SUBSTANCE ABUSE

law enacted in 1996 prohibits states from administering federal Supplemental Security Income (SSI) benefits to people whose sole disability is drug or alcohol addiction. And in his 1998 State of the State address, Governor Engler proposed Operation Zero Tolerance—to end drug abuse among welfare recipients. The initiative, now incorporated into SB 944, would require people to be tested for drugs before receiving state government assistance. People who test positive would be referred to treatment; failure to participate could result in benefits being denied. The state estimates that at least 20 percent of women on welfare have drug or alcohol problems severe enough to warrant treatment.

Opponents of such initiatives argue that by denying SSI and other welfare benefits, the state is depriving AOD abusers' children of certain basic necessities, including food and clothing. Supporters contend, however, that children suffer equally or more when the state subsidizes a bad parental lifestyle.

Employers too are grappling with the dichotomy of substance abuse/dependency as both disease and choice. For many, the bill for substance abuse treatment has risen faster than their overall health care bill, and some are beginning to limit the length of treatment they cover. Those who object to treatment limits say they add to—not reduce—employers' long-term health care costs because inadequate treatment is likely to lead to relapse and future health problems. Others argue that the employer should not be solely responsible for providing treatment to AOD-using employees; when an employers' coverage for such services runs out, the employees themselves should help pay for their treatment. If an employee cannot gain control over his/her condition, the employer should have the prerogative of replacing him/her.

### Punishment

Another AOD-related policy issue is punishment for possessing or selling illicit narcotics. Each year in the United States, more than 8 million people are arrested for drug-related crimes. Currently, there are more than 1.3 million people in the nation's prison system, and this number is expected to grow by 25

percent in the next decade, mainly because of drug-related arrests.

Michigan lawmakers have appropriated substantial funding for law enforcement and passed strict sentencing guidelines (including life without parole for certain drug offenses and repeat offenders) in the hope of deterring drug possession and sales. The results are mixed. On the one hand, the arrest rate is up, and officials argue that this helps ensure public safety by deterring would-be offenders and locking behind bars those who commit drug crimes. On the other hand, the sheer volume of drug-related arrests and the cost of incarceration make it hard to do much for prisoners in the way of drug treatment.

Many people hold the view that drug suppliers/traffickers constitute a greater threat to society than those who use/possess drugs. This viewpoint, based on the addictive nature of many controlled substances, causes the public and policymakers to hold suppliers in great part responsible for the nation's drug and drug-related problems. This standpoint is reflected in the American judicial system, which tends to punish drug traffickers more harshly than those who buy or use illicit narcotics. It also is reflected in public opinion polls that indicate that more than half of all Americans support the death penalty for drug kingpins.

Whether for pushing, possessing, or using, however, the *type* of punishment frequently is the same—imprisonment; only the security setting and duration differ. Unfortunately, whether criminals are placed in minimum or maximum security, or whether they are imprisoned for only a few months or a lifetime, their incarceration is costly. Since the primary intent of prisons is to punish, financial resources for corrections are allocated mainly for personnel, facilities, and so on; rehabilitating substance-dependent inmates often is only a secondary objective. State data show that adult arrestees are over five times more likely than the general population to need but not receive substance abuse treatment.

This concerns many, who contend that when unrehabilitated prisoners are released, they usually

resume their abuse and the destructive behavior that accompanies it. They suggest that even if policymakers cannot find alternatives to incarcerating criminals who commit crimes or possess drugs to support their addiction, they should ensure that substance abuse rehabilitation is an integral component of their incarceration.

The Substance Abuse Programs Section (SAPS) of the Michigan Department of Corrections (MDOC) is charged with coordinating rehabilitation services for Michigan's substance abusing criminals. The section's rehabilitation strategy has four components.

- Outpatient treatment is provided by professionals from licensed treatment agencies as a first phase of service in all prison camps and several prisons. It also is offered to parolees, prisoners released to community corrections centers, and probationers. In FY 1995–96, more than 11,000 received outpatient treatment.
- Residential treatment is provided to prisoners or parolees whose need for structure is greater than can be provided through outpatient services. These clients often have exhibited behavioral problems or have unsuccessfully completed less intensive treatment. In FY 1995–96, nearly 3,000 received residential treatment.
- Prison staff who have received at least five days of training by the SAPS use both printed and video material to provide drug education/treatment in preparing prisoners for release. In FY 1995–96, 2,500 prisoners received such services. Prisoners also have access to self-help programs such as Alcoholics Anonymous and Narcotics Anonymous; each year, nearly 7,000 participate in the former and nearly 4,500 in the latter.
- Drug tests are conducted to monitor prisoners, parolees, and probationers and to deter them from abusing substances. In FY 1995–96, almost 335,000 drug tests were administered.

Over the years the SAPS's rehabilitation services have expanded substantially: In 1988—the year the sec-

tion was established—only 149 people received outpatient and residential care. In FY 1995–96, nearly 14,000 were served. From FY 1994–95 to FY 1995–96, the number served by outpatient and residential programs climbed almost 20 percent.

Although the SAPS regards its programs as successful, detractors argue that the programs are inadequate. Critics point out that prisoners, parolees, and probationers often must wait months to obtain outpatient or residential services, and once they in a program, many—nearly 40 percent—do not complete it. Supporters of the SAPS's efforts respond that its ability to serve all substance-abusing criminals who desire help is limited by the rapid growth of this population and a lack of corresponding funding. Also, SAPS officials point out that nearly one-third of participants drop out of outpatient and residential programs because they are paroled or transferred to a new prison.

Today, those who come into contact with the corrections system have better access to substance-abuse rehabilitation than did their predecessors, and studies indicate that those who undergo rehabilitation are less likely to repeat AOD-related crimes than those who do not. Still, funding for the SAPS's substance abuse education, treatment, and prevention operations in FY 1995–96 totaled less than \$14 million—approximately one percent of the entire corrections budget for the year. As the state's AOD-abusing criminal population continues to grow, policymakers will have to decide whether this funding level is adequate.

*See also* AIDS and HIV infection; Automobile Insurance; Child and Family Services; Corrections; Crime; Early Childhood Development; Tobacco Use and Regulation; Traffic Safety.

## FOR ADDITIONAL INFORMATION

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## SUBSTANCE ABUSE

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[www.madd.org](http://www.madd.org)

National Council on Alcoholism and Drug Dependence  
913 West Holmes Road, Suite 160  
Lansing, MI 48911  
(517) 394-1252  
(517) 394-1518 FAX  
[www.ncadd.org/index.html](http://www.ncadd.org/index.html)

Office of Drug Control Policy  
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320 South Walnut Street  
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[www.mdmh.state.mi.us/ODCP/index.htm](http://www.mdmh.state.mi.us/ODCP/index.htm)

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