Massachusetts Profile

cigarettes

crime

traffic accidents

treatment

smoking

marijuana

prevention

heroin

health care

teen drinking

medicaid

lost productivity

cocaine

alcohol abuse

Alcohol, Tobacco & Drugs

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Department of Transitional Assistance
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Table of Contents

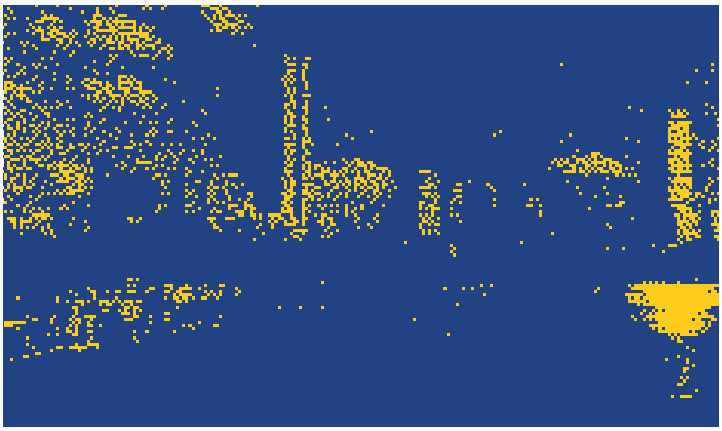
I. Introduction

This report is designed to inform the people of Massachusetts about the dimensions of the problems caused by tobacco, alcohol and illicit drugs, and about public and private initiatives to reduce these problems in their state. The aim is not to evaluate state efforts but to highlight positive developments and to identify areas to be strengthened. The report focuses on:

- the extent of alcohol, tobacco and illicit drug use
- drug and alcohol-related crime
- impact on health
- costs of substance abuse

This report is the first in a series of state profiles prepared by Drug Strategies, a non-profit organization in Washington, D.C., dedicated to promoting more effective approaches to the nation's drug problems. This project is supported by a grant from the Robert Wood Johnson Foundation.

In preparing this report, Drug Strategies worked with the Massachusetts Department of Public Health (Bureau of Substance Abuse Services, AIDS Bureau, Office for Non-Smoking, and the Bureau of Family and



Community Health), the Department of Correction, the Department of Transitional Assistance, the Department of Mental Health, the Department of Justice, and other agencies, as well as experts in prevention, education, treatment and law enforcement across the state.

A distinguished Advisory Panel guided the project. In addition, interviews with federal and state program officials, care-givers from treatment facilities, individuals in recovery and community groups helped provide a comprehensive picture of public and private efforts. While we are grateful for the insight and wisdom of those who contributed to the preparation of this report, Drug Strategies is solely responsible for its contents.

This profile will be distributed broadly in Massachusetts to legislators, researchers, private organizations, government agencies and the media. We hope it will increase public understanding of alcohol, tobacco and illicit drug problems in the state and generate political and financial support for more effective policies.

II. Massachusetts **Profile**

The Massachusetts population is large, young and diverse. The 13th-largest state in the nation, Massachusetts is home to 6 million people. One in five residents is age 18 or younger. Eight communities contain a quarter of the state's population and minorities make up 14 percent of the residents. Dominated by high-tech industries, small manufacturers, defense industry contractors and major financial services firms, the state is also home to 120 institutions of higher education.

During the past decade, changes in the Massachusetts economy have played a major role in shaping the state's response to substance abuse. Massachusetts endured a long period of recession in the late 1980s. Economic restructuring began in the early 1990s, but not before the poverty level rose to nearly 12 percent in some regions, accompanied by high unemployment rates (8.5 percent in 1992). Simultaneously, state budget cuts threatened the stability of substance abuse treatment and prevention efforts across the state.

By 1993, the economy began to rebound: per capita income was $20,985—15 percent higher than the national average of $18,177. With the economic recovery, the substance abuse budget and treatment admissions are again on the rise.

Massachusetts has established itself as a leader in addressing substance abuse problems. The state's **unique initiatives** include:

- a long-term school survey of adolescent substance abuse trends
- a 10-year database on publicly funded treatment admissions
- a managed care network for Medicaid recipients
- a comprehensive continuum of prevention and treatment services
- a series of innovative collaborations to address substance abuse

In addition, developments in several areas hold promise for continued leadership in the future. These include:

- the Massachusetts Tobacco Control Program
- the Quality Improvement Collaborative
- community partnerships
- citizen involvement in public health planning at the grassroots level

Organization and Funding. Massachusetts addresses substance abuse within its broad public health initiatives. The nucleus of the state's substance abuse programs is the Bureau of Substance Abuse Services (BSAS) in the Department of Public Health. Responsible for planning, funding and monitoring a network of treatment and prevention initiatives throughout the state, BSAS works cooperatively with other government departments to provide a continuum of services to clients entering the state system from various agencies. In addition, the Governor's Alliance Against Drugs (GAAD) receives $2 million per year from the federal Safe and Drug Free Schools and Communities block grant, of which it distributes $1 million for prevention programs in schools and communities around Massachusetts.

BSAS plays an integral role in most treatment in the state. Those who qualify for Medicaid receive the same treatment services (usually from the same vendors) as those who receive BSAS-funded treatment, although Medicaid is administered through a managed care system. The Department of Correction (DOC) funds treatment for inmates in state facilities, while BSAS funds treatment for inmates in county jails, a program for women in state prisons, and treatment for parolees from the DOC (some parolees may also qualify for Medicaid-funded treatment). BSAS also funds and administers treatment for probationers, as well as for first and second-time drunk driving offenders who are mandated to receive treatment by the courts and monitored by the Commission on Probation in the Department of Justice.

From 1985 to 1989, BSAS funding increased from $24 million to almost $39.5 million, but due to the recession, funds were slashed to $28 million in 1992. To cut costs, Massachusetts implemented a statewide program in 1992 that provided Medicaid recipients health care, including mental health and substance abuse treatment, through a **managed care** organization. This initiative is widely regarded as a prototype for state and federal health care reform efforts across the nation. In 1993, BSAS funding increased to $30 million; in 1994, the budget reached $32.7 million.

III. Substance **Abuse** in Massachusetts

While Massachusetts has outpaced the nation and the Northeast region in providing adult substance abuse services, the illegal use of alcohol, tobacco, and drugs by younger teens is on the increase and is consistently higher than national trends.

Alcohol. Good news here: drinking in Massachusetts has been declining in recent years. Per capita alcohol consumption dropped 19 percent from 1989 to 1991, while national alcohol consumption decreased only five percent during the same period. In 1993, one in twelve men in Massachusetts reported chronic drinking (60 or more drinks a month), a decline of 32 percent since 1988. One in three men reported binge drinking (five or more drinks at a time), which has remained relatively stable since 1988.

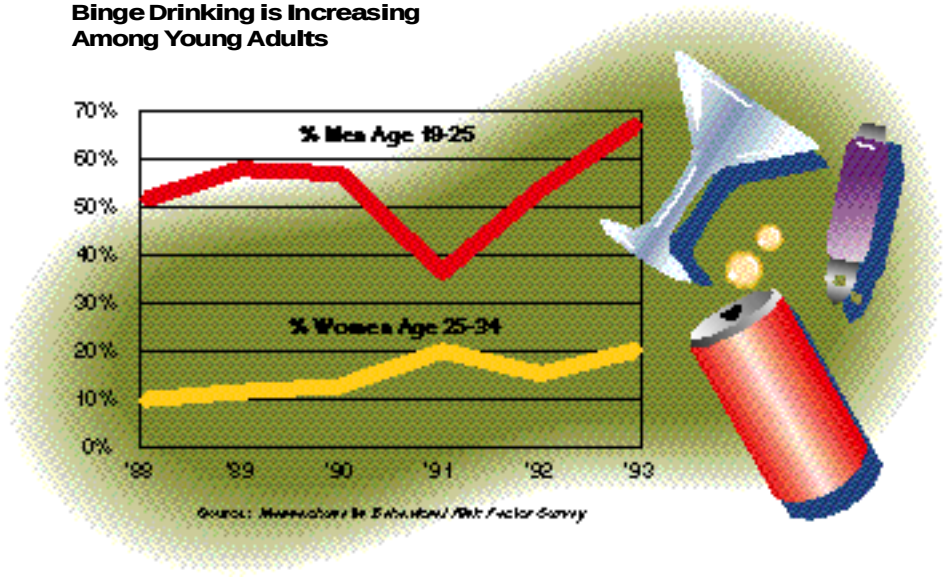
The bad news: men under age 25 consume more alcohol per capita than any other age or gender group. Binge and **chronic drinking** in this group have increased 31 percent since 1988.

About 11 percent of adult women in Massachusetts are binge drinkers, while 1 percent drink chronically. These rates have been stable since 1988. However, binge drinking among young women between the ages of 25 and 34 has more than doubled in the past seven years.

The picture of youthful drinking is disturbing. One in three teenagers reports having a first drink by age nine. By age 14, nine in ten have tried alcohol. In both 1987 and 1994, 28 percent of junior high school students drank at least once a month.

There is a bit of silver lining. Among older teenagers, regular drinking has been declining since the late 1980s. In 1993, 49 percent of high school students said they drank alcohol at least once a month, down from 60 percent in 1987.

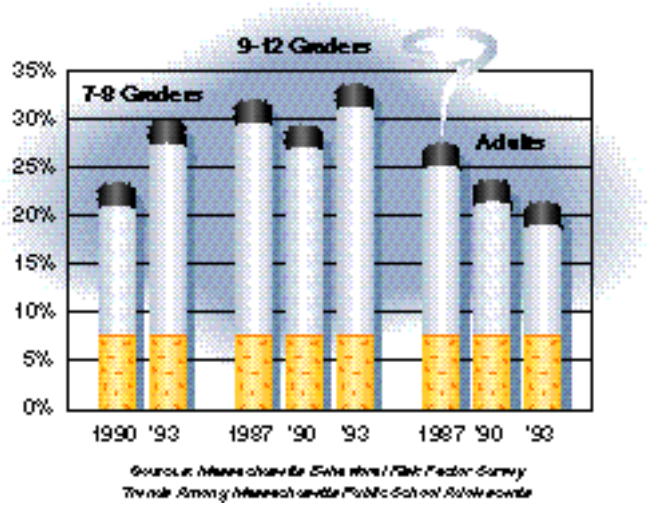
Binge Drinking is Increasing Among Young Adults



Tobacco. Adult smoking dropped 19 percent from 1988 to 1994. One in five Massachusetts adults smoked in 1994—a total of one million people, lower than the national average of one in four Americans. Cigarette sales in Massachusetts dropped 31 percent from 1987 to 1994, compared to a 27 percent decline nationwide.

However, 71 percent of women smokers in Massachusetts in 1994 were in their childbearing years (18 - 44), an increase from 58 percent in 1989. The consequences for this group are especially serious because of the health risks that maternal smoking poses for unborn children.

Current Smoking Increases Among Teenagers but Drops Among Adults



Approximately 100 children start smoking in Massachusetts every day. By 7th grade, one in five Massachusetts teens smokes daily; by 9th grade, the figure is one in three. Lifetime smoking (trying at least once) declined among 7th and 8th graders during the 1980s (down to 37 percent in 1990). But the downward trend has reversed since 1990. By 1993, 45 percent of these junior high school students reported having tried cigarettes.

Among high school students, smoking has not increased in the past decade: about two-thirds continue to try cigarettes, while one-third smoke regularly. Chewing tobacco and snuff are increasingly popular among young teens: use quadrupled between 1990 and 1993. One in four high school students tried smokeless tobacco in 1993. Regular use among teens of all ages (9 percent) was more than three times higher in 1993 (9 percent) than in 1987 (2.8 percent).

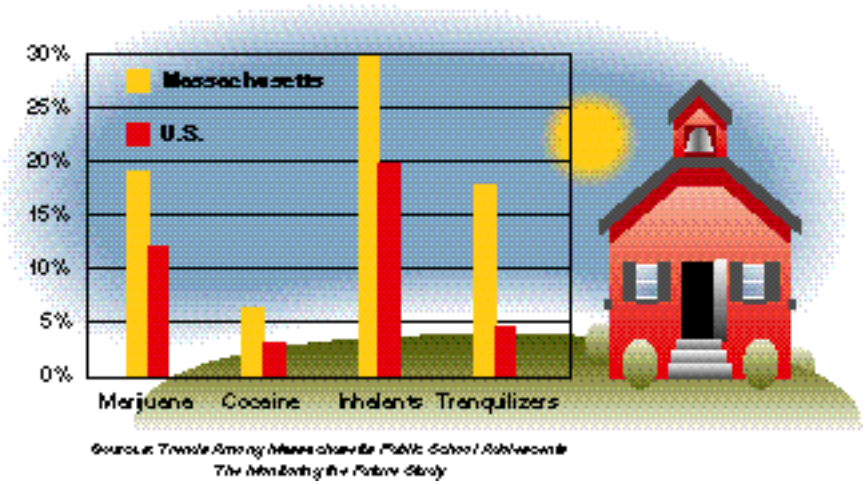
Illicit Drugs. Surveys of adult drug abuse are not presently available in Massachusetts. A treatment need survey will be completed in spring 1996. Instead, the Northeast regional rates reported in the annual National Household Survey on Drug Abuse are used as one estimate of drug use within the state. In 1993, this survey reported one in ten people in the Northeast used illicit drugs—lower than the national rate of one in eight.

Use patterns can also be estimated from "drug of choice" reports in state-funded substance abuse treatment programs. From 1990 to 1994, the percent of admissions reporting cocaine as their primary drug of choice remained relatively stable in Boston (about 27 percent) and elsewhere in the state (about 17 percent). During the same period, reports of **heroin** as the primary drug of choice increased from 15 percent to 27 percent. It is worth noting that the street cost of heroin decreased sharply during this period.

Among those admitted to treatment, alcohol use has decreased, while heroin, crack/cocaine and injection drug use have increased. In 1992, 38 percent of treatment admissions were for alcohol alone (31,700); 15 percent were for drugs alone (12,600); but 47 percent were for both alcohol and drugs (38,500).

Drug abuse is climbing among teenagers in Massachusetts and across the nation. As with drinking and smoking, adolescent drug use in Massachusetts declined in the late 1980s, but these gains were short-lived:

- Inhaling common household substances (glues, solvents and aerosols) is widespread among **young teens.** In 1993, one in four 7th and 8th graders tried inhalants, compared to one in 10 in 1990.
- Teenage marijuana use rose by 60 percent between 1990 and 1993; the lifetime use rate of 19 percent for 8th graders was 50 percent higher in 1993 than the national rate.
- In 1993, one in 20 junior high students had tried cocaine or crack, more than twice the number in 1990.

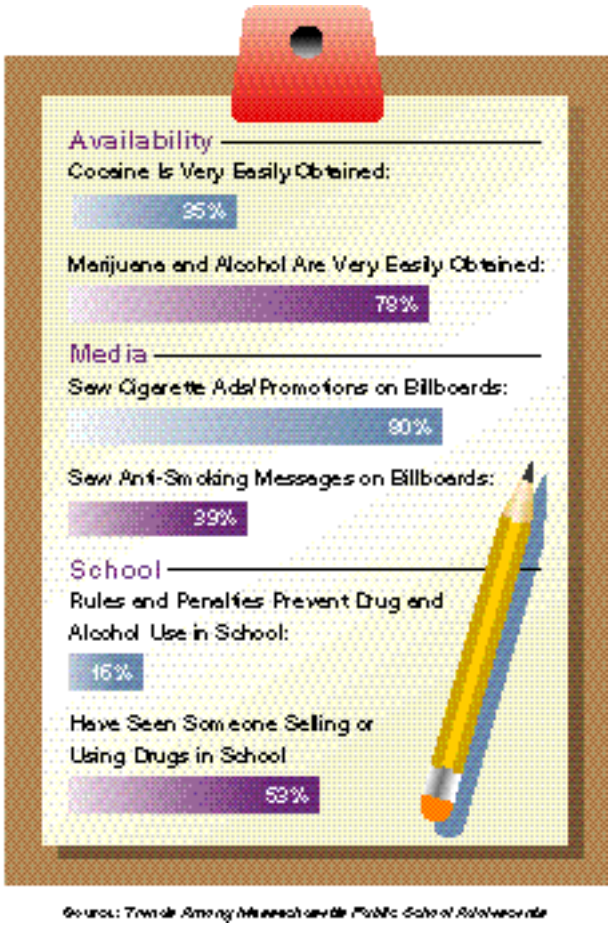


Drug Use by 8th-Graders Outpaces National Figures in 1993

Among older teens in Massachusetts, drug use trends are more encouraging. Although the rate of inhalant use rose slightly from 16 percent in 1990 to 19 percent in 1993, cocaine use dropped to 5 percent (a 57 percent decline), and rates for marijuana, psychedelic and amphetamine use also declined slightly.

Teen Perception of Alcohol, Tobacco and Illicit Drug Availability. Adolescents generally try drugs in stages: tobacco and alcohol before marijuana, and marijuana before other illicit drugs. Although it is illegal for teens in Massachusetts to purchase tobacco, alcohol and marijuana, 78 percent of high school students report that alcohol and marijuana are **easy to get,** while 93 percent say cigarettes can be easily obtained. More than half of Massachusetts high school students have seen illegal drugs sold or used in their public schools—a 12 percent increase from 1990.

What 7th and 8th Graders in Massachusetts Say About Alcohol, Tobacco, and Drugs



Source: Trends Among Massachusetts Public School Adolescents

How effective are school policies? In 1993, only 19 percent of high school students believed that rules and penalties prevent drug, alcohol, or tobacco use at school. Junior high students also report that it is easy to obtain alcohol (55 percent) and marijuana (35 percent). And they intend to avail themselves. In this age group, 40 percent say they are likely to use alcohol in the next year, 20 percent say they will smoke, and one in 12 say they will use drugs. We will soon find out the actual usage rates: the Department of Public Health plans to conduct a follow-up statewide survey of teenage substance abuse in 1996.

The Role of the Media. Editorials often are able to **influence policy** by mobilizing public opinion to support political and legislative change. At the two main Boston newspapers (*The Boston Globe* and *The Boston Herald*), editorial writers have addressed substance abuse with varying frequency over the past six years. Editorials about drugs vastly outnumber those about alcohol and tobacco, even though smoking and drinking have greater impact on health care costs.

Considerable attention was paid to illicit drug use in 1989 (51 editorials), 1990 (40 editorials) and 1994 (47 editorials). These editorials focused on various aspects of U.S. international drug policy as well as domestic issues, such as the strain on the court system from drug convictions, prevention efforts to reduce drug addiction in neighborhoods, and drug-addicted infants.

Editorials on alcohol abuse have been devoted primarily to drinking and driving, with the highest number occurring in 1994 (22 editorials). Tobacco—the least discussed editorially of the three substances—drew the most attention in 1994 (12 editorials), when a smoking ban in restaurants was introduced statewide.

Editorials generally follow the patterns of news coverage. For example, in March 1994, the death of a Boston minister after an anti-narcotics team mistakenly raided his residence prompted numerous editorials. However, those concerned with substance abuse issues should not wait for headlines before educating editorial boards about this important topic.

Making A Difference

Prevention Programs

Boston. Spreading the Prevention Message One Neighborhood at a Time.

Boston's neighborhoods are a multicultural patchwork. To tailor programs to neighborhood needs, Boston Against Drugs (BAD)—a unique collaboration between residents, government and leading corporations—identifies neighborhood-based strategies and models for substance abuse prevention.

The organization is made up of 16 teams, each working with residents from a different Boston neighborhood to identify local substance abuse issues. BAD then designs and implements a plan to address these issues. Local corporations are teamed with each of the 16 BAD teams. These BAD Business Partners work with the Neighborhood Teams in implementing the plans by providing administrative assistance and funding.

The results include the development of a Vietnamese language video on peer intervention in a substance abuse situation, a directory for Mission Hill residents on substance abuse prevention services, and a prevention training program for community youth workers. For more information, call (617) 635-3283.

Central Mass. Fighting Back and Striking Early. Given the substance abuse trends among young people in Massachusetts, early identification of problems is more urgent than ever. To that end, Worcester Fights Back (WFB), part of the Robert Wood Johnson Foundation's national Fighting Back network, is spreading the word about the importance of early identification and intervention in the war against drugs.

WFB has developed an extensive early identification network that helps professionals, parents and care givers develop expertise in identifying substance abuse at an early stage. The program reaches the Worcester community through a wide range of initiatives, each targeting a specific population segment.

For example, the High Risk Youth Initiative uses a student assistance program and a juvenile court substance abuse program to provide education on substance abuse issues and training on early identification and referral. Other initiatives target senior citizens, parents and the business and religious communities. To find out more about the Early Identification Program or other WFB programs, call (508) 752-0508.

Northeastern Mass. Community Coalitions Finding Solutions. The Gloucester Prevention Network (GPN) has formed coalitions with all segments of the community to develop strategies to combat substance abuse.

GPN trained high school peer leaders to teach middle school students about the health risks of smoking. The Network also worked with the Gloucester Board of Health to develop new regulations regarding exposure to second-hand smoke in public places and to enforce restrictions on minors purchasing tobacco.

Recently, GPN supported three middle school students who campaigned to establish a citywide ban on tobacco vending machines. The students went before the City Council and succeeded in having the vending machines banned everywhere except bars and nightclubs. To learn more about the Gloucester Prevention Network's wide range of services, call (508) 281-0311.

Making A Difference

Prevention Programs

Boston. Helping Teens "Krooz" Through Peer Pressure. If you want to prevent drunk driving among teenagers, you don't talk with them in groups—you rap to their crews—and most importantly, you do it all through peer-to-peer interaction. This is the strategy of "Krooz Controlled," a campaign to prevent underage drinking and driving, sponsored by the Arbella Mutual Insurance Company and the Medical Foundation of Boston.

The program developed a training manual, called "Road Rap," which trains young people to be peer leaders who can effectively convey the dangers of drinking and driving. Training sessions introduce the concept of prevention, discuss the physical effects of alcohol and other drugs, and explain how to plan and deliver a presentation on the risks of drinking and driving.

Krooz Controlled has provided this training manual free to all schools that request it. School administrators select trainees and a trainer to implement Road Rap.

So far, more than 200 schools have requested Road Rap and have trained members of their student body. To obtain Road Rap, call (617) 437-8493.

Northern Mass. Teaming Up to Provide Support for Our Students. The Carlisle Education Center, a division of the Education Development Center, Inc., has developed a comprehensive Student Assistance Program (SAP) to provide support for students with substance abuse problems or whose lives are impacted by a substance abuser. The program is available in all schools in the Lawrence Public School System and provides each school with a standardized method of responding to students in need. Each school has a SAPTeam made up of a senior administrator, guidance counselor, school nurse, and a classroom teacher. All referrals are based on observable information or behavior and students may be referred by any source, e.g., a teacher, parent, or fellow student. As a result of the referral, the student may be enrolled in a peer leadership or alcohol and drug education program, referred to a chemical dependency program, or to an outside mental health provider. To find out more about any of the programs at the Carlisle Education Center, call (508) 371-9898.

IV. Crime and Substance Abuse

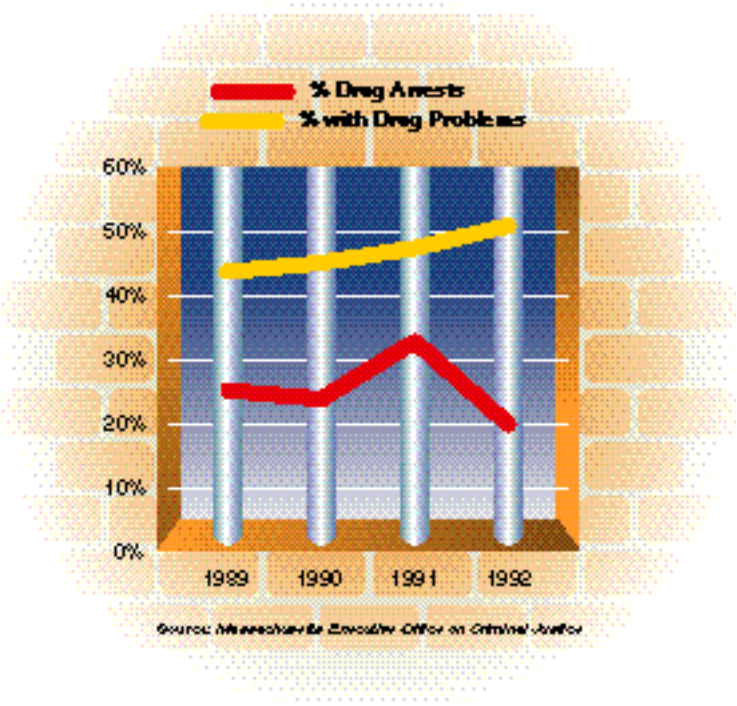
Substance abuse is the greatest single challenge for law enforcement, according to a 1993 survey of police departments in Massachusetts, with alcohol, cocaine and heroin reported to cause the greatest enforcement problems. From 1989 to 1993, Massachusetts arrests for drug possession fell from 25,812 to 10,730—a 58 percent decline. At the same time, arrests for drug sales dropped from 22,224 to 7,031—a 68 percent decline.

However, during this same period, incarceration for drug offenses increased. In 1988, 883 drug offenders made up 14 percent of the state inmate population. In 1993, the number of inmates in this category increased by 123 percent—to 1,973—accounting for 20 percent of the prison population. In addition, the proportion of the inmate population with prior charges for one or more drug offenses increased from 47 percent in 1988 to 53 percent in 1993.

Substance Abuse By Arrestees and Prison Inmates. Regardless of the offense committed, substance abuse is a **widespread** problem among arrestees and convicted offenders in Massachusetts. In 1992, about half of all those arrested reported having a drug or alcohol problem—a rate 21 percent higher than just four years earlier.

Within prison, the figures are even worse. According to Department of Correction surveys, alcohol abuse problems among incarcerated offenders doubled between 1989 and 1991. Four out of five inmates have a history of drug abuse, and one in two has a history of daily alcohol or drug abuse. In addition to alcohol, cocaine and marijuana are the drugs of choice for at least three-quarters of Massachusetts prisoners.

Fewer Drug Arrests, More Drug Problems Among Total Arrestees

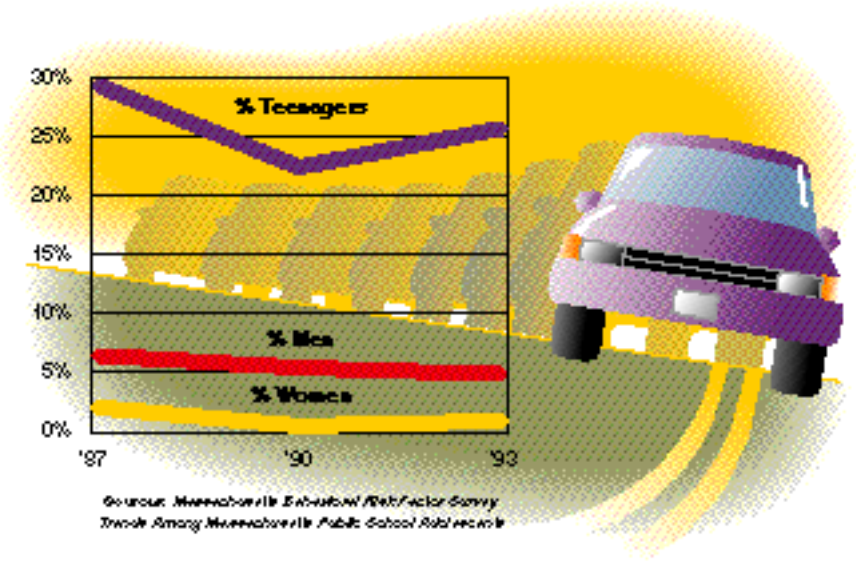


Alcohol and drugs were problems for 76 percent of adult probationers in 1994 (up 21 percent from 1989), although only 19 percent committed drug crimes. The same is true for juvenile probationers: 53 percent had alcohol or drug problems in 1994, but only 8 percent were drug offenders.

Drinking and Driving. According to self-reports, drunk driving in Massachusetts dropped by a third in recent years. The number of adult men admitting to driving after drinking dropped from 7 percent in 1988 to 5 percent in 1993. Rates among adult women have remained very small.

Unfortunately, after declining in the late 1980s, teenage driving after drinking is again on the rise. Twenty-seven percent of Massachusetts teens admitted to driving after drinking in 1993—up 22 percent from 1990. It is encouraging to note that teens who drink and drive report drinking less alcohol than in the past. In 1993, one in nine had had five or more drinks before getting behind the wheel, compared to one in six in 1987.

Drugged driving, however, is increasing rapidly. Fully one-fifth of the Massachusetts high school population drove after smoking marijuana in 1993, double the number in 1990.



Driving Under the Influence (DUI) convictions now account for over one-third of all probation cases in Massachusetts, up from one-quarter in 1989. However, arraignments and convictions for DUI dropped 42 percent from 1988 to 1992. Reasons for this sharp decline include decreased funding to cities and towns for police personnel, the change of political emphasis on DUI arrests, and education efforts.

Drinking and Driving Up Among Teens, Down Among Adults

The legal limit for blood alcohol in Massachusetts was .1 percent until 1994, when it was lowered to .08 percent—the equivalent of about two or three drinks—one of the toughest standards in the country.

Treatment for Drug Offenders and Convicted Drivers. BSAS, the Department of Correction (DOC) and the Office of the Commissioner on Probation work together to provide **treatment** for drug offenders and drunk drivers. Both the offender's sentence and criminal history determine the type of facility and treatment provided. An increasing percentage of criminals convicted of drug-related offenses serve their sentence in county jails rather than in state prisons. The number of jail sentences for drug offenses in Massachusetts increased between 1989 and 1993, while state prison sentences for drug crimes decreased.

BSAS and the Executive Office of Public Safety have contracted with licensed community organizations to provide treatment in the state's 13 county jails. After release, inmates can continue receiving treatment through BSAS without interruption. First-time DUI offenders are given a 16-hour driver alcohol education program; second-time offenders are required to complete a 14-day residential program as part of their probation. Both programs are licensed and monitored by BSAS. Multiple DUI offenders (three or more convictions) are sentenced to a 90-day prison program administered by DOC.

DOC provides most of the substance abuse treatment in state correctional facilities, although the Department of Health funds substance abuse services in the women's prison. DOC's treatment budget for 1995 is $1.6 million, which includes $300,000 for expansion of treatment programs to three minimum security facilities.

In 1993, DOC switched to a single-vendor system for treatment in state prisons to allow for consistent classification of prisoners, to enhance continuity of care across facilities and to simplify evaluation of program effectiveness.

Efforts are underway to create **alternatives to incarceration** for non-violent offenders with drug and alcohol problems. Following the recommendations of a Supreme Judicial Court Task Force, the Commission on Probation received a grant to open the first Massachusetts drug court in Dorchester in June 1995.

Making A Difference

Corrections Programs

Boston. Beginning Life Clean and Sober. Social Justice for Women runs a program for pregnant/post- partum, substance abusing offenders which helps them get clean and improve their babies' chances of being born drug-free.

Located on the Dimock Community Health Center campus in Roxbury, the Neal J. Houston House is a pre-release program which provides pregnant women who would otherwise be incarcerated with substance abuse treatment, prenatal care and parenting classes. Houston House also provides strong resettlement support for the transition back into mainstream society by helping new mothers contend with practical issues, such as housing, job placement, child care and continued substance abuse treatment. Since its beginning in 1989, Houston House has provided services to 125 women, and 91 healthy, drug-free babies have been born. Call (617) 445-3066 for more information.

Boston. Alternatives to Imprisonment for Low-Level Drug Offenders.

The Boston Coalition and the Office of the Commissioner of Probation are working together to rehabilitate low-level, non-violent, drug involved offenders before they become serious offenders. The Drug Diversion Court Program diverts selected offenders to an intensive court-supervised treatment program.

The program requires offenders to work with a primary counselor to formulate an individualized service plan which then serves as a contract between the client and the program. The service plan also helps guide the judge in the establishment of probationary conditions as they relate to treatment. Each offender must be enrolled in the program for at least one year and, as release nears, aftercare issues such as job development and placement are addressed. For more information contact the Boston Coalition at (617) 451-1441.

Boston. A Hope of Stopping a Killer. The Addict's Health Opportunity Program and Exchange (AHOPE) is a needle exchange program begun in 1994 by four local agencies cooperating with the Boston and Cambridge Police Departments. The program's goal: preventing the spread of HIV/AIDS among intravenous drug users who share needles.

The approach: offering supervised needle exchange, HIV counseling and testing, and medical care. The program also provides substance abuse counseling, offers case management services and provides a direct linkage to treatment.

There are eight locations in the Boston and Cambridge areas, and to date they have provided services to over 1,300 clients, 17 percent of whom have been referred for treatment services. To find out more, call AHOPE at (617) 534-3964.

V. Impact on Health

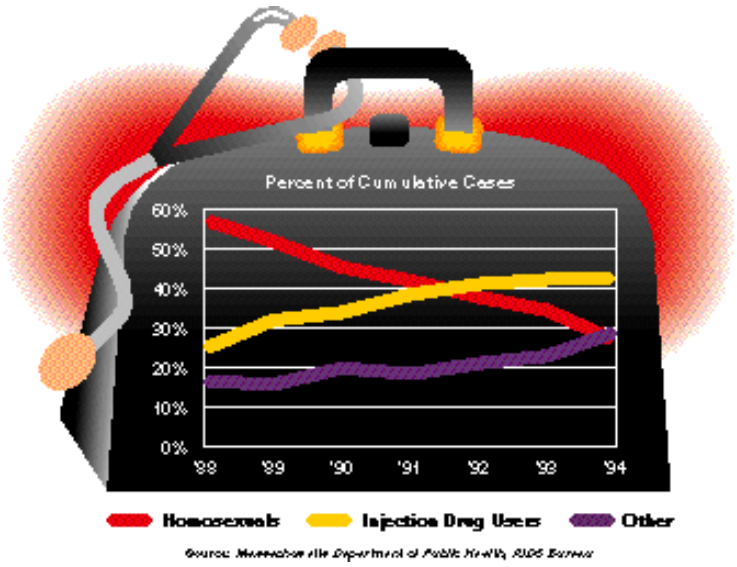
Substance abuse, like second-hand smoke and drunk driving, has far-reaching effects on the health of millions of Americans, even those who do not use drugs themselves. Substance abuse is a major factor in the spread of infectious diseases, the increase in hospital emergency room visits, newborn health problems, violence and auto fatalities. In addition, substance abuse greatly increases Massachusetts' **health care costs.**

Tobacco-related health problems include heart disease, cancers, emphysema, and other respiratory problems in both tobacco users and those who inhale secondary smoke. For alcohol abusers, chronic diseases of the liver, pancreas and heart are common, as are injuries resulting from drunk driving. Illicit drug abuse can result in a wide range of medical problems, including hepatitis, AIDS, severe weight loss, malnutrition, and psychosis. Infants born to substance abusers are at high risk for fetal alcohol syndrome, premature birth, low birth weight and developmental delays. Compounding these medical difficulties are drug- and alcohol-related domestic violence, suicide, joblessness, homelessness, child abuse and neglect.

Deaths From Substance Abuse. Smoking is the leading preventable cause of death and disease in Massachusetts, accounting for one in five deaths—about 26 people every day. Smoking kills more people in Massachusetts every year than AIDS, illicit drugs, alcohol, motor vehicle crashes, homicides and suicides combined. Because the deadly effects of chronic tobacco use take time to surface, it will be many years before the current declines in smoking are reflected in the numbers of smoking-related deaths.

Since the late 1980s, alcohol and other drugs have been directly responsible for about 2,000 fatal **overdoses** and other deaths in the state each year. On a positive note, the number of deaths from alcohol-related traffic accidents has dropped from 253 in 1989 to 132 in 1993—a decline of 48 percent. This includes drivers, passengers and pedestrians who died in alcohol-related accidents.

Injection Drug Users Lead in Massachusetts AIDS Cases



The AIDS Connection. Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) are deadly consequences of substance abuse. In 1993, the definition of AIDS was revised by the U.S. Centers for Disease Control and Prevention (CDC), allowing more cases to meet the criteria for AIDS. The number of AIDS cases increased for all risk categories in Massachusetts, but the largest increase was among injection drug users (IDU). Under the old case definition, 26 percent of AIDS cases were IDUs, whereas 46 percent of new definition cases are in this group.

Drug abusers are the fastest-growing group of new AIDS cases in Massachusetts. The number of new AIDS cases attributed to injection drug use quadrupled from 1993 to 1994, and injecting drug users now account for 43 percent of the cumulative AIDS cases reported in the state. This is not strictly an urban problem. Only 15 percent of new drug-related cases are reported in Boston.

Most HIV transmission results from **high-risk behavior**—either injection drug use or unprotected sexual activity. The combination of drugs and sex can be even more risky. Teens who use alcohol and illicit drugs are more likely to have multiple sex partners and less likely to practice safe sex. One in four sexually active Massachusetts teens says he or she used alcohol, drugs, or both before the most recent sexual intercourse.

Treatment for Substance Abuse. BSAS is responsible for planning, funding and monitoring a statewide network of publicly funded substance abuse treatment services. The treatment system is comprehensive, with a large continuum of services and extensive collaborations among state agencies, including the Departments of Public Health, Mental Health, Social Services, Youth Services, Correction, Probation, Parole, and the Medicaid system. In addition to the general public, BSAS provides treatment to people on probation and parole, inmates in county jails and women in state correctional facilities.

In fiscal year 1993, BSAS provided approximately $67 million for treatment and prevention programs in the state. Massachusetts provides greater substance treatment resources on a per capita basis than the national average (22 percent higher) and other states in the northeast (33 percent higher). While only 2.3 percent of the U.S. population resides in Massachusetts, the state administers about 5 percent of the nation's substance abuse treatment, and has the seventh highest statewide admission rate to publicly funded treatment programs in the country.

Substance abuse treatment in Massachusetts ranges from inpatient programs to outpatient clinics to residential treatment lasting up to a year. Between 1989 and 1992, admissions to publicly funded treatment programs in Massachusetts declined substantially, from 98,070 to 84,496—primarily due to a 30 percent decrease in state funding. By the end of fiscal year 1994, due to increased federal block grant funds, state funds, and Medicaid funding for clients, admissions were back to the 1989 level (98,190).

Substance abusers without private insurance coverage often face waiting lists when seeking treatment. At present, people seeking treatment may be counted on more than one waiting list, making it difficult to determine the level of demand. To address this problem, Massachusetts has a plan for a centralized **waiting list** that will facilitate statewide referrals for treatment. Once in place, this system will allow the state to count the precise number of people seeking treatment.

Making A Difference

Treatment Programs

South Boston. One House, Many Levels. Sponsored by the Arch Foundation, Gavin House offers prevention, education and treatment programs under one roof for substance abusers in the South Boston community. The treatment program for men has two components that address clients' needs at different stages of rehabilitation.

The residential program at Gavin House is equipped to house 30 male residents, many of whom are unemployed and/or homeless. In addition to the Alcoholics Anonymous Way of Life program, Gavin House also assists each client in becoming employed.

For clients who have completed the four-to-six month residential treatment program, Gavin House administers a secondary residence to provide extended support. While less structured than the primary treatment program, it requires residents to participate in after-care meetings designed to address long-term rehabilitation. To learn more about Gavin House, call (617) 268-5517.

Boston. Treatment for an Often Forgotten Population. Andrew House in Boston is a 26-bed voluntary detoxification and drug treatment center for men and women. What makes this inpatient program unique is that it serves a much-neglected population, the homeless.

Andrew House was designed to meet the needs of homeless men and women who are both chemically dependent and have a serious mental illness. The program provides clients with medically supervised detoxification, various types of counseling and carefully planned transitioning back into mainstream society.

This aftercare program regards highly structured living as crucial for successful reintegration into mainstream society. Therefore, clients are often placed in half-way houses, long-term sober centers and transitional care facilities to provide effective transition support and avoid relapse. Call Andrew House at (617) 479-9320 for more information.

Cape Cod. Comprehensive Treatment Services for Women of All Ages. Emerson House, a branch of the Gosnold Treatment Center, is a residential treatment center for teenage girls and women located in Falmouth, Massachusetts. Emerson House offers 30-day and three-month intensive treatment for adolescent girls and a prenatal/postpartum program for women substance abusers, as well as a program for adolescent and adult women with significant hearing loss.

For more information about Emerson House or any of the programs at the Gosnold Treatment Center call (508) 540-1554.

VI. Costs of Substance Abuse

Substance abuse reaches deep into taxpayers'pockets, increasing the costs of health care, criminal justice and other services. Beyond these direct expenditures, there are also indirect costs, such as the **lost productivity** of a young employee who dies from a drug overdose, or absenteeism due to alcohol abuse.

This section surveys eight cost areas: the total cost of substance abuse in Massachusetts, including Medicaid expenditures; Bureau of Substance Abuse Services expenditures; acute care hospital charges; federal grants for treatment services; Supplemental Security Income (SSI) payments; smoking-related cost estimates; incarceration and court costs; and costs of alcohol-related traffic accidents.

Treatment Costs. Substance abuse treatment is financially supported by a variety of sources, including grants from the federal Center for Substance Abuse Treatment (CSAT), BSAS, acute care hospitals and private treatment sources. Medicaid dollars may be used for services licensed by BSAS or in acute care hospitals.

Between 1989 and 1991, the budget of BSAS was reduced by $12 million. At the same time, unemployment was rising. As individuals lost their jobs and medical insurance, they were more likely to qualify for federally subsidized Medicaid programs. By 1992, BSAS'substance abuse budget reductions were partially offset by Massachusetts'increased contribution to the Medicaid program. State and federal Medicaid expenses for substance abuse in Massachusetts increased 25 percent between 1992 and 1993, rising from $28 million to $35 million.

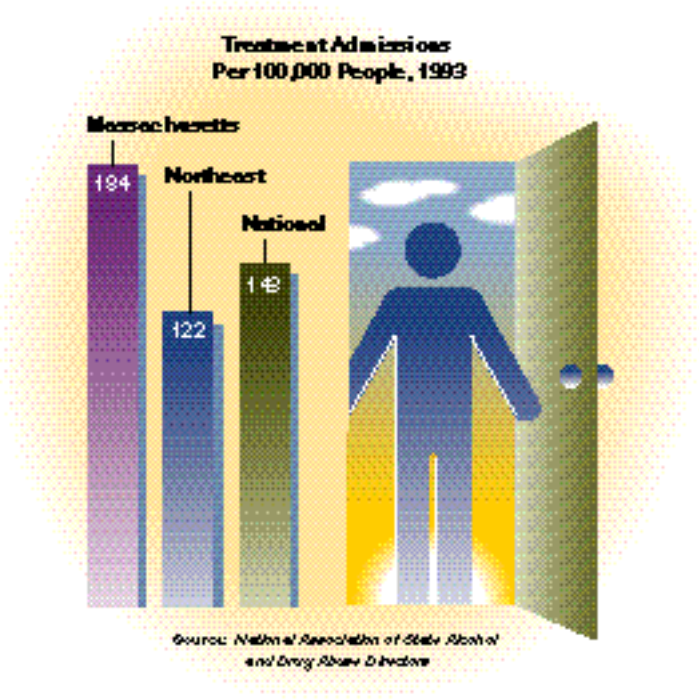
From 1990 to 1993, the number of publicly funded alcohol and drug abuse treatment slots in Massachusetts remained fairly stable despite funding reorganization. Clients who could not pay and were ineligible for Medicaid made up one-third of the substance abuse treatment cases in acute care hospitals in 1993, up from one-twelfth in 1988. Charges for their treatment totaled $23 million in 1993—charges borne largely by taxpayers because they were incurred at **hospitals** funded in part by tax revenue.

Medicaid, BSAS and acute care hospital expenditures for treatment exceeded $120 million in 1993. Afive-year grant to Massachusetts from the federal Center for Substance Abuse Treatment supported treatment through community-based partnership efforts totaling $16 million. This total does not include costs for privately funded treatment, which accounts for about 8 percent of all treatment clients, and about $23 million in acute care hospitals alone. Annual costs for privately funded services are not readily available, but it is likely that the unit cost is at least as high as publicly funded treatment or acute care hospital charges.

Disability Costs. Transfer payments related to substance abuse are made largely through the Social Security Administration. In 1994, 2,675 people in Massachusetts received Supplemental Security Income (SSI) for the Aged, Blind, and Disabled who had a primary diagnosis of alcoholism or drug addiction. Based on the national average, SSI payments for substance abusers cost the state $9.6 million in 1993. The medical determination in one-fifth of the cases included both alcohol and drug addiction, about the same number as for drug addiction alone. The remaining 60 percent of the determinations were for alcohol addiction. Additionally, there are disability payments to those unable to work as a result of tobacco and alcohol related illnesses.

Cost of Smoking and Drinking. According to the Massachusetts Tobacco Control Program, diseases attributed to smoking cost approximately $1.8 billion annually. These costs include health care, smoking-related disability and indirect costs, such as revenue declines due to productivity losses. However, this estimate may be low, since it does not include costs associated with the effects of second-hand smoke.

Treatment is a State Priority: Massachusetts Funds more Treatment than the Nation or the Northeast



Federal and state governments pay for more than 43 percent of all medical expenses attributed to smoking. Alcohol-related traffic accidents in Massachusetts during 1992 cost $477 million, according to Mothers Against Drunk Driving. This includes roughly $2.7 million in **"quality of life"** factors, such as years of potential life lost.

Court and Incarceration Costs. In the early 1990s, drug control efforts accounted for about 13 percent of Justice Department expenditures in Massachusetts. Atotal of $23 million is spent annually on court costs related to drugs (including court operations, legal services, prosecution and public defense). In 1991, Massachusetts spent an additional $101 million to incarcerate criminals with substance abuse problems. Incarceration per capita costs in state facilities increased 50 percent from 1990 to 1993, to $29,000 per prisoner annually. In 1992, Department of Correction expenditures cost the average Massachusetts taxpaying family of four $329.60.

Making A Difference

Treatment Programs

Somerville/Cambridge. The Power of Multiple Treatment Options.

Cambridge and Somerville Program for Alcoholism and Drug Abuse Rehabilitation (CASPAR), a multi-service center serving the communities of Cambridge and Somerville, offers a wide range of options for substance abuse rehabilitation. Residential and outpatient substance abuse programs for men and women, a hearing-impaired treatment program for women and a transitional housing program for graduates of the men's or women's residential program are just a few of the diverse selections available.

The Phoenix Center is a drop-in center for alcoholic men and women where clients come for support and socialize with fellow abstaining alcoholics. Alcoholics Anonymous meetings are held at the Center daily and clients are also offered case management and counseling services.

CASPAR also offers emergency shelter, education programs and detoxification services. Contact CASPAR at (617) 628-3850 to learn more about the many services offered.

Springfield. My Sister's House. Atwenty-bed recovery home for alcohol and drug-addicted women and their children, My Sister's House provides group and individual counseling in a protective residential setting. Apregnant addict component serves post-detoxification women at any stage of pregnancy. Women may stay at My Sister's House until their infants are six months old.

The program focuses on establishing self-discipline through a structured day, assigned duties, group and individual counseling and treatment planning, and mothering skills. Legal and employment services are provided, and clients have access to medical and obstetric care. Graduates remain in treatment for four to six months and then return for weekly post-residence meetings. Those who complete the program often come back as volunteer mentors for the women in treatment. For more information, call My Sister's House at (413) 733-7891.

VII. The Massachusetts **Response**

The Massachusetts Department of Public Health has adopted a comprehensive **prevention strategy,** articulated in its three-volume Blueprint for Prevention. This manual for community action provides step-by-step instructions for planning, assessment, implementation and evaluation. At its core are six components:

- community development and coalition building
- education, information and skill development
- creating alternatives
- policy development
- environment change
- access to primary care and preventive health services

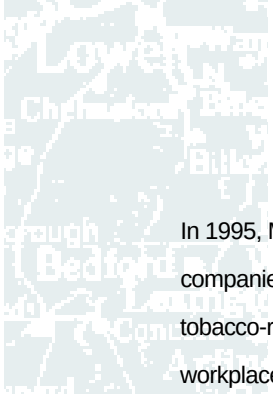
Community Partnership Grants. The federal Center for Substance Abuse Prevention (CSAP) supports comprehensive, community-wide prevention coalitions. CSAPcurrently funds 251 coalitions and partnerships nationwide, 20 of which are in Massachusetts. These programs have forged networks of more than 230 partnerships, serving about 26 municipalities in Massachusetts. Most grantees are either local government agencies (41 percent) or nonprofit agencies (50 percent). Since 1990, CSAPhas awarded more than $110 million in partnership prevention grants to Massachusetts.

The Department of Public Health (DPH) has established 27 Community Health Network Areas (CHNAs) throughout the state to help determine community public health priorities. Through citizen involvement in problem identification, eight of these networks have chosen some facet of substance abuse as a **health priority.** DPH collaborates with schools, local businesses, the Governor's Alliance Against Drugs (GAAD) and other state authorities in addressing substance abuse. In 1995, more than 150 grants—totaling approximately $1.2 million—have been made by GAAD to community-level substance abuse prevention programs.

All 331 school districts in Massachusetts receive funding from the federal Safe and Drug-Free Schools and Communities Program, which has provided Massachusetts schools a total of $46.2 million since 1990. These funds are used for prevention curricula, materials, and training, as well as implementation by school staff and other professionals.

Tobacco Control Program. Launched in 1993, the Tobacco Control Program supports school health services ($6 million), youth prevention ($26 million); and smoking cessation campaigns and public policy initiatives ($26 million). During its first year, anti-smoking messages from the Bureau of Family and Community Health reached 90 percent of Massachusetts residents through contracts with private companies, citizen groups and state agencies.

Like many states, Massachusetts has enacted legislation restricting smoking in restaurants serving more than 25 patrons and in child care facilities. These regulations reflect growing public intolerance for smoking, particularly the effects of second-hand smoke.



In 1995, Massachusetts legislators authorized their Attorney General to sue tobacco companies to recover state Medicaid funds spent to care for people suffering from tobacco-related diseases. And although the state has not legislated restrictions on workplace smoking, many private and government offices have instituted restrictions. In June 1995, Massachusetts enacted the first **ban on smoking** at outdoor recreation facilities: the city of Sharon, Massachusetts, no longer permits smoking at ball fields, parks, and public beaches.

Since 1993, the Synar Amendment to the Public Health Service Act has required states to prohibit the sale and distribution of tobacco products to minors and to enforce this prohibition. Massachusetts has responded to these Synar requirements with "sting" operations, and has also facilitated enforcement through Department of Public Health community intervention and primary prevention projects. The Office for Non-Smoking and the Bureau of Substance Abuse Services both support peer leadership programs in which youth educate their peers about the dangers of smoking.

Overall, the Tobacco Control Program, as well as employee assistance programs, smoke-free workplaces and non-smoking sections in restaurants have helped reduce adult smoking in Massachusetts. Increased taxes on cigarettes (raised from 26 cents a pack in 1993 to 51 cents a pack in 1994) also contributed to the decline.

A Landmark Lawsuit. *Kyte vs. Store 24,* filed in the Massachusetts Superior Court for Middlesex, was the first successful case in the nation to invoke civil enforcement of a criminal statute that had generally been ignored concerning the sale of tobacco to minors. Theresa Kyte, a minor, sued Store 24, a Massachusetts convenience store chain, and Philip Morris, Inc., for selling tobacco to her illegally.

The complaint listed a variety of infringements, including negligence in selling to a minor and failure of duty to warn. In an anti-smoking **victory,** the suit was settled out of court in June 1991. The terms of the settlement included:

- an agreement by Store 24 to initiate an aggressive training program for managers and employees on the illegality of selling tobacco to minors
- the placement of signs in all stores warning that the store will not sell tobacco to minors
- the requirement of positive identification by youthful looking patrons trying to buy tobacco
- an aggressive monitoring campaign
- and an undisclosed monetary settlement

In a ripple effect, this case prompted several state Attorneys General to meet on the issue and to produce the publication "No Sales: Youth, Tobacco and Responsible Retailing."

Criminal Justice. In Massachusetts, there is more to prison than punishment. For instance, the Correctional Recovery Academy was designed in 1993 to serve the needs of inmates in state correctional facilities. The Academy begins with a risk/need assessment at a Massachusetts Correctional Institution (MCI), in either Framingham (women) or Concord (men). Need assessments for services—including substance abuse services—are done for men serving a minimum of one year and women serving a minimum of three months, if their criminal records suggest risk for recidivism.

The Academy is a structured residential treatment program. Substance abusers and violent offenders participating in treatment are separately housed within prison facilities. The Academy focuses on substance abuse, violence reduction, life skills, problem solving, use of leisure time, holistic health, stress management, fitness and reading/ creative writing. There are also special programs for female inmates. Every two months, inmates'progress is reviewed. Outcome data on this newly standardized program are still being gathered. There is also a plan for a randomized assignment trial to determine treatment effectiveness.

New efforts are also underway to create alternatives to incarceration for addicted offenders. The Supreme Judicial Court established a Substance Abuse Task Force in 1993 to coordinate substance abuse efforts in the Massachusetts judicial system. Chaired by Justice Francis P. O'Connor, the Task Force held seminars on substance abuse in courts throughout the state and formulated 21 recommendations for effectively addressing substance abuse in the courts.

The Task Force called for stronger coordination between the courts and the Departments of Public Health, Social Services, Mental Health, Youth Services and Education. It also concluded that the Supreme Judicial Court should have greater responsibility in dealing with the challenges of substance abuse.

Drug Courts. In response to rising caseloads and overcrowded prisons, cities in other states have created special courts for low-level, non-violent drug offenders, which have substantially reduced rearrest rates at a fraction of the cost of incarceration. Adopting this successful model, Massachusetts opened its first drug court in June 1995. Part of Dorchester's District Court, the drug court handles drug abusers charged with prostitution, property offenses and drug possession. Defendants convicted of violent crimes within the last five years are not eligible for the program.

Held in the newly renovated Boston Specialty and Rehabilitation Hospital in Mattapan every other Friday, the drug court expects to serve 100 clients in its first year. Drug court defendants participate in a year-long program that includes treatment, counseling, drug testing, job training and placement. Upon successful completion of the program, defendants are released as probationers rather than parolees. Those who violate the terms of treatment are returned to the corrections system to serve their sentences in state and county prisons.

Making A Difference

Workplace Programs

Northern Mass. Enhancing Productivity Through Prevention. Drugs in the workplace decrease productivity and profits while increasing absenteeism and on-the-job accidents. To combat this problem, the Center for Addictive Behaviors Inc. (CAB), in Salem, offers a Workplace Services Program which helps businesses develop employee assistance programs for employees with substance abuse problems.

CAB's comprehensive services include training for managers on the use of the employee assistance program and education on the recognizable signs of substance abuse. To get more information, call (508) 745-8890.

Western Mass. Businesses Unite Against Drugs. Partnership works. That's the lesson of a workplace assistance program—Drugs Don't Work! (DDW) in Chicopee—that has cultivated a close partnership with the Chicopee Chamber of Commerce. The program helps employers detect and prevent substance abuse among employees and also provide resources and support for employees with problems.

By working in collaboration with the Chamber of Commerce, DDW enjoys an excellent opportunity to reach nearly all of the businesses in the area. DDW representatives attend all Chamber functions, where they meet with business owners and share valuable information on the impact of drugs in the workplace and the benefits of establishing employee assistance programs (EAPs).

DDW offers resources and assistance in establishing EAPs, general information on workplace substance abuse, referrals to drug testing vendors and workshops and seminars on key issues. To find out more, call (413) 594-HELP.

VIII. Looking to the Future

Massachusetts can be proud of its response to the problems of substance abuse. The state's efforts would be strengthened by designating one of the key government agencies as overall coordinator for substance abuse strategy and programs. This would avoid duplication of services as well as expedite the exchange of information and best practices among public and private organizations. Certain areas deserve special attention as the state moves toward greater progress:

Prevention Efforts for Young Teens Must be Strengthened. Young teens are especially vulnerable to substance abuse. Half the middle school students in Massachusetts who experiment with tobacco, alcohol or illicit drugs later report monthly use.

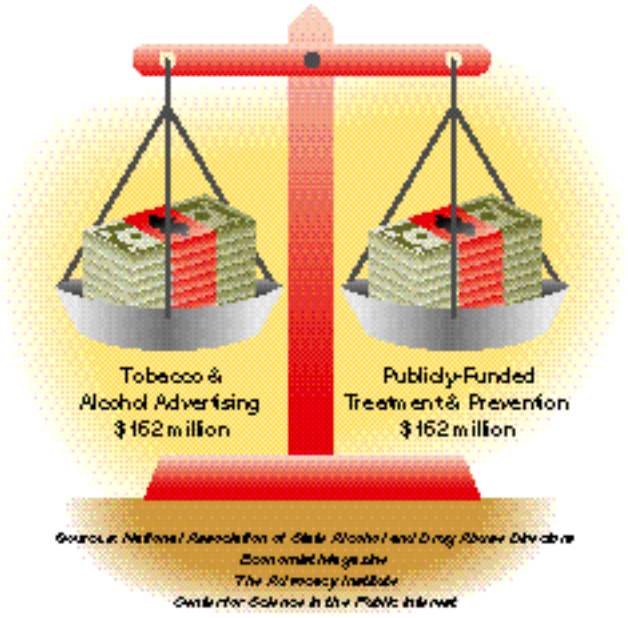
Trends in smoking among youth are especially worrisome because more than 90 percent of chronic adult smokers become addicted while still in their teens. In Massachusetts, tobacco, alcohol, inhalant and illicit drug use have increased among young teens, particularly boys, at much higher rates than the national average.

Prevention efforts have succeeded in reducing substance abuse among older teens and adults in Massachusetts. More targeted, effective programs are needed for young teenagers.

Restrictions on Tobacco Marketing. One way to help teens is to protect them from the influence of tobacco marketing. Massachusetts has no **legislation** restricting tobacco advertising, vending machines, or distribution of tobacco samples.

About $7 billion is spent on promotions and advertising for alcohol ($1 billion) and tobacco ($6.03 billion) annually in the United States—$162 million in Massachusetts alone. Even though sales to minors are illegal, tobacco and alcohol advertisers target young people.

Advertising Matches State's Prevention and Treatment Budget



At least 83 percent of Massachusetts teenagers say they remember seeing some form of tobacco or alcohol advertising in a given month—a larger proportion than have seen or heard anti-smoking messages. These ads often glamorize smoking and drinking and can distort teens' perceptions of the pervasiveness of use.

Needle Exchange Programs can Reduce HIV/AIDS. In 1993, the state legislature allowed the Department of Public Health to establish a pilot needle exchange program in eight locations, pending local approval. The Department of Health and Hospitals, Cambridge Cares About AIDS and ACT-UP collaborated with police to provide clean needles and treatment on demand, funded by the AIDS Bureau and the Bureau of Substance Abuse Services.

Recent studies in other cities have found that needle exchange programs can reduce transmission of HIV by half without encouraging increased drug use. These programs also bring hard-core addicts into treatment. For every dollar provided for needle exchange services in Massachusetts, two dollars are set aside for treatment. Preliminary data show that 16 percent of those enrolled in the needle exchange program sought treatment.

Nine new locations have been approved by the legislature, subject to local jurisdiction support. If funding for treatment is allocated in the next fiscal year, these sites will soon open needle exchange programs.

Smoking by Women of Child-Bearing Age Needs Special Attention. Why emphasize smoking prevention in women who might bear children? Recent studies indicate that smoking may cause as many as 7.5 percent of all miscarriages: most of them occur before the woman knows she is pregnant. In addition, 26,000 newborn babies are admitted to intensive care units each year in the United States because of low birth weight caused by maternal smoking.

In 1993, nearly three-quarters of female smokers in Massachusetts were of child-bearing age (18-44), a 22 percent increase over 1989. Focus on preventing smoking in this age group should receive high priority.

Expand Data Collection for Substance Abuse Indicators. In preparing this profile, significant gaps emerged in the available data. These are the same data that shape Massachusetts drug policies, budget allocations, and resource management.

Currently, state agencies collect data on drug-related deaths, hospital discharge statistics, and the number of self-help meetings but use Northeast regional prevalence data to estimate rates of adult drug use. Statewide survey efforts could be developed to close the **data gap** on adult drug use. There is an effort underway to begin gathering such information: a federally funded statewide household telephone survey on substance abuse is being conducted from fall 1995 through spring 1996. Efforts should also be made to obtain data on the extent of substance abuse treatment and prevention within the private sector in order to provide a more complete statewide portrait.

Data on substance abuse history among prison inmates is collected in the state and should be matched by appropriate treatment programs. Since drug offenders can serve up to two and a half years in local jails before going on to state prison facilities, the availability and utilization of treatment within jails should also be carefully studied.

Massachusetts has forged strong partnerships involving public and private agencies, businesses, community groups and service providers. Much has been achieved in responding to alcohol, tobacco and illicit drug abuse problems. Massachusetts is poised to address the challenges that remain.

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		1988	1989	1990	1991	1992	1993
Binge Drinking (> 5 drinks at a time)							
% men		27.4	33.8	30.8	31.8	29.7	29.5
%women		10.5	9.2	8.5	12.4	11.8	11.1
% men by age:	18-24	51.7	57.8	57.2	38.1	54.1	67.9
	25-34	37.0	46.5	40.4	48.5	37.4	38.8
	35-44	21.0	39.1	30.8	30.7	29.5	26.1
	45-54	18.2	14.1	25.4	33.5	27.7	19.6
	55-64	22.1	14.8	9.0	7.1	13.3	10.2
	65+	3.8	13.1	5.8	7.1	3.8	3.3
% women by age:	18-24	32.1	26.3	22.7	26.2	35.4	29.0
	25-34	9.9	12.1	13.2	19.9	15.9	21.3
	35-44	9.5	8.6	7.8	11.2	8.2	6.3
	45-54	7.5	3.8	4.0	4.8	4.0	6.6
	55-64	4.0	1.5	3.3	4.5	7.0	3.9
	65+	0.4	2.8	0.5	1.5	0.9	0.4
Chronic Drinking (> 60 drinks/month)**							
% men		12.9	11.4	9.6	9.6	8.0	8.8
% women		3.0	1.3	1.4	1.6	1.3	0.7
% men by age:	18-24	15.6	22.7	13.8	14.4	15.1	20.5
	25-34	16.8	11.0	12.8	12.5	6.7	11.1
	35-44	12.8	12.2	7.0	11.5	7.1	4.2
	45-54	8.3	3.8	10.3	6.3	4.0	7.8
	55-64	11.2	7.4	6.3	3.5	9.9	1.9
	65+	8.0	9.6	5.0	3.9	6.0	5.4
% women by age:	18-24	7.0	3.3	2.8	2.3	3.9	1.9
	25-34	1.2	0.3	0.6	1.8	0.9	0.3
	35-44	1.9	1.7	*	1.1	1.4	0.9
	45-54	4.5	*	3.0	1.7	1.0	*
	55-64	1.3	*	1.7	2.6	1.4	*
	65+	2.3	1.9	1.5	0.5	*	0.7

		1988	1989	1990	1991	1992	1993▼	1994▼
Current Smoking								
% men		26.5	22.2	26.4	23.4	24.9	20.6	22.9
% women		25.8	25.0	21.5	23.1	21.1	21.6	19.5
Among female smokers								
	% age 18-44	63.8	58.2	68.5	65.4	65.4	63.3	71.0
	% age 45 and older	36.2	41.8	36.8	36.7	34.6	36.7	29.0

Source: *Massachusetts Behavioral Risk Factor Survey,* Department of Public Health, 1986-90; 1991; 1992; 1993; 1994.

▼ Includes current and irregular users.

* Not reported.

** Prevalence of chronic drinking is 4 percent overall; the cell frequencies represented by these percentages are very small.

[1] All figures are based on the standard samples for the Massachusetts BRFS (does not include minority oversampling). Alcohol questions not asked in 1994.

Teen Substance Use

		1987	1990	1993
Alcohol				
Grades 9-12	% lifetime use (ever tried)	91.1	85.1	85.0
	% current use (last 30 days)	60.5	51.5	49.2
Grades 7-8	% lifetime use	74.5	58.2	73.7
	% current use	28.4	19.5	28.5
Cigarettes				
Grades 9-12	% lifetime use	66.0	62.7	63.6
	% current use	31.8	29.2	33.6
Grades 7-8	% lifetime use	46.4	36.6	45.4
	% current use	13.7	12.8	22.6
Smokeless tobacco				
Grades 9-12	% lifetime use	19.0	19.3	24.6
	% current use	2.8	6.4	9.3
Grades 7-8	% lifetime use	*	4.1	16.4
	% current use	*	1.7	5.7
Any Illicit Drug				
Grades 9-12	% lifetime use	50.8	47.9	51.4
	% current use	24.5	20.4	28.8
Grades 7-8	% lifetime use	22.9	19.8	36.1
	% current use	8.2	5.5	16.3

Source: *Tobacco, Alcohol, and Other Drug Use Trends Among Massachusetts Public School Adolescents 1984-1993.* Executive Office of Health and Human Services, Department of Public Health, Bureau of Substance Abuse Services, 1994.

* not reported

Drug of Choice Among Treatment Admissions

		1990	1991	1992	1993	1994
Percent of admissions to state-funded treatment programs naming three primary drugs of choice						
Greater Boston						
	Alcohol	52	51	46	45	43
	Heroin/other opiates	16	19	19	22	26
	Cocaine/crack	26	27	32	28	26
Remainder of Massachusetts						
	Alcohol	63	62	57	53	50
	Heroin/other opiates	15	17	18	25	27
	Cocaine/crack	15	15	18	17	18

Source: *Epidemiological Trends in Drug Abuse, Volume II: Proceedings of the Community Epidemiology Working Group.* National Institute on Drug Abuse, June 1994.

Adults Who Admit Drinking and Driving

	1987	1988	1989	1990	1991	1992	1993
% men	6.5	7.0	5.4	5.3	4.1	4.2	4.8
% women	2.3	2.6	1.3	0.6	1.6	2.5	0.9

Source: *Massachusetts Behavioral Risk Factor Survey,* Department of Public Health, Boston, 1986-90; 1991; 1992; 1993; 1994.

Teens Who Admit Drinking and Driving

	1987	1990	1993
Grades 9-12			
% drove after having anything to drink	29.6	22.5	26.9
% had 5 or more drinks before driving	17.3	11.6	11.8
% drove after having marijuana	16.3	10.2	19.6
% drove after having other illicit drugs	5.5	3.8	3.9

Source: *Tobacco, Alcohol, and Other Drug Use Trends Among Massachusetts Public School Adolescents 1984-1993.* Executive Office of Health and Human Services, Department of Public Health, Bureau of Substance Abuse Services, 1994.

Deaths Due to Alcohol, Tobacco or Drugs

	1988	1989	1990	1991	1992
# of all deaths related to alcohol or drugs (per 100,000)	32	32	30	30	32
% of all deaths age 35 and up related to smoking [1]	21				
# of deaths age 35 and up related to smoking [1]	11,305				

Source: *Indicators of Substance Use in Massachusetts (1985-1992).* Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 1994. (BSAS Indicators)

[1] The state describes these figures as unchanged since 1988; exact numbers were not reported.

Fatally Injured Drivers Testing Positive for Drugs or Alcohol

	1988	1989	1990	1991	1992	1993
Percent of fatally injured drivers with blood alcohol content > .1	20%	21%	18%	16%	19%	16%

Source: Registry of Motor Vehicles, Commonwealth of Massachusetts.

Teen Attitudes and Perceptions

	1990	1993
Grades 9-12		
% who thought substances fairly difficult or probably impossible to get:		
cigarettes	*	7
alcohol	*	22
marijuana	26	22
cocaine	61	65
% who saw someone selling or using drugs in school	47.6	53.5
% who think rules and penalties keep students from using drugs or alcohol	18.9	15.9
Grades 7-8		
% likely to use alcohol in next year	*	41
% likely to use cigarettes in the next year	*	21.3
% likely to use other drugs in the next year	*	13.4

Source: *Tobacco, Alcohol, and Other Drug Use Trends Among Massachusetts Public School Adolescents 1984-1993.* Executive Office of Health and Human Services, Department of Public Health, Bureau of Substance Abuse Services, 1994.

* not gathered

Drug and Alcohol Involvement of Inmates

	1989	1991	1993
% prisoners with prior alcohol problems	25	23	56
% prisoners with prior drug problems	50	54	53

Source: Massachusetts Department of Correction, Boston, 1995.

Drug and Alcohol Involvement of Arrestees

	1988	1989	1990	1991	1992
% arrestees having drug problem	42	44	46	48	51
% arrestees having alcohol problem	40	43	44	44	45

Source: Executive Office of Public Safety (formerly the Committee on Criminal Justice), Massachusetts Department of Justice, Boston, 1995.

Drug and Alcohol Involvement of Probationers

	1989	1990	1991	1992	1993	1994
Adults–Number of probationers	12,446	14,797	13,300	14,972	15,592	16,988
% with alcohol treatment as a term of probation	40	43	46	48	51	53
% with drug treatment as a term of probation	42	44	44	44	45	51
% probationers with alcohol/drug abuse problem as a risk characteristic at time of release	63	66	68	70	72	76
% probationers under DUI Liquor Supervision	23	25	31	30	35	34
% probationers involved in a drug offense	26	24	22	20	18	19
Average length of supervision (months)	21	21	18	18	17	17
Juveniles–Number of probationers	*	3,536	3,212	3,568	3,364	3,246
% with alcohol treatment as a term of probation	*	24	21	24	26	33
% with drug treatment as a term of probation	*	19	15	18	22	34
% probationers with alcohol/drug abuse problem as a risk characteristic at time of release	*	40	35	38	41	53
% probationers involved in a drug offense	*	7	6	5.5	6	8
Average length of supervision (months)	*	11	11	12	11	11

Source: Commission on Probation, Massachusetts Department of Justice, Boston, 1995.
*not reported

Rate of Drug Arrests

	1989	1990	1991	1992	1993
All Adult Arrests					
% crimes against people	26	28	37	44	51
% crimes against property	31	31	29	25	22
% drug crimes	26	24	22	20	18
% other crimes	17	17	12	11	10
Incarcerated Drug Sentences					
Total	3,251	3,499	2,886	2,947	2,741
Possession	1,563	1,633	1,193	1,296	1,247
Sales	1,462	1,638	1,501	1,490	1,373
Other offenses	226	228	192	161	121

Source: Executive Office of Public Safety (formerly the Committee on Criminal Justice), Massachusetts Department of Justice, Boston, 1995.

New AIDS Cases Related to Drug Abuse

	1988	1989	1990	1991	1992	1993	1994
Number of New Cases Related to Drug Abuse[1]							
IV Drug Users	196	267	314	455	627	600	2459
IV Drug Users Who are Homosexual	39	47	41	49	54	52	282
Heterosexuals Who Had Sex with IV Drug User	29	30	46	47	71	85	308
Pediatric: Mom IV Drug User	8	3	13	5	6	8	43
Pediatric: Mom Had Sex with IV Drug User	6	2	11	3	5	3	30
Cumulative AIDS Cases by Risk Categories							
% homosexual	57	52	46	42	38	35	28
% injection drug user	26	32	34	39	41	42	43
% other	17	16	20	19	21	23	29

Source: AIDS Bureau, Department of Public Health.

[1] In 1993 the Centers for Disease Control and Prevention changed the definition of AIDS to include cases in an earlier stage of the disease. As a result, many more new cases were reported in 1994, particularly among injection drug users. Under the old definition, only 26 percent of cases were injection drug users, compared to 46 percent of new definition cases.

Number of People in Drug and Alcohol Treatment

	1989	1990	1991	1992	1993
Treatment Totals					
Treatment Admissions - men	75,760	69,524	64,805	61,033	64,379
Treatment Admissions - women	20,704	22,422	22,379	23,291	24,546
Alcohol Admissions	61,675	55,205	53,817	51,659	51,226
Other Drug Admissions	34,789	36,741	33,367	32,671	37,699

Sources: *State Resources and Services Related to Alcohol and Other Drug Problems: Analysis of State Alcohol and Drug Abuse Profile Data.* National Association of State Alcohol and Drug Abuse Directors, Inc., 1990; 1992; 1993; 1994; 1995.

	1989	1990	1991	1992	1993	1994
Special Population Admissions						
Probation	*	*	20,584	22,634	23,432	26,673
Parole	*	*	980	1,207	1,282	1,421
Pregnant women	*	*	497	784	857	974
Treatment Modality						
Detoxification	30,267	28,246	27,945	25,659	32,100	34,970
Residential	8,420	7,837	8,339	8,723	10,491	10,827
Residential (includes long-term care)	14,641	9,957	10,318	10,230	10,491	10,827
Outpatient	46,181	46,115	44,786	43,102	42,262	44,002
Methadone	3,312	3,715	2,737	3,323	3,457	3,324

Source: Massachusetts Bureau of Substance Abuse Services, Department of Public Health.

* not reported

Government Disability Payments for Substance Abuse

	1988	1989	1990	1991	1992	1993	1994
Massachusetts SSI and SSDI recipients medically determined to be alcoholics or drug addicts							
Total	380	472	675	933	1,389	1,890	2,675
Alcohol addicted	277	332	468	640	903	1,218	1,695
Drug addicted	37	56	73	105	178	282	494
Both alcohol and drug addicted	66	84	134	188	308	390	486

Source: United States Social Security Administration.

Drug Strategies

The mission of Drug Strategies is to promote more effective approaches to the nation's drug problems and to support private and public initiatives that reduce the demand for drugs through prevention, education, treatment and law enforcement.

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