ALASKA STATE LEGISLATURE
HOUSE JUDICIARY STANDING COMMITTEE
March 19, 2001
1:10 p.m.

MEMBERS PRESENT

Representative Norman Rokeberg, Chair
Representative Jeannette James
Representative John Coghill
Representative Kevin Meyer
Representative Ethan Berkowitz

MEMBERS ABSENT

Representative Scott Ogan, Vice Chair
Representative Albert Kookesh

COMMITTEE CALENDAR

HOUSE BILL NO. 32
"An Act relating to the forfeiture of property used to possess or distribute child pornography, to commit indecent viewing or photography, to commit a sex offense, or to solicit the commission of, attempt to commit, or conspire to commit possession or distribution of child pornography, indecent viewing or photography, or a sexual offense."

- MOVED CSHB 32(JUD) OUT OF COMMITTEE

HOUSE BILL NO. 4
"An Act relating to offenses involving operating a motor vehicle, aircraft, or watercraft while under the influence of an alcoholic beverage or controlled substance; relating to implied consent to take a chemical test; relating to registration of motor vehicles; relating to presumptions arising from the amount of alcohol in a person's breath or blood; and providing for an effective date."

- HEARD AND HELD

HOUSE BILL NO. 97
"An Act relating to court approval of the purchase of structured settlements."

- BILL HEARING POSTPONED

PREVIOUS ACTION

BILL: HB 32
SHORT TITLE:SEX CRIME AND PORNOGRAPHY FORFEITURES
SPONSOR(S): REPRESENTATIVE(S)HAYES

Jrn-Date	Jrn-Page		Action
01/08/01	0032	(H)	PREFILE RELEASED 1/5/01
01/08/01	0032	(H)	READ THE FIRST TIME - REFERRALS
01/08/01	0032	(H)	JUD, FIN
02/09/01	0286	(H)	COSPONSOR(S): MCGUIRE, GUESS
02/14/01	0327	(H)	COSPONSOR(S): MURKOWSKI
02/21/01		(H)	JUD AT 1:00 PM CAPITOL 120
02/21/01		(H)	Heard & Held
02/21/01		(H)	MINUTE(JUD)
03/09/01		(H)	JUD AT 1:00 PM CAPITOL 120
03/09/01		(H)	Heard & Held MINUTE(JUD)
03/19/01		(H)	JUD AT 1:00 PM CAPITOL 120

BILL: HB 4
SHORT TITLE:OMNIBUS DRUNK DRIVING AMENDMENTS
SPONSOR(S): REPRESENTATIVE(S)ROKEBERG

Jrn-Date	Jrn-Page		Action
01/08/01	0024	(H)	PREFILE RELEASED 12/29/00
01/08/01	0024	(H)	READ THE FIRST TIME - REFERRALS
01/08/01	0024	(H)	TRA, JUD, FIN
02/22/01		(H)	TRA AT 1:00 PM CAPITOL 17
02/22/01		(H)	Heard & Held MINUTE(TRA)
02/27/01		(H)	TRA AT 1:00 PM CAPITOL 17
02/27/01		(H)	Moved CSHB 4(TRA) Out of Committee MINUTE(TRA)
02/28/01		(H)	JUD AT 1:00 PM CAPITOL 120
02/28/01		(H)	Heard & Held MINUTE(JUD)
02/28/01	0470	(H)	TRA RPT CS(TRA) NT 1DNP 2NR 2AM
02/28/01	0471	(H)	DNP: SCALZI, NR: KAPSNER, KOOKESH;
02/28/01	0471	(H)	AM: MASEK, KOHRING
02/28/01	0471	(H)	FN1: (ADM); FN2: (ADM)
02/28/01	0471	(H)	FN3: (COR); FN4: (CRT)

02/28/01	0471	(H)	FN5: (HSS); FN6: (HSS)
02/28/01	0472	(H)	FN7: (HSS); FN8: (HSS)
02/28/01	0472	(H)	FN9: (LAW); FN10: (DPS)
02/28/01	0472	(H)	REFERRED TO JUDICIARY
03/09/01		(H)	JUD AT 1:00 PM CAPITOL 120
03/09/01		(H)	Heard & Held
			MINUTE(JUD)
03/12/01		(H)	JUD AT 2:30 PM CAPITOL 120
03/12/01		(H)	Heard & Held
03/12/01		(H)	MINUTE(JUD)
03/14/01		(H)	JUD AT 2:15 PM CAPITOL 120
03/14/01		(H)	Scheduled But Not Heard
03/16/01		(H)	JUD AT 1:00 PM CAPITOL 120
03/16/01		(H)	Heard & Held
			MINUTE(JUD)
03/19/01		(H)	JUD AT 1:00 PM CAPITOL 120

WITNESS REGISTER

REPRESENTATIVE JOE HAYES
Alaska State Legislature
Capitol Building, Room 426
Juneau, Alaska 99801
POSITION STATEMENT: Sponsor of HB 32.

ERNIE TURNER, Director
Central Office
Division of Alcoholism & Drug Abuse (DADA)
Department of Health & Social Services (DHSS)
PO Box 110607
Juneau, Alaska 99811-0607
POSITION STATEMENT: Provided information regarding the treatment element of HB 4 and answered questions.

LOREN JONES
CMH/API Replacement Project Director
Division of Mental Health & Developmental Disabilities
Department of Health & Social Services
PO Box 110620
Juneau, Alaska 99811-0620
POSITION STATEMENT: Provided additional information regarding the treatment element of HB 4 and answered questions.

RON TAYLOR, Coordinator
Alcohol Safety Action Program (ASAP)
Division of Alcoholism and Drug Abuse (DADA)
Department of Health & Social Services (DHSS)

303 K Street
Anchorage, Alaska 99501
POSITION STATEMENT: Provided additional information regarding the ASAP portion of the treatment element of HB 4, and answered questions.

SARAH WILLIAMS, Coordinator
Substance Abuse Program
Inmate Programs
Division of Institutions
Department of Corrections (DOC)
4500 Diplomacy Drive, Suite 109
Anchorage, Alaska 99508
POSITION STATEMENT: During discussion of HB 4, provided information regarding the DOC's treatment programs, and answered questions.

CANDACE BROWER, Program Coordinator/Legislative Liaison
Office of the Commissioner
Department of Corrections
431 North Franklin, Suite 203
Juneau, Alaska 99801
POSITION STATEMENT: Provided information regarding the DOC's fiscal note as it relates to the treatment element of HB 4, and answered questions.

DENITA SOLITAIRE, Substance Abuse Counselor
Akeela House, Inc.
PO BOX 201412
Anchorage, Alaska 99520
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of the treatment element.

SHEILA SANFORD, Meeting the Challenge
320 South Bragaw
Anchorage, Alaska 99508
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of the treatment element.

ODIS ADAMS
5800 Lake Otis Parkway, Number 360
Anchorage, Alaska 99507
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of the treatment element.

RUDOLF NEWMAN, Meeting the Challenge
3252 Carriage Drive

Anchorage, Alaska 99507
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of the treatment element.

LEONA HAWKENSON (ph) CROW, Meeting the Challenge
PO Box 8567
Kodiak, Alaska 99615
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of treatment for DWI offenders.

KATHERINE FRIDAY
PO Box 980
Craig, Alaska 99921
POSITION STATEMENT: During discussion of HB 4, spoke on the issue of treatment availability in rural areas for substance abuse.

CLARA M. PETERS
PO Box 65087
Nulato, Alaska 99765
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of the treatment element.

BRIAN MASSEY
PO Box 2324
Sitka, Alaska 99835
POSITION STATEMENT: During discussion of HB 4, shared personal experience and spoke in support of substance abuse treatment.

ACTION NARRATIVE

TAPE 01-35, SIDE A
Number 0001

CHAIR NORMAN ROKEBERG called the House Judiciary Standing Committee meeting to order at 1:10 p.m. Representatives Rokeberg, Coghill, Meyer, and Berkowitz were present at the call to order. Representative James arrived as the meeting was in progress.

HB 32 - SEX CRIME AND PORNOGRAPHY FORFEITURES

Number 0033

CHAIR ROKEBERG announced that the first order of business would be HOUSE BILL NO. 32, "An Act relating to the forfeiture of property used to possess or distribute child pornography, to

commit indecent viewing or photography, to commit a sex offense, or to solicit the commission of, attempt to commit, or conspire to commit possession or distribution of child pornography, indecent viewing or photography, or a sexual offense."

Number 0069

REPRESENTATIVE JOE HAYES, Alaska State Legislature, sponsor, requested that the committee consider the proposed committee substitute (CS) for HB 32, version 22-LS0270\C, Luckhaupt, 3/7/01. He added that this Version C gives a narrow definition of forfeiture, and a definition of property that addresses computer and electronic equipment.

Number 0133

REPRESENTATIVE COGHILL made a motion to adopt the proposed committee substitute (CS) for HB 32, version 22-LS0270\C, Luckhaupt, 3/7/01, as a work draft. There being no objection, Version C was before the committee.

Number 0175

REPRESENTATIVE COGHILL moved to report the CS for HB 32, version 22-LS0270\C, Luckhaupt, 3/7/01, out of committee with individual recommendations and the accompanying zero fiscal notes.

Number 0200

REPRESENTATIVE BERKOWITZ objected for the purpose of discussion. He asked why HB 32 had been referred to the House Finance Committee if it had zero fiscal notes.

Number 0214

CHAIR ROKEBERG responded that he did not know, and suggested that the sponsor request a waiver from the House Finance Committee. Chair Rokeberg noted that the objection was removed. There being no further objection, CSHB 32(JUD) was reported from the House Judiciary Standing Committee.

HB 4 - OMNIBUS DRUNK DRIVING AMENDMENTS

Number 0231

CHAIR ROKEBERG announced that the next order of business would be HOUSE BILL NO. 4, "An Act relating to offenses involving

operating a motor vehicle, aircraft, or watercraft while under the influence of an alcoholic beverage or controlled substance; relating to implied consent to take a chemical test; relating to registration of motor vehicles; relating to presumptions arising from the amount of alcohol in a person's breath or blood; and providing for an effective date." He noted that the focus for this meeting would be on the treatment element of HB 4. [Before the committee was CSHB 4(TRA).]

Number 0270

ERNIE TURNER, Director, Central Office, Division of Alcoholism & Drug Abuse (DADA), Department of Health & Social Services (DHSS), explained that his slide presentation was titled "Understanding Alcoholism and the Treatment of Alcoholism -- An Overview." He prefaced his presentation with some personal background information. He said he is a chronic recovering alcoholic, and that he had spent many years on the streets as a very hopeless alcoholic. He added that in the 1960s he was a "guinea pig" in a research center at the University of Washington, which only took hopeless alcoholics; the center did not accept anyone who was expected to survive his/her alcoholism. The center subjected him to a variety of tests, which he noted he somehow survived. He recounted that he tried various methods of recovery such as psychiatry and drug therapy (including prescribed LSD - lysergic acid diethylamide), and that he also tried seeking help through the church. He also recounted that he made many trips to jail because at the time he was drinking, alcoholism was considered a crime, not a disease; there were no detoxification facilities, simply the "drunk tank."

MR. TURNER added that during that time he made many trips to the hospital; that he suffered internal bleeding; and that he has had surgery to remove portions of his intestines and stomach, and to repair his esophagus. His alcoholism physically wore him out, he said, and for a long period of time suicide ideation was a constant companion. However, suicide was a mortal sin according to the way he was raised; he also had three children, and he said that he did not want them to live the rest of their lives knowing that their father had committed suicide. He said that one day in court he told the judge that he was "at the bottom of the barrel" and had no way out. The judge consequently sentenced him to 120 days of treatment, which consisted mostly, at the time, of work therapy. Participants were given jobs involving four hours of work a day for the

county; participants also spent four hours every day in therapy at "school."

Number 0530

MR. TURNER explained that it was during this 120-day treatment that he learned that he did not "cause" his alcoholism. He learned, instead, that it was a "no-fault" disease, which had been activated by his initial experimental use of alcohol, and had progressed to the point of nearly causing his death. He noted that he had attended this treatment program in 1970, and that nine months later he made the decision to devote the rest of his life to the field [of alcoholism]. He then went back to school for two years at the University of Utah, School of Social Work, and completed a project at the Western Region Alcoholism/Training Center. He also graduated from Lesley College in Cambridge, Massachusetts, with a degree in substance abuse management.

MR. TURNER said that he has worked in both the public and private sectors. He worked for four years at Lakeside-Milam Recovery Centers in the state of Washington, which at that time had approximately 160 beds. The center averaged about 20 referrals a month from all over Alaska, including Representatives, Senators, aides, and business people; many of those referrals were from the Juneau area. He added that they averaged seven adolescent referrals a month from Alaska, approximately five of which were from Juneau. He reported that they treated people from all over the world, and that he learned what it was like to treat affluent alcoholics - people who were millionaires and/or had a lot of resources at their disposal such as good insurance. He added that they treated doctors, ministers, college professors, bankers, and other people from all walks of life.

MR. TURNER said that in 1988 he read a series of articles from the Anchorage Daily News entitled "People in Peril," which detailed the destruction in rural communities from alcoholism such as the high homicide and suicide rates, and it was at that point that he made the decision to return to Alaska. He explained that he was born in the village of Shageluk, and was therefore familiar with village-style drinking because that was where he started drinking at age 16. He noted that he did not get into recovery until age 40.

Number 0761

MR. TURNER, moving on to his slide presentation, said that it was a brief overview. [This slide presentation was made available in the form of handouts and placed in members' packets.] He said that the clinical definition used for alcoholism is that it is a disease of the brain with genetic and environmental factors, which influences development and manifestations, and that the disease is often progressive and fatal. He added that the most recent research - via a web search - indicates that the "reward" pathway in the brain may be even more important to the craving associated with addiction compared to the reward itself. Further, scientists have learned a great deal about the biochemical, cellular, and molecular basis of addiction, and have said it is clear that it is a disease of the brain, rather than simply a weakness of the will or a moral problem. He went on to say that [alcoholism] is characterized by impaired control over drinking; preoccupation with alcohol, even when not drinking; use of alcohol despite all of the negative consequences; and distortions in thinking, most notably the denial factor.

MR. TURNER suggested that by looking at the disease of alcoholism as a root - something that is buried underground that can't be seen - all of the problems associated with alcoholism become clearer. He said that the disease affects the family first. Family problems such as child abuse, spousal abuse, and neglect begin to occur. Also FAS and FAE (Fetal Alcohol Syndrome and Fetal Alcohol Effects) situations crop up. School dropout rates increase as well due to alcohol and drug use. Drinking affects a person's job in terms of absenteeism and poor work performance. There is also a tremendous cost to the legal system, the court system, and the prison system. He acknowledged the financial burdens of people with the disease, as well as the physical symptoms such as an increase in accidents. He added that about 53 percent of the fatal accidents that occur in Alaska are alcohol-related. In addition, people with the disease suffer emotional and mental anguish and despair, and their value systems and morals [deteriorate]. Mr. Turner said he believed that when a person's spirit dies, his/her thoughts begin to turn to suicide.

Number 0968

MR. TURNER said that the amount of money spent treating the symptoms compared to the amount of money spent on the treatment of alcoholism is more than ten to one. He mentioned a national study that said ".04 percent" of the total cost of alcoholism and drug addiction goes into prevention of the problem.

Referring to a slide in his presentation, he said it all adds up: the costs of alcoholism to society are extremely high. His slide listed the percentages of suicides; child abuse; domestic violence; sexual assaults; fatal automobile crashes; fatal fires; and homicides that are alcohol-related. He noted that in fiscal year 2000, the Alaska Court System (ACS or "the courts") data reflected approximately 5,300 arrests for DWI (driving while intoxicated). He added that DWI seems to get an awful lot of attention, yet it is seen as one of the symptoms of the disease (of alcoholism), not the disease itself. Many of those who get DWIs may get assessed as being dependent on alcohol and are in need of treatment, but many more are not alcoholic. They are people who have been to a wedding or to a funeral or to some other occasion where they had too many drinks and then attempted to drive home, which is simply a sign of really poor judgment.

MR. TURNER reported that the rate of alcoholism in Alaska is one of the highest of any state; the results of a 1998 Gallup poll showed that 41,108 adult Alaskan residents are dependent on alcohol, and that about 17,294 are what are known as "alcohol abusers."

Number 1110

CHAIR ROKEBERG sought comments on why Alaska's statistics were double the national average.

MR. TURNER said that there were a lot of theories. He acknowledged that there are races [of people] for which the rate of alcoholism is much greater than in other races. To illustrate, he said that in the Jewish and Italian races it is a very low rate, and in the American Indian/Alaskan Native races, it is extremely high, and he added that Alaska is about 17 percent Alaskan Native. He also said that Alaska is a frontier state, and as such, has a history of drinking as the norm. He said that he was unaware whether any research has been done within Alaska to determine the reasons for the high numbers.

CHAIR ROKEBERG inquired whether the aforementioned statistics had been applicable over a number of years.

MR. TURNER replied that those numbers had held pretty steady. On the point of responding to the problem of alcoholism, he said that there are four main responses, but over the years it has been found that there is only one response that really works, and that is treatment. With the response of locking people up, they eventually get out [of jail], and if they haven't gone

through treatment, they go back into society and begin causing problems again. He explained that the treatment process starts from the time the patient gets into referral, and continues on with screening, assessment, placement, treatment, [continuing care, and follow-up monitoring].

MR. TURNER explained that there are many ways in which people enter into the treatment system. Most people enter at the urging of others, some at the urging of the court/judge, but very few are self-referred. He noted that some people will come in to a treatment facility and say they are self-referred but it is later found out that they are "self-referred" by a spouse or some other family member. He acknowledged that there are some who say patients can only be successful when treatment is entered into without coercion. He pointed out, however, that coercion is the basic reason why people get into treatment to begin with - coercion through their bosses, family members, friends, or the court system.

Number 1278

REPRESENTATIVE BERKOWITZ asked how success was being defined with regard to treatment.

MR. TURNER asked to defer that question until later, when he would answer in detail. On the topic of screening, he said that it is an initial review of a person's symptoms to determine whether drinking or drug use is out of bounds. He added that screening is used to rapidly distinguish between those who need education and those who need treatment. He noted that there are different forms of screening, and for the purposes of this slide presentation he used CAGE - Concern, Anger, Guilt, and Eye-opener - but he also noted that another form was SASSI - Subtle Alcohol Substance Screening Inventory - which is technical in nature and requires training to administer. With CAGE, which is a tool that has been used for many years, four questions are asked: "Is someone concerned about your drinking? Do you get angry when someone wants to talk to you about drinking? Do you feel guilty the morning after? Do you need an eye-opener upon awakening?" If a person answers yes to one of those questions, then he/she proceeds to the assessment stage of the treatment process because there is an indication that there is a problem. If a person answers yes to two of those questions, then there is an indication that he/she needs treatment. Three questions answered in the affirmative reflect the late stages [of alcoholism], and if the answer is yes to all four questions,

then there is an indication that the disease has progressed to the chronic stage.

MR. TURNER next described assessment as gathering and evaluating information to diagnose substance abuse disorders, and then developing a treatment plan that addresses the specific problems identified in the assessment. The assessment may include questioning what the person drinks; the frequency of drinking; the amount which is drunk; if it is a court-referred DWI case, looking at the blood alcohol concentration (BAC); looking at how the drinking affects the person's schooling, job, and family; getting information about other arrests; looking into the person's financial situation; and determining the presence of any physical, emotional, mental, or spiritual disorders. All of this information is used to determine the severity of the disease and then determining, according to a scale, what the best placement would be.

MR. TURNER then described placement as putting patients in the setting where they can receive the most effective treatment. He explained that in Alaska, the American Society of Addiction Medicine, Patient Placement Criteria, Second Edition (ASAM PPC-2), is used to determine whether outpatient or inpatient treatment, and short-term or long-term treatment would provide the best possible chance for a person to respond and get well. He also explained that treatment can take many forms, depending on the patient. It can include detoxification; drug-assisted therapy, such as Naltrexone; longer-term care; or treatment for mental illness in dually diagnosed clients.

Number 1498

REPRESENTATIVE MEYER asked for more information regarding detoxification coupled with the use of the drug Librium. He asked whether, in such instances, these are people who are chronic alcoholics, and if so, would going without Librium be dangerous for them.

MR. TURNER, in response, confirmed that most such instances do involve the chronic alcoholic. He also acknowledged that sometimes if a person withdraws suddenly from a substance, his/her state of anxiety increases to the point of perhaps causing seizures or delirium tremens (DTs), and because Librium keeps patients slightly sedated, it consequently prevents that stage from occurring. He added that the DTs can involve severe hallucinations, which can, in some instances, be controlled by the person experiencing them. He also said that any drug

similar to Librium, when used to sedate a person, could prevent the DTs. He reported that about one in sixteen dies from the DTs and about one in twelve dies from alcohol-induced seizures.

REPRESENTATIVE MEYER commented that if the experience of going through the DTs is so unpleasant, he could understand why a person would avoid treatment just to avoid the experience of the DTs.

MR. TURNER responded that unpleasant as that experience is, a person eventually has to go through it because a constant level of intoxication cannot be maintained indefinitely; the person either dies or has to withdraw at least occasionally.

REPRESENTATIVE BERKOWITZ asked how the DTs become fatal.

Number 1663

MR. TURNER explained that if a person is withdrawing from a substance by himself/herself without any assistance, and he/she begins to hallucinate, fatal accidents can occur; he also noted that there are some instances of heart failure associated with the DTs, although heart failure is more common in alcohol-induced seizures. Returning to the issue of treatment, he said it could also include education about the disease (he said that in his own case when he learned that he suffered from a disease that could be brought into remission, he had hope for the first time); confrontation to break through denial; referral to support groups; relapse-prevention-skills development; and recovery-life-skills development.

CHAIR ROKEBERG asked whether, in the rural parts of the state where perhaps there is not an existing Alcoholics Anonymous (AA) chapter or similar group, [the DADA] works to establish any non-state-funded support groups.

MR. TURNER said that the DADA does not establish any such groups; instead, it informs people where informational material can be obtained. He added that the focus of the DADA is in establishing a continuum of care - referred to as "aftercare." Also, if people in a community are interested in forming a 12-step group or a cultural group, the DADA can assist them in locating startup informational materials or refer them on to other groups that can offer assistance. He noted that the Natives for Sobriety is one such cultural support group, and that there are various similar groups throughout the state.

MR. TURNER explained that it is the therapist's job to focus on the disease of alcoholism - to break through the denial barriers. However, much of the therapist's time is taken up working with the family because the family needs to be involved and understand that there is a plan for recovery, as well as working with teachers or employers. Furthermore, much time is spent in the legal system, since therapists can be subpoenaed to appear in court on behalf of the patient many times. He added that one of the biggest complaints [the DADA] receives from treatment centers is the amount of time therapists are required to spend in responding to subpoenas. With regard to patients' financial situations, he also explained that therapists assist patients in finding housing and jobs. Therapists must also coordinate with physicians, psychologists, psychiatrists, churches, and ministers. Thus a lot of a therapist's time is spent working with the symptoms of a patient's disease, rather than the disease itself.

Number 1882

MR. TURNER, on the topic of continuing care, said that a New Standards study done between 1994-1998 showed that participation in continuing care is the best predictor of treatment outcomes at the one-year follow-up session. Referring to a chart in his slide presentation, he said that a person who attends a support group after treatment is more likely to be sober after a year of treatment compared to a person who does not attend a support group.

CHAIR ROKEBERG, referring to the chart, asked what the difference was between the aftercare given to residential-treatment recipients and the aftercare given to outpatient-treatment recipients.

MR. TURNER responded that the percentages for the outpatient-treatment recipients looked better because they had been assessed as not having as severe a problem. He added that the earlier the disease is caught, the better the results. If a patient is suffering from the later chronic stages of the disease, such as with those assessed as needing inpatient treatment, then the results go down because a person's ability to respond is not as good. Thus, he confirmed for Representative Berkowitz, in looking at the chart, a person should not misconstrue that outpatient treatment is more effective; simply, patients assessed as needing outpatient treatment, as opposed to inpatient treatment, are affected by the disease to a lesser extent and therefore respond better to

the treatment they are given. Mr. Turner also went on to explain that there are various types of inpatient [treatment], and that there are very long-term inpatient facilities for the more chronic alcoholic and drug addict in addition to short-term inpatient facilities for those less affected by the disease. He added that ASAM PPC-2 is used to move patients to the next phase of treatment - from inpatient to outpatient and then on to continuing care.

MR. TURNER then posed the question: "Does treatment work?" He answered, "Yes, it works, and I'm a living example that it works." He went on to say that a recent study of Alaskan treatment outcomes shows 56 percent of outpatients and 42 percent of inpatients abstained from alcohol for a year after treatment. He remarked, however, that abstention is not the only measure of success. He went on to say this study also shows treatment has benefits that significantly reduce the costs of alcoholism to the state. Directing attention to the slide showing columns that reflected behavior-pattern percentages during the year prior to treatment and the year after treatment for both inpatient (residential) and outpatient-treatment recipients, he commented that the results were easy to see. He referred to a study done in Oregon, which showed that for every dollar spent on treatment, there was a savings of $5.60 to that state. He also noted that California had spent $30 million doing a similar study, which showed that for every dollar spent on treatment, there was a savings of $7 to the state in alcohol-related costs.

Number 2038

REPRESENTATIVE MEYER, referring to Mr. Turner's statement that treatment works and that it worked for him, surmised that it worked for Mr. Turner because really he wanted help. He offered, by way of contrast, that what was being proposed with HB 4 was offering a choice to DWI offenders to either go to treatment or go to jail. He said he wondered, given those two choices, whether the success rate would be as high for those offenders opting for treatment - whether offenders in that situation would really want the treatment.

MR. TURNER recounted that he had worked for a number of years in the state of Washington, which has a two-year deferred prosecution program whereby all DWI offenders are given the choice between prison and treatment. In comparing the two-year deferred clients with the self-referred clients, there was a much better success rate with the two-year deferred clients

because those clients attended the program for the full two years, whereas the self-referred clients often dropped out of treatment after 30-40 days. A person who refers himself/herself to treatment can also refer himself/herself out of treatment, he added, but the two-year deferred clients had to finish the two years of treatment or face going to prison. He commented that his daughter is an example of the success of the two-year deferred prosecution program; eight years ago she got a DWI and opted for the two-year deferred prosecution program and has remained sober ever since.

CHAIR ROKEBERG clarified that HB 4 has mandatory treatment at every aspect of it, including during incarceration, with the exceptions of the Alcohol Safety Action Program (ASAP) provision wherein only the educational necessity assessment is required, and the diversion program for .08-.10 BAC levels.

Number 2158

MR. TURNER continued by posing the question: "Who has a better success rate, people who buy their own treatment or people whose treatment is paid for by the state?" He then said that some studies show that private-pay treatment facilities have a higher success rate. He added that again, as in comparing differences between inpatient and outpatient [treatment], those people who go to private facilities and who still have jobs and insurance and thus retain the ability to pay for treatment are, therefore, not as debilitated as people that are in need of public treatment centers. Also, too, if the disease is caught at the earlier stages of its progression, there is a greater chance of success.

MR. TURNER clarified that the state does not provide treatment. The DADA is a "grant in aid" program, and because this is so, no employee of the state provides alcohol treatment; all of the treatment centers are privatized.

MR. TURNER then posed the question: "Who pays for treatment in programs that receive public funds?" He explained that the state actually pays for less than half the treatment costs in programs that receive public funds. Treatment programs are held to a rigorous review, through private audits, of their sources of revenue and of expenditures for treatment services to ensure that "double-dipping" does not occur. He stated that treatment is not free. He acknowledged that people can be more committed to something if they put their own resources into it, but they

have to have resources to put there, and alcoholism is a disease that robs people of their resources.

MR. TURNER next posed the question: "What is the cost of treatment?" He explained that the cost per day varies depending on the treatment center and type of treatment provided, for example, $71/day at Nugens [Ranch] compared to $345/day in a hospital-based setting where doctors, psychiatrists, and psychologists are available.

MR. TURNER posed another question: "How can we improve treatment outcomes?" Develop more capacity so that systems can provide timely service, he offered; when a person is ready, that is the time to get him/her into treatment, but very often that is not possible because of waiting lists that are sometimes six months long. In six months, a person is not as ready as when he/she is first contacted. He said that there is also a need to look into providing more specialized treatment to women, youth, and patients with co-occurring disorders such as mental illness. He said he knew there were a lot of people "dropping through the cracks," and he opined that a "no wrong door" approach needed to be developed so that whether a person is in a mental health program or an alcohol program, he/she still gets the treatment needed. He remarked that there was a need to stabilize, restore, and extend the ASAP.

Number 2314

REPRESENTATIVE BERKOWITZ asked for an outline of the current standing of the ASAP as well as an indication of Mr. Turner's vision of the ASAP's future.

MR. TURNER remarked briefly that testimony prepared for later in the meeting will show an increase in ASAP referrals without any corresponding increase in funding, which has, in fact, decreased to the point of mandating the closure of [six] facilities (Cordova, Valdez, Sitka, [Barrow, Nome, and Seward]). At Chair Rokeberg's urging, however, he offered to return to this issue later.

MR. TURNER then referred to his slide presentation and an additional handout that showed the number of beds available through programs that receive grant funds, where those beds are located, and where the funds come from for those beds. He added that 84 percent of the DADA beds for adults (which total 376 beds) are funded by the general fund (GF), 11 percent by the SAMHSA (Substance Abuse & Mental Health Services Administration)

Federal Block Grant, 3 percent by the Mental Health Trust Authority Authorized Receipts (MHTAAR), and 2 percent by interagency receipts from other agencies. In regard to [DADA beds] for women (which total 81 beds), he said that 40 percent are funded by the SAMHSA Federal Block Grant, 31 percent by interagency receipts from other agencies, and 29 percent by the [GF]. [Tape changed with approximately 2.5 minutes blank at the end of Side A.]

TAPE 01-35, SIDE B
Number 2393

[There are approximately 2.5 minutes blank at the beginning of Side B.]

MR. TURNER said that [the DADA beds] for youth (which total 32 beds) are 100 percent funded by the GF.

CHAIR ROKEBERG asked Mr. Turner to provide this information to the committee in a short memo, and pointed out that at some future juncture the committee would be taking up the issue of waiting lists, either via HB 4 or some other legislation, and thus a good understanding of this information was crucial.

MR. TURNER continued by saying that there are more people requesting services than the system can serve. He reported that statewide there were 223 people waiting to receive inpatient treatment (although that number changes from month to month), and 81 people were waiting for outpatient treatment.

CHAIR ROKEBERG interjected, requesting clarification regarding capacity because he had heard others mention that only 10 beds in Fairbanks and 14 beds in Anchorage were available.

REPRESENTATIVE BERKOWITZ noted that 10 and 14 reflected the number of beds designated for "detox" in Fairbanks and Anchorage. He also noted that the numbers given by Mr. Turner reflecting available DADA beds included beds designated as detox beds, treatment beds, and dual-diagnosis beds.

MR. TURNER followed up by confirming that there are only 14 detox beds available at Clitheroe Center ("Clitheroe"), which is located in Anchorage, and that a lot of clients who are designated as needing those detox beds are flown in from other parts of the state. He also confirmed that while there are other beds available at privately funded facilities (such as "Charter North"), and, while the Ernie Turner Center did have

privately funded beds, the chart he provided only reflected facilities that received public funds. He added that he himself had built the Ernie Turner Center, and that he had built it overcapacity with the hope that he could get additional public funds in order to fill it up. However, since he has not gotten the additional funding, he has opted, instead, to have those extra beds made available for private-pay clientele; while this has helped, the facility is still not filled to capacity.

CHAIR ROKEBERG asked for suggestions on how to cut the waiting list. He said he had concern that if the courts, under HB 4, begin meting out additional treatment time as conditions of punishment and/or release, the treatment beds would not be available for, in some cases, up to 60 days.

Number 2116

MR. TURNER suggested deferring that question to Loren Jones, who would speak later. He then continued with his slide presentation by saying, on the topic of specialized treatment, that a 1998 Gallup poll of Alaskan households revealed that two out of every five Alaskans who wanted alcohol treatment but had not received it in the past year were women of childbearing age. He added that those women were at risk of giving birth to a child with FAS or FAE.

MR. TURNER also said that another group in need of specialized treatment are youths. He referred to a chart reflecting minor consuming/possessing violations, and noted that these offenses were increasing. He said that while there is some belief that adolescents may not be addicted to alcohol, his experience in treating adolescents has shown him that this is a fallacy; he has known some adolescents who, at 14 and 15 years of age, were just as addicted as many chronic alcoholics. He added that in hindsight, he has no doubt that he was an alcoholic at age 16. He remarked that there is a three-to six-month waiting list for youth residential treatment, and that publicly funded youth residential treatment programs are only available in Anchorage, Fairbanks, and Sitka, while outpatient treatment for youths is only available in Wasilla, Anchorage, Juneau, and Fairbanks.

MR. TURNER, returning to the point of the Alcohol Safety Action Program (ASAP), said that although it is not a treatment program, the ASAP refers offenders for assessment and monitors offenders referred by the courts to ensure that they complete required treatment. He added that ASAP is a very successful program for monitoring treatment. He reported that a University

of Alaska Anchorage (UAA) survey found that monitoring the treatment of Alaskans convicted of drunken driving and other drug- and alcohol-related crimes significantly reduced their tendency to repeat their crimes. He advised that the ASAP needs more resources in order to do the job effectively; from 1988 to 1995 the ASAP experienced an 87 percent increase in its caseload and a "zero" increase in funding.

MR. TURNER added that in the past three fiscal years, while funding for treatment (not including prevention) has dropped, the need for treatment has increased. He noted that there was a $500,000 fund source change from the "GF to FAS," and that a $529,000 Center for Substance Abuse Treatment (CSAT) grant, which was for rural treatment in the Hooper Bay area, has expired, although a portion of that grant was carried forward into 2001 along with $125,000 from another expired grant. He pointed out that as federal grants expire, which happens after three to five years, the amount of treatment available in the state is significantly reduced.

Number 1902

LOREN JONES, CMH/API Replacement Project Director, Division of Mental Health & Developmental Disabilities, Department of Health & Social Services, noted that he was formerly the director of the DADA, and said that the preliminary numbers he arrived at regarding the waiting list were approximately $4 million, some of which is capital money and some operating money.

CHAIR ROKEBERG asked Mr. Jones if he meant that beds were available if there was funding for them.

MR. JONES responded that in looking at the specific facilities and programs that had waiting lists, specifically waiting lists for women and children or for family treatment, it was found that the current facilities are at physical capacity and thus those programs cannot be expanded. Therefore, [the state] would need to find other facilities in order to expand specific programs, and that takes time. It takes both time and money to remodel a facility in order to pass local zoning requirements, and building and fire codes, he added. He noted that the only facility that had room to expand was the Ernie Turner Center, but because it is set up as a coed program, it would not do as a women-and-children-only program. Again, he added, all other women-and-children programs, such as at the Alaska Woman's Resource Center, the Salvation Army and the Fairbanks Native Association, are at capacity. Hence, to add additional

treatment beds to those residential facilities that are already at capacity would require those facilities to procure other physical locations.

CHAIR ROKEBERG remarked that that information was very distressing. He then said the assumption is that because it is privatized, the private sector - either through for-profit companies or nonprofits - will step up to do that in the urban areas. He asked if that is correct.

Number 1782

MR. JONES said that was not necessarily the case. Most of the nonprofits that the DADA deals with can usually - through the grant payment, operating funds, or revenues - cover rent if they can rent a facility. But generally the cost they cannot cover upfront is the initial remodeling cost to turn a facility that was used for some other purpose into an appropriate treatment center - especially if it is for women and children's treatment. He added that every woman that enters treatment usually brings one or two children with her; therefore, an onsite daycare center must be developed at the facility, and the rooms for clientele must be larger because zoning requirements stipulate that an almost equal square-footage be given to each child (depending on the age of the child) as is given to the mother. Facilities suitable for this kind of conversion are hard to find, he also added, and most nonprofits don't have the capital available to undertake such a conversion.

CHAIR ROKEBERG said he inferred that Mr. Jones's testimony is that it is a combination of capital requirements - grubstake grants, so to speak - that would initially provide the facilities, coupled with per-diem head-costs.

MR. JONES said that was correct.

MR. TURNER added that some facilities - including the facility in Nome, which has since closed down - have reduced their capacity to 16 beds because of Medicaid requirements; Medicaid will only cover 16 beds due to the IMD (institution for mental disease) exclusion.

MR. JONES elaborated by saying that under the federal Medicaid rules, an IMD is a facility that treats adults from the ages of 21 through 64, generally for a mental illness. And further, the Health Care Financing Administration (HCFA), which operates the federal Medicaid program, has determined that any facility

greater than 16 beds that treats adults for mental diseases is an IMD, and Medicaid cannot pay for the care of those persons, even if they are Medicaid-eligible, in an IMD. As an example, he said that Alaska Psychiatric Institution (API) is an IMD and as such does not receive any Medicaid payment for adults treated at that facility; Medicaid only pays for youths treated at API. Under this ruling, residential substance abuse treatment programs are considered to be mental institutions; consequently, as an example, the Salvation Army is not permitted to bill Medicaid for treatment to any person who is on Medicaid because the Salvation Army has 54 beds. For this reason, most of the newer programs that have come online are limiting themselves to 16 beds so that they fall under the IMD exclusion and thus retain the ability to bill Medicaid for treatment provided to Medicaid-eligible recipients.

Number 1588

REPRESENTATIVE COGHILL raised the question of future labor problems brought about by mandated treatment. He asked what the forecast was for having an adequate pool of qualified people who could work in treatment centers.

MR. TURNER said he had the opportunity last year to visit many treatment programs throughout the state, and he acknowledged that retention of treatment staff is a basic problem. Some of the programs are paying a starting salary of $10.50/hour for a counselor, and as soon as this counselor is trained, he/she moves on to either the social services field or the mental health field, which pays more, and then that counselor is lost to the alcoholism field. Treatment programs just don't have the funds to bring salaries up in order to retain personnel. Another problem he acknowledged was a lack of training money. There is one contract for doing training for the state, and there is not enough money in that contract to hire the staff who could provide statewide training.

REPRESENTATIVE COGHILL asked if there was any way, within the grants that provide funding for staff, to create an incentive for staff to build careers within the field of alcoholism treatment.

MR. TURNER mentioned that there were some nonprofits that do have a career ladder, and have a retirement program. However, very few of them do, he added.

CHAIR ROKEBERG, on the topic of mandating offenders to pay for their court-ordered treatment, asked Mr. Turner what rate of success the DADA had in collecting money for treatment.

Number 1436

MR. TURNER explained that [the DADA] did not make collections. In response to further questions, he said that any funds paid by an individual for his/her treatment costs are put back into the program to help pay for the overall costs, but it was up to the individual organizations to make their own collections. He noted that individual programs are only required to come up with a 10 percent match of funds provided by the DADA. He added, however, that the funds the DADA provides, plus that match, are not enough to pay for the treatment facility; programs generally have to raise additional funds. For example, when he was the director of the Alaska North Addictions Recovery Center (now known as the Ernie Turner Center), that organization received a $340,000 grant from the state, but the total cost to operate that facility was $1.5 million. Consequently, through other sources, the program had to come up with enough money to operate the facility. Some funds (about $260,000) came from the Indian Health Service (IHS), but the rest were collected as fees for services. He noted that fees for services were based on a sliding scale and the minimum a client had to come up with was 10 percent. In cases covered by insurance, the insurance company paid anywhere from 50 percent to 100 percent, depending on the type of coverage an individual had.

MR. JONES added that when programs submit their annual budgets to the DADA through the grant process, they are to identify all of their other sources of income, such as insurance payments. When the annual audits are done through the state's "single honor" process, it is to double-check whether programs could have raised the revenue needed to operate their programs, and to verify that what was stated in the grant discussions matches what the "single audit" shows. He added that all grantees are required under the state's single audit provisions to have an audit each year on their use of funds so that the state can guarantee that the funds raised by the grantees do actually go back into the program.

MR. JONES noted some of the problems the DADA's programs have in terms of collecting fees. If a person were to assign his/her permanent fund dividend (PFD), the DADA is the last on the list of many. And if a person does not apply for a PFD, then that source is unavailable altogether. Small claims court is

sometimes utilized, although it is not a very productive way in which to collect a fee that is owed, he observed. He added that 75 percent of all people who come to publicly funded treatment programs have an annual income of less than $10,000. Therefore, a program might get $5 as payment from a low-income individual for a group session, whereas if an insurance company were covering the cost, it would pay $25-$35 for that same group session. He said that [programs] do try and collect some fees, but it is oftentimes a very difficult process to get a meaningful return in terms of actual dollars.

Number 1200

CHAIR ROKEBERG asked if the DADA made per-diem contractual arrangements with the providers, or just grants.

MR. JONES responded that the process of funding is through a grant process. The potential provider is asked to describe, based on the request for funding, what services it intends to provide and how much it anticipates that service costing, not only for a certain number of people, but also to achieve certain outcomes related to the client's job, and related to his/her legal issues stemming from drug/alcohol use. In most of those cases, it is found - by listing how much treatment providers want from the state versus what they are going to collect from fees, services-in-kind, donations, third-party/first-party payees, and municipalities - that the state is paying roughly half of the treatment costs. He explained that the DADA does not, at this time, do a per-diem rate for the cost of the care. He added that that was because in the past, the mechanism has always been the grant-in-aid process. [The DADA] has looked at doing per-diem contracts so that the full cost of a bed could be determined in terms of, if the capacity of a bed were purchased, how much it would cost on an annual basis. That concept has never been fully developed, he noted; there has not been a lot of desire generated over the years to move from a grant process to a per-diem process.

CHAIR ROKEBERG commented that there have been complaints that the state is being subsidized for some of the treatment programs this year because the costs are higher than the state grants.

MR. JONES addressed that point by saying that about six years ago, the legislature transferred from the Department of Corrections (DOC) to the DADA approximately $630,000 to pay for residential treatment in the communities. In the DADA's budget there is a separate component called Corrections that has those

dollars in it. The agreement the DADA had with the DOC was to try to purchase as many beds as the DADA could, based on the DOC's historical information. The money available in that component for the number of beds that the DOC really wanted in the community is approximately $49/day. He noted that $49/day is approximately half, or less, of the full cost of the care provided. Thus, he acknowledged, the DADA's grant is picking up the difference. If additional funds could be made available through appropriation, he added, then there would be more capacity in programs because they would not have to use some of the grant funds to cover costs. He noted that this is a situation that has developed over time but which has never been addressed in a budgetary fashion.

CHAIR ROKEBERG asked Mr. Jones to provide the committee with a memo outlining that issue in that it might have influence on the House Finance Committee. He acknowledged that when providers aren't being paid for their basic costs, it acts as a disincentive to provide more beds.

REPRESENTATIVE COGHILL thanked Mr. Turner for sharing his personal experiences. He asked, with regard to the ASAP, whether all treatment programs are working with the same philosophy, and also, how a distinction is made at the time of referral in determining which type of treatment would be more appropriate.

Number 0873

RON TAYLOR, Coordinator, Alcohol Safety Action Program (ASAP), Division of Alcoholism and Drug Abuse (DADA), Department of Health & Social Services (DHSS), explained that the Anchorage office of ASAP is not only responsible for the monitoring and oversight of defendants who are referred from the court on misdemeanor probation, but is also the central office for the entire Alaska ASAP system; his job entails arranging for technical assistance and training, and ensuring that all of the ASAP offices operate on a standardized basis. He noted that this is a problem when there is approximately an 87 percent increase in caseload but no increase in funding. He added that the caseload is continuing to increase, and that the ASAP has recently closed six of its programs. Back in the mid-'80s the ASAP had 22 programs, and now it has 11 programs - a decrease by half. He noted that the ASAP is anticipating reinstating six programs in the rural areas that are really "hurting" for some type of monitoring service.

MR. TAYLOR said the six programs that have recently been cut back are Cordova, Valdez, Sitka, Seward, Nome, and Barrow. On another point, he said that there is no misdemeanor probation whatsoever in Alaska; ASAP is the closest thing to misdemeanor probation, but the ASAP does not do supervision, only the monitoring of alcohol/drug-related requirements. In the past, the ASAP monitored community work service (CWS), weapons awareness, parenting classes, and domestic violence intervention, but it became so burdensome to an already taxed staff that the ASAP has had to decline those duties. The ASAP has only four probation officers in the Anchorage office who each have a caseload of anywhere from 800-1,100 cases a year. The ASAP also has grantee offices that are staffed with anywhere from one person to (in the biggest grantee office, in Fairbanks) three persons, and there is tremendous cost in terms of cases. He noted that the ASAP's case management fee is only $100, which, when compared with other states, is probably the very lowest. Other states are charging anywhere from $300-$500 for case management fees, and are also making it a requirement that the fee be collected before signoff services are provided for Division of Motor Vehicles (DMV) purposes, or for condition-of-probation purposes.

MR. TAYLOR said that if he were to make any "pitch" to the committee, it would be to point out that the committee has an opportunity [with HB 4] to make a real difference. There is an opportunity in the ASAP to begin helping treatment programs and prevention programs to become more efficient and more effective by collecting data from ASAP clients who come through programs. This is a "captured population," and if the ASAP is able to do its job and do it effectively, it can pay some very handsome results for the state in the next couple of years.

Number 0538

MR. TAYLOR, when queried about raising the case management fee, said that it was possible that the money might filter back down to the ASAP if the ASAP also made payment of those fees a requirement before signoff services were provided for (DMV) purposes or for condition-of-probation purposes. He added that the current case management fee generates approximately $140,000 a year in revenue, and if the fee were doubled, that might pay for two more probation officers; however, he cautioned that the increase would only affect the Anchorage office, and the ASAP does have grantee offices to consider when seeking sources of additional funds. On the point of whether the market would bear an increase in case management fees, he said it would depend on

how that increase was pursued. One method would be to pursue the increase as a collections matter. Another is to make payment mandatory before signoff services are provided for (DMV) purposes or for condition-of-probation purposes. And yet a third method would be to have the increased case management fee in lieu of, or to help offset, the court fine. He added that for those individuals who cannot afford the case management fee, the DHSS could, via regulation, exercise a waiver.

MR. TAYLOR, in response to Representative Berkowitz, confirmed that the Anchorage ASAP office had never monitored community work service (CWS), though in the outlying areas the other ASAP offices were monitoring CWS but have since stopped. He also noted that ASAP did not monitor any anger management or domestic violence (DV) programs; the only similarity the ASAP has to a DV program is a grant of $50,000 that the ASAP has through AWAIC (Abused Women's Aid in Crisis) to monitor DV. He reiterated for Representative Berkowitz that the ASAP had four probation officers in Anchorage with a caseload ranging from 800-1,100 per probation officer. He also confirmed that, unfortunately, there were no national standards for an ideal caseload.

Number 0353

CHAIR ROKEBERG referred to a handout provided by Mr. Turner, which said that 75 percent of first-time DWI offenders assigned to the ASAP office and 52 percent of the non-DWI offenders did not receive a new criminal/traffic offense within three years of the original ASAP referral. Chair Rokeberg asked Mr. Taylor what non-DWI offenders were, and how they came to the ASAP.

MR. TAYLOR explained that those non-DWI offenders were referred by the district court through cases such as domestic violence assaults, shoplifting, larceny, and any type of alcohol/drug-related cases.

REPRESENTATIVE BERKOWITZ suggested that it would be appropriate for the committee to observe the district court in order to see how it functions.

CHAIR ROKEBERG said that was not a bad idea and that he had, in fact, visited Judge Froehlich's court a couple of weeks ago. He then asked Mr. Taylor if the ASAP dealt with any youthful offenders.

MR. TAYLOR responded that the only program serving youthful offenders currently is the Fairbanks ASAP office, which is

helping out with a pilot program dealing with minor-consuming offenders. However, it is not being funded via ASAP/DADA; it is something the grantee is doing on its own. He added that it is proving to be a very successful program, and was started in September of 1999.

MR. TURNER added that he would get the committee the most recent figures on the results of this pilot program.

CHAIR ROKEBERG called an at-ease from 2:36 p.m. to 2:39 p.m.

[Tape changed with approximately 1.5 minutes blank at the end of Side B.]

TAPE 01-36, SIDE A
Number 0001

SARAH WILLIAMS, Coordinator, Substance Abuse Program, Inmate Programs, Division of Institutions, Department of Corrections (DOC), said the handouts she has provided would be helpful in outlining what services the DOC provides with regard to substance abuse treatment. She said there is a $200,000 increment needed for the next fiscal year just to keep afloat the services already provided across the state. This does not involve any new programs; without these funds, the DOC will have to cut some of the [substance abuse] programs out. She noted that the $200,000 increment was not funded in the House budget, nor has the DOC's [substance abuse] program received an increase in eight to nine years. She stressed that the DOC desperately needs those funds, without which the DOC will have to cut its [substance abuse] programs, which she offered was not what the committee wanted to see. She added that the DOC has a lot of people who are DWI offenders in [substance abuse] programs. For example, she said that at the [Pt. MacKenzie Farm Program's] intensive outpatient program, 50 percent of the participants in that program are felony DWI offenders.

MS. WILLIAMS pointed out that included in the handouts she provided was one addressing frequently asked questions about substance abuse treatment in the DOC. She added that this program is a bit "mysterious" because it occurs behind bars; there are not many, aside from participating inmates, who have seen the program. She said that she wanted to convey to the committee why [the DOC] does treatment in certain types of facilities, and what the whole point [of treatment] is. As an example, she noted that some might ask why the DOC provides treatment at all at the [Sixth Avenue Correctional Center], when

the turnaround at that institution is so fast; she answered that treatment is provided because it is an opportunity to do some intervention work with very high-risk people such as pregnant women who have been drinking, or IV (intravenous) drug users before they go back out on the street. She added that unfortunately that program has been reduced to just five hours a week, and the program at the [Mat-Su Pre-Trial Facility], which is also another key intervention point, has been reduced to just three hours a week.

Number 0315

MS. WILLIAMS said [the DOC] hates to see its services dwindle, and that there is a great need for these programs. There are over 70 people on the waiting list at [Spring Creek Correctional Center], which is an outpatient treatment program. She added that [the Spring Creek Correctional Center] is probably the DOC's most extreme site in terms of a waiting list. She acknowledged that the committee is concerned about those people who refuse court-ordered treatment, but she offered that in her experience, those cases are really quite the exception; the DOC has people in all of its facilities wanting treatment.

REPRESENTATIVE BERKOWITZ noted that at [the Spring Creek Correctional Center], most people are there for relatively long periods of incarceration, and he asked whether everyone who is there with court-ordered treatment gets that treatment before leaving state custody.

MS. WILLIAMS replied affirmatively. She also commented that sentences being served at [the Spring Creek Correctional Center] are much shorter than they used to be, primarily due to having 800 people in Arizona; the DOC tries to send the more long-term people there. Thus some people in [the Spring Creek Correctional Center] may be doing six months to two years, but the DOC prioritizes the waiting list on a person's length of time at the facility. So, eventually, the DOC "gets to them" and provides treatment. But, she added, it is good to provide treatment early because they make much better inmates if they are not engaging in alcohol/drug-seeking behavior and can instead focus on education programs, chaplaincy programs, and other programs.

REPRESENTATIVE BERKOWITZ asked, "So, it's cheaper to incarcerate them if we treat them?"

MS. WILLIAMS responded that it is a lot easier, but that is not the main reason [the DOC] provides treatment. [The DOC] provides treatment so that people will be less of a risk to the public when they are released, and almost all of them are getting out, she added.

REPRESENTATIVE JAMES asked how much access there is in prison to drugs and alcohol.

MS. WILLIAMS replied that there is access, and of course it is not something [the DOC] condones or is in the least bit proud of. [The DOC] is constantly working to decrease access, but people are extremely resourceful, especially when they have addictions. She added that she has seen things in [the DOC] she never would have anticipated, for example, melting down stick-deodorant for the alcohol content. And of course there are always the situations in which visitors bring in contraband, which is something the DOC tries very hard to minimize, although, unfortunately, it does happen.

Number 0507

REPRESENTATIVE COGHILL, with regard to treatment, commented that since the [prison] population is a fluid population, one of the things that he has seen is somebody getting a certain degree of a treatment program under his/her belt, and then getting moved along. He asked whether that is something [the DOC] takes into consideration, and how significant is [that problem].

MS. WILLIAMS responded that that situation does occur, especially when [the DOC] is trying to manage a population that is fluid, such as moving people to Arizona. What [the DOC] does is transfer the treatment progress to the next stop, and this involves a release of information and a movement of treatment materials, client files, and so forth. She added that this is disruptive to a program; it is not ideal, but the DOC does some things to minimize the impact. Substance abuse education programs have a minimum of ten required topics, and [the DOC] keeps track of which topic somebody has had; that way, a person who gets moved to another facility can pick right up in the education cycle wherever he/she goes. She explained that [the DOC] does not want to be pulling people in and out of programs, but in managing this overcrowded population, it does happen. Hence, [the DOC] provides treatment and education against all odds.

REPRESENTATIVE COGHILL remarked that he has heard people complain that just when they get started in a program, they get moved and have to start all over again, which impedes their progress and impedes their ability for probation discussions.

MS. WILLIAMS explained that [the DOC] keeps track of why someone is terminated from a program, whether it is a transfer to another facility or something beyond his/her control, so that a break in treatment is not treated in a punitive manner. She added that the two programs that [the DOC] never disturbs are the residential substance abuse treatment programs and the 6-to-12-month intensive programs at [Hiland Mountain Correctional Center] and [Wildwood Correctional Center]. These are [the DOC's] federally funded programs, and [the DOC] receives a 26 percent state match - thanks to the Mental Health Trust Authority.

MS. WILLIAMS went on to say that the 6-to-12-month intensive program for women at [Hiland Mountain Correctional Center] has been up and running for two and a half years. At the two-year juncture, [the DOC] did an outcome study (provided as a handout) that shows a significant difference between the women who had treatment and the comparison group of women who needed the program but did not get it. To obtain this information, [the DOC] combed through the Offender Based State Corrections Information System (OBSCIS) records, which show prisoner movement and re-offenses. [The DOC] discovered that among the graduates of the Residential Substance Abuse Treatment (RSAT) program, which is a therapeutic community for women, there was only one new felony offense and one new misdemeanor offense committed within six months of being back in the community, compared with five new felony offenses and eleven new misdemeanor offenses committed by the comparison group. When [the DOC] is asked whether treatment works, [the DOC] interprets the question as whether offenders come back through the system, and [the DOC] saw significant differences between the two groups of women - treated and untreated - who were part of the outcome study.

Number 0790

MS. WILLIAMS noted that [the DOC] has just started a similar men's program at the [Wildwood Correctional Center], and will also do a two-year study in which [the DOC] anticipates dramatic results as well. She added that the tricky part for [the DOC] is arranging for continuing care in the community because the federal dollars cannot be used outside the institution. That is

where [the DOC] will have to get very creative with its linkages in the communities. She remarked that [the DOC] is currently establishing a halfway house at Akeela House, Inc., just for these RSAT graduates. This is so that when the RSAT graduates arrive, they are not mixed in with confined misdemeanants; the graduates will be with people who are serious about treatment, and will be recognized for their accomplishments.

MS. WILLIAMS pointed out that included in the handouts are pages describing both the women's RSAT program and the men's RSAT program. She added that these two programs are among [the DOC's] major accomplishments within recent months, and if ever there is an opportunity to expand on this level of care, [the DOC] would very much like to do it. For felony DWI cases, she explained, probably 50 percent need intensive outpatient treatment, and another 50 percent need a residential level of care. Currently the men's RSAT program holds 42 people, 6 of whom are felony DWI cases already, and the women's RSAT is a 48-bed program. She added that there are DWI cases across the state - some offenders are in programs and some are not. In order for [the DOC] to prepare for an influx of DWI cases it needs to "gear up" because DWI offenders do need treatment.

REPRESENTATIVE COGHILL commented that with many of the halfway houses, some of the other issues dealing with incarceration relate to trying to get offenders back into working society. And with regard to treatment, he asked how [the DOC] was doing with family unification and/or family treatment, which goes beyond just the person in treatment.

Number 0966

MS. WILLIAMS responded that at the [Hiland Mountain Correctional Center] women's community, there is a social worker - funded through federal dollars and a state match - who just works on permanency planning and custody issues for the women in the program with children. She added that at least 70 percent or more of these women have at least one child under the age of 19, and in [the DOC's] program they are being prepared to make plans for the custody of their children, or to plan on regaining custody. The aforementioned social worker connects with the Division of Family & Youth Services (DFYS) and the community because oftentimes [society] says getting to be a parent again is the reward for going through treatment, yet realistically, without help from [the DOC], the women are not prepared. She also explained that [the DOC] has a transition counselor funded just by state dollars to work with the women; the counselor

actually goes into the community and visits the women while they are in the halfway houses, and especially pending aftercare. If there is a break between being in the treatment program in the facility and then graduating out onto the street, and if those women are on a waiting list for services, it is such a critical time, and the transition counselor "tides them over."

MS. WILLIAMS said the relationship between the community and the DOC is a symbiotic one; all of the folks in [the DOC's] facilities need at least aftercare upon release. [The DOC] says they may be "program complete" but they are not "treatment complete"; they need that aftercare piece desperately. She noted that the programs are only as good as the aftercare in the community. A lot of the folks coming out of the therapeutic communities are going to need aftercare support services, so [the DOC] works hand-in-hand with the DADA; all of [the DOC's] programs are contract agencies that are approved by the DADA.

REPRESENTATIVE JAMES commented that from what she has read and heard from the folks who have had these sorts of problems, sometimes the best treatment is to not go back into the same community and to not have the same group of friends. She asked how [the DOC] evaluates whether a person is strong enough to go back to the same influences that he/she had before going to treatment.

Number 1111

MS. WILLIAMS said that was a good question because for so many people, when they enter treatment, that is their goal - to go back home. Sometimes during the course of treatment, especially an intensive program, people realize they can't go back. And that is a very sad realization that they can't go back to their village or their community. If [the DOC] can set up transitional services, it does, and [the DOC] is making those connections; at the men's RSAT program at [Wildwood Correctional Center] there is a transition counselor built into that program to contact the community and set up structure. If, however, the person goes back and family and friends are drinking, it is such a sad setup for failure; sometimes when a person has had all this intensive treatment, Ms. Williams said she believes that when that person relapses, it hits even harder because of the guilt and the hopes that he/she had to stay clean. She acknowledged that [the DOC] has to be constantly aware of those transitional situations. She commented that about 80 percent of people coming through [the DOC's] programs do go back into

Anchorage, where there are resources; it is the rural clients that [the DOC] needs to take extra care with.

CHAIR ROKEBERG directed attention to the treatment element's fiscal note, which is over $1 million. He asked whether, currently, participation in the substance abuse programs is voluntary.

MS. WILLIAMS replied that participation in [the DOC's] programs is voluntary; however, there are repercussions for offenders if they don't participate in treatment. "You may not receive the furlough that you had hoped for if you don't earn it, [or] you may have probation revoked while you're actually in the institution; so there are some built-in incentives," she explained. She noted that some people go to treatment because once they get behind bars, they get bored. [The DOC] does not care if people come to the program for the wrong reason. She added that a lot of inmates get into the [Wildwood Correctional Center's] program simply because they don't want to go to Arizona, and then once they get in the program, they consider it a privilege to be there. So, even if inmates enter the programs for all the wrong reasons, [the DOC] takes advantage of it.

CHAIR ROKEBERG asked what calculations were used to arrive at the $1 million fiscal note.

Number 1299

CANDACE BROWER, Program Coordinator/Legislative Liaison, Office of the Commissioner, Department of Corrections (DOC), explained that according to her understanding, the treatment element in HB 4 applies to felony offenders. And while it is difficult to anticipate in a generic fashion what an individual offender might need in terms of treatment, she offered that the prevailing belief is that a third-time DWI offender would, at a minimum, require outpatient treatment in order to achieve a full recovery, and his/her problem might even be severe enough to require inpatient treatment.

MS. WILLIAMS added that at the [Wildwood Correctional Center], the 6-to-12-month inpatient program costs approximately $6,380/person, which she noted is very reasonable, and she confirmed that that is in addition to the standard per-diem hard-bed costs.

MS. BROWER also added that that $6,380/person was only for the cost of [the DOC's] contract for 6 to 12 months. With regard to

calculating the fiscal note, she said her numbers for the first year were 240 felony offenders, with an estimated 50 percent needing intensive outpatient treatment at a cost of $2,500/person and 50 percent needing residential treatment at a cost of $6,380/person. She added that although her calculations were simplistic, she did add in those people who were already in ongoing treatment on a voluntary basis (minus those in the [Wildwood Correctional Center's] program). She confirmed that all of the RSAT-program beds at [the Wildwood Correctional Center] were already full.

MS. WILLIAMS added that the RSAT-program at [the Wildwood Correctional Center] did not involve adding any extra hard beds to the DOC, those beds were available anyway; there were no state employees hired for the program; and it is all contract treatment. Thus, the dollars go directly towards the treatment services; there is no extra overhead.

CHAIR ROKEBERG remarked "just a million bucks."

Number 1466

MS. BROWER countered by referring to Mr. Turner's testimony, and asked the committee to calculate the potential savings incurred by investing in treatment.

MS. WILLIAMS added that the treatment programs the felony-DWI offenders will need, in general, are nothing new to [the DOC]; those offenders are already in [the DOC's] programs; they have high-risk behaviors; and in so many aspects, the addiction issues are the same as for those offenders who are there for other reasons. She said she had asked the coordinator of the [Wildwood Correctional Center's] RSAT program how many participants were there for felony DWI, and the answer was six, but the coordinator also stipulated that those offenders all drive drunk - they all lead irresponsible lifestyles that do not take into account victims' issues. Ms. Williams offered that the whole host of topics that apply to treating DWI cases are already being addressed by [the DOC's] substance abuse programs.

REPRESENTATIVE JAMES asked if the fiscal note reflected only the change to a .08 BAC, or also reflected calculations for mandatory treatment. She also asked if it addressed any of the aforementioned shortages to the DOC's budget.

CHAIR ROKEBERG commented that the change to a .08 [BAC] should not affect [the DOC's] fiscal note.

MS. BROWER added that it did not, except that [the DOC] was anticipating a slight increase in felony offenders who have a .08 [BAC]. She noted, however, that [the DOC] is also looking at the increased "look-back" provision of HB 4, which would entail having more offenders in [the DOC]. She added that the provision mandating treatment also influences [the DOC's] fiscal note, as do a number of other factors that [the DOC] anticipates might bring in more offenders who will need to be accommodated. And the number of offenders that [the DOC] will need to accommodate will also be increasing considerably each year, she warned. Ms. Brower said [the DOC] would like to provide people with the treatment they truly need, but the way things are right now, [the DOC] does not have the capacity, especially if, through HB 4, treatment is going to be mandated.

Number 1630

MS. WILLIAMS added that the aforementioned $200,000 increment would just keep [the DOC's] substance abuse treatment programs afloat. Currently, all seven of the community treatment providers that [the DOC] uses subsidize the DOC; it costs the treatment providers to provide their services to [the DOC]. She added that [the DOC] could not ask the community treatment providers to do that anymore. She noted that the specific details of both this increment and the Inmate Substance Abuse Treatment (ISAT) programs were included in the handouts. She said that [the DOC] has lost providers in recent years. In answer to the question of why any organization still provides treatment services if it costs providers to do so, she offered that it is because people in this profession are very passionate, they feel that the prison is actually a part of their community, and they would like to provide the services if they can. But, for example, Seward Life Action Council finally had to quit; its board said it could not keep subsidizing [the DOC] $7,000 a year in order to provide services. She noted that this sort of thing has happened in several places across the state.

MS. WILLIAMS explained that the $200,000 increment would simply go towards adequately paying the existing providers so that [the DOC] does not lose any more providers. Without that increment, programs will have to be cut - which does not have anything to do with the DWI package - and [the DOC] will then be going in the opposite direction from what she said she believes the legislature wants.

CHAIR ROKEBERG asked how many third-time, or more, DWI offenders are not getting treatment, either on a voluntary or mandatory basis.

MS. WILLIAMS said she did not have specific numbers, but she added that she imagined that many are sneaking through because, for example, at [the Pt. MacKenzie Farm Program] the people in treatment have an average of seven DWIs; therefore, there are probably a number of third- and fourth-time DWI offenders that [the DOC] does not see.

Number 1808

CHAIR ROKEBERG expressed the concern that "this increment" is going to be vulnerable as HB 4 progresses through the legislative process. He asked if it would be possible to put some sideboards or parameters [on the treatment requirements in HB 4], which would still make sense from a treatment aspect, in order to lower the fiscal note - perhaps either by making treatment semi-voluntary or finding ways to more selectively triage offenders who qualify for treatment.

MS. WILLIAMS responded that [the DOC] has an assessment specialist position that (if all goes well) will start July 1, and that this person can "red-flag" DWI offenders so that they can be targeted for treatment; [the DOC] can make that a priority.

CHAIR ROKEBERG noted that [the DOC's] current program is for all types of offenders, while the current fiscal note [for CSHB 4(TRA)] only speaks to the DWI-offender portion of the treatment programs - which, he said, was not necessarily a bad thing, because by helping throw the net out there for these people, HB 4 affects domestic violence [problems], and it affects almost every other aspect that affects our society. And if the treatment elements are in place because of HB 4, it may not solve all the problems, but it covers a lot of ground and makes a major step forward. He requested that [the DOC representatives] assist him in finding ways to lower the fiscal note while maintaining the spirit of the legislation.

Number 2126

DENITA SOLITAIRE, Substance Abuse Counselor, Akeela House, Inc., noted that she has just accepted a position working at the Ernie Turner Center. She relayed that she was incarcerated for shoplifting, and that she was part of the RSAT program at

[Hiland Mountain Correctional Center]. At that time, she said, she could not go back to her family environment, nor did she have access to a halfway-house situation during that critical time. She added that later she graduated from the program at Akeela House and was able to move into the transitional housing. She reported that she has since been "clean" for five years due to that support. She mentioned that she has four kids who were in state custody for four years. She remarked that [providing treatment] is a worthwhile cause; whenever she hears of budget cuts, domestic violence problems, and problems in the schools, she considers substance abuse treatment to be the most important part of the solution. Yes, it may cost money right now, she argued, but in the long run, substance abuse treatment will curb crime, substance abuse, and deterioration of the family system. She urged the committee to continue funding treatment because it does work.

Number 2170

SHEILA SANFORD, Meeting the Challenge, said that she, too, has been a part of the [Hiland Mountain Correctional Center] RSAT program, and was a successful graduate. She said that afterwards, she participated in the Clitheroe Center's aftercare program for six months. She recounted that previous to her participation in the [Hiland Mountain Correctional Center] RSAT program, she was a patient at the Reflections program at [Clitheroe Center] for 42 days, but relapsed because she had not, at that time, dealt with issues surrounding a sexual assault that occurred against her. She said that after her relapse, she was arrested for a felony offense, and was subsequently placed in the RSAT program at [Hiland Mountain Correctional Center].

MS. SANFORD reported that the RSAT program taught her very effective life-building skills, not only with relationships, but also with finances, and also how to change her thinking patterns so that she could change her life for the better. Without that program, she said, she did not think she would be where she is today; because of the RSAT program, and because of the people who took the time to care about her, and the people who put the proper programs (such as STAR - Standing Together Against Rape) in place, she is no longer incarcerated, out on the streets, or facing death due to her addictions. She encouraged the committee to provide the funding for treatment because it does work. "If it worked for me, then it can work for anybody," she stated.

Number 2314

ODIS ADAMS said that he has been in prison for 23 of the last 25 years; he has had 7 DWIs and 47 convictions. He remarked that he has been through the system, and he knows what works and what doesn't work. He noted that while people in jail can get treatment, those on the street cannot; people on the street who want treatment have to go to jail to get treatment. He said he went to [the Clitheroe Center] and did the five-day detox, and while there, he asked if he could "go upstairs" and was told that there was not a bed available for him, that he would have to "call back every Tuesday." He noted that for the addict on the street, it was hard to get treatment because he/she generally doesn't have any money, and if he/she does get a job, he/she probably also owes court fines, the CSED (Child Support Enforcement Division) for child support, or state restitution.

MR. ADAMS offered that if there were a treatment center available where addicts could go to get treatment without having to go to jail or API, it would be very beneficial and save the state money in the long run. He suggested that the crime rate would be reduced considerably if addicts who are out of jail were given as much help as is given to addicts who are in jail. He said that in addition, there is a need for treatment criteria that offer complete help; treatment should address the needs of the addict in other areas of his/her life so that the transition from addiction to recovery could be successfully completed. He suggested this treatment should consist of at least 12 months of treatment followed by 12 months of aftercare, and include transitional housing; assistance with food stamps; bus passes; some medical coverage; financial advice; assistance with setting up a payment plan for unpaid bills; and receiving the same help that welfare clients receive at job service centers, such as counseling, testing, resume writing, on-the-job training, computer classes, and job placement. All of this additional assistance would provide a tremendous boost to the addict as he/she strives for recovery.

MR. ADAMS said it has taken him a long time to get where he is today, and he added that he received help from a lot of different entities such as the DHSS, the Department of Revenue (DOR), "Housing," and the Department of Labor & Workforce Development (DLWD). In closing, he asked the committee to fund treatment programs.

REPRESENTATIVE JAMES said she appreciated hearing Mr. Adams's perspective. She asked whether there are any treatment

facilities that allow a person in recovery to stay after his/her treatment is finished in order to facilitate that person's efforts to stay sober as he/she reenters the workforce.

MR. ADAMS said none that he was aware of, although he acknowledged that that sort of facility might have begun operating recently. He added that if a person is in the DOC system, there is the option of entering a halfway house after coming out of a treatment center, but if a person is on the street without a place to go, then that person just lives on the street until he/she gets a chance to receive treatment. He noted that there are a lot of addicts living on the street.

TAPE 01-36, SIDE B
Number 2491

MR. ADAMS suggested that the price of sending an addict to jail for a year is three times what it would cost to send him/her to treatment for a year. He reiterated that it is hard for an addict [on the street] to get treatment without money, and he noted that most addicts don't have money. Mr. Adams shared a picture of his daughter with the committee, and said that his daughter is very proud of him; she was ten years old when he went to jail, and she is his reason for being here. He added that he is now doing a lot of good things: he is working for the Alaska Mental Health Trust Authority, he is participating in his daughter's education, he is a student of Tae Kwon Do, and he has taken a vacation with his daughter. He has never been able to do these types of things before because he has been in jail all his life, he explained. He has been out of jail for two years, two months, and he said he is really enjoying his sobriety and does not want to lose the life he has built for himself since becoming sober. When he was on the street and using [drugs], he added, he did not have anything to lose; he couldn't get a job, and he owed $140,000 in child support (currently only $11,000 with help from the DOR). Now, when he works, he can pay his bills and still take care of his family. Today he feels like a part of society; he has something to lose and therefore he is not as reckless as he once was. He concluded by saying he would like to see more treatment centers so that others could also get a chance to turn their lives around.

Number 2417

RUDOLF NEWMAN, Meeting the Challenge, said that during the years he was drinking, he did not see his kids; he did not see them

grow, and he did not see them raised. That part of his life is blank because of his alcohol abuse. Treatment was available to him, but he did not participate fully until he made up his mind to do so with the help of the court system and the DOC; "they" scared him into participating fully. He recounts that he went to jail May 30th for his third DWI conviction, and then participated in Judge Wanamaker's wellness court, where he was given the option of going to treatment or spending a year and a half in jail. He chose treatment, and during treatment he was given the opportunity to take Naltrexone for 120 days. He said he took it every day, and that it took the craving [for alcohol] away. He added that he has since been off of Naltrexone for three months and has not experienced any side effects. He keeps a supply of Naltrexone with him just in case the craving for alcohol returns. He said he has recently obtained a job on the Slope, but before starting it, he wanted to come before the committee to speak in favor of treatment.

Number 2195

LEONA HAWKENSON (ph) CROW, Meeting the Challenge, said that she works at the Kodiak Area Native Association. She also said that she came to share her story and speak in support of treatment for DWI offenders. She recounted that for her first DWI, in addition to spending 30 days in jail, she was ordered to go to the ASAP, but, due to a lack of understanding the consequences, she failed to do so. Shortly thereafter, she received another DWI, which, she said, would never have happened had she followed through with her initial court-ordered treatment. She has since received the treatment needed to turn her life around via a women's treatment center (Dena A Coy, [Future Generations, run by Southcentral Foundation]), which specializes in helping pregnant women with substance abuse problems. She reported that after treatment, she felt a lot better about who she is and where she comes from, and that today she is living a healthy, clean, and sober life. She then thanked the committee for hearing her.

Number 2088

KATHERINE FRIDAY said she was from Craig, Alaska, on Prince of Wales Island (POW). She said that there is definitely a problem in the state of Alaska [with substance abuse]; she said she would almost consider it a genetic epidemic that really needs to be addressed. She also said she has noticed that there is a divide between rural and urban communities with regard to treatment availability. Rural communities don't have much in

the way of resources, she explained, and there are not a lot of rehabilitation opportunities. She noted that in her area there is Communities Organized for Health Options (COHO), but all it can provide is information on rehabilitation facilities outside the area; in addition, there is no funding for rehabilitation available. Also, in her community, in order to get to a facility that offers rehabilitation, a person has to first get on a ferry and then a plane, and must buy his/her own tickets, which can cost as much a $1,000.

MS. FRIDAY said that there should be more focus on providing rehabilitation resources in the rural communities. For POW, Ketchikan, and Metlakatla the only "rehab" facility that is available is KAR House, which has only 15-20 beds for a population of perhaps 30,000-35,000 people. She said she wonders where people go once those 15-20 beds are filled. She noted that she was lucky enough to be able to afford to go to Seattle for rehabilitation, but a lot of people don't have the finances it takes to get someplace where they can get the treatment they need - it is simply out of reach. She said she has looked at the problem, and she suggested that maybe what is needed is an income-based rehabilitation program for the rural communities so that it can become easier for people in those communities to get help.

MS. FRIDAY, to illustrate, said that her mother (who is at a critical stage) has had to go to COHO to get information on where to go for rehabilitation; next, she will have to pick up Medicaid papers from a different organization seven miles away. She has no money; she has no insurance; she has no home; she has nothing; she does not have a way to get the Medicaid paperwork; and even if she did, by the time she gets the paperwork filled out and sends it, she will be put on a waiting list (perhaps as far down as number 12). Meanwhile, her mother is supposed to go back into the community and simply wait to get help. That isn't going to happen, Ms. Friday said; her mother is addicted to alcohol, and even though she has been trying for ten years to get into rehabilitation, she still drinks. Ms. Friday noted that her family could not afford to send her mother to [a self-pay rehabilitation center]. To finalize, she suggested focusing more on the rural communities.

Number 1861

CLARA M. PETERS said she is from Nulato. She also said she is a recovering alcoholic, and that she has been sober for 12 years. She added that she comes from a village of about 400 people, and

that the village only has one alcohol and mental health counselor - herself. She noted that she got into this field because she was tired of seeing counselors come for a month, leave, come back, and then leave again. She said she really believes that people need to take responsibility and be accountable for their actions. She explained that it took her a year to understand the phrase: "In order to keep it, you have to give it away." She reported that she was once so heavily into drinking that nothing around her mattered, not even her children. In retrospect, she does not know how she paid her bills during that time, she said. She commented that because she grew up in an environment where there was drinking in the home, she learned that lifestyle, but no one explained to her the consequences of that lifestyle such as addiction and bearing children with FAS/FAE.

MS. PETERS says she advises the children in her village to not start drinking because when children start drinking at a very young age it accelerates the addiction process. She acknowledged that it is hard for people to understand what it is like to be caught up in an addiction unless they have been through it themselves, but that is something she would not recommend people do simply to gain an understanding of the problems. She said she has watched people die due to alcohol abuse because nothing matters to them but drinking. She said she cannot say enough about the effectiveness of treatment - treatment works - and she said it is a better alternative than simply sitting in jail without treatment because when a person is released from jail, he/she is back in society but nothing has been done to change the drinking problem.

MS. PETERS explained that she participated in a 30-day treatment program. Someone turned her in (she said she does not want to know who did it, but she is grateful that someone did) and her children were taken away from her. Once her children were taken, everything of importance was taken away, and at that point, her children became more important to her than "the bottle." She said that she did not go to treatment just to get her children back; she went because she knew she needed help but did not know how to ask for it. She stated that she was really grateful for that treatment, and that she is alive today because of that treatment; without treatment, she predicted, she would be buried six feet underground and would have lost the opportunity to see her first grandson. On the issue of treatment in rural areas, she said that coming from the small village of Nulato, she can understand a person's reluctance to

have to go to a big city for treatment, and she advocated that it is important to offer people hope in their own communities.

Number 1601

BRIAN MASSEY noted that he was born in the territory of Alaska, that he is a lifelong resident of the state, and that he is a recovering alcoholic. He said he was here today to say that treatment works, and to help put a face on treatment dollars. He cost the state a lot of money over the years while he was drinking, he explained. He was responsible for getting judges out of bed many times for search warrants, protective orders, and other related items. He cost the jail system money, he continued, by taking up space in its facilities. He cost the health care system money by being there with alcohol-related injuries, illnesses, and detoxifications. He cost the companies that he worked for money via lost productivity and sick time. He acknowledged that for all these reasons and more, he was a drain on this state's resources and on his community. But, he added, fortunately for him, in his community there was state-funded substance abuse treatment.

MR. MASSEY noted that treatment did not work for him the first time he participated, but it did the second time. What the state got for its treatment dollars, he offered, was the following: He is a better father and a healthy role model for his children and their friends. He is not passing on his substance abuse to his kids, and he is trying to lead by example. He volunteers when asked by sitting on boards and commissions. He has taught junior achievement, he coaches his daughter's softball team, and he coaches his son's T-ball team. He goes to work every day, and he is a productive member of his community. In contrast to when he was drinking, he said that he has not had the occasion to get a judge out of bed, nor has he needed any jail space since he attained sobriety. In addition, he has not ended up in the hospital for any alcohol-related problems, he pays his bills, and he contributes to his community, he said.

MR. MASSEY stated that treatment for substance abuse works; it works at the state level, and it works in local communities. Treatment dollars help produce productive, sober people. He encouraged the committee to include treatment provisions in any legislation that addresses drunk driving; whether people get their treatment in jail or their communities does not matter as long as they get it. Substance abuse is the 800-pound gorilla that sits in Alaska's living room, he said, that most people

don't want to talk about. "Let's address this beast and get our citizens the help they need to become productive and healthy once more," he concluded.

[HB 4 was held over.]

ADJOURNMENT

Number 1459

There being no further business before the committee, the House Judiciary Standing Committee meeting was adjourned at 3:50 p.m.