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INTERDEPARTMENTAL
COORDINATING COMMITTEE (ALCOHOLISM)

REPORT TO THE GOVERNOR

CHAPTER ONE

INTRODUCTION

THE FOLLOWING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

1. Assumptions

The following assumptions were made in the preparation of this document:

1. State government should not do for local communities that which they can do for themselves.
2. State government should not do for individuals that which they can do for themselves.
3. There should be maximum public participation into the policy making machinery of State government.
4. State government programs should be goal directed, have measurable outputs, and be cost effective.
5. Because the State sanctions the sale and distribution of beverage alcohol, and derives revenue from such sales, the state is responsible for ensuring that the negative effects of alcohol abuse are addressed in a rational manner.
6. Beverage alcohol is an addictive drug and is easily abused.
7. There is high public tolerance for relatively heavy drinking in Alaska.
8. No one theoretical model can account for all known types of alcohol abuse and alcoholism.
9. Alcohol abuse and alcoholism manifest many interrelated causes and effects which include cultural, economic, social, political, physical, and psychological considerations.
10. Given low average age of the population, high per capita consumption of beverage alcohol, apparently high public tolerance of heavy drinking, relatively low prices of beverage alcohol, rapid growth, cultural change and conflict, and other related conditions and events in Alaska, alcoholism and alcohol abuse will be costly problems for some time to come.
11. Therefore, a realistic prevention and control strategy is not one that expects dramatic reductions in alcoholism and alcohol abuse over the short term.

12. A realistic prevention and control strategy is one that organizes and sets in motion conditions and systems which can be expected to result in gradual and lasting reductions in alcohol abuse and alcoholism while immediately attacking certain specific aspects of the problem which seem to be improvable over the short term.

13. A realistic treatment strategy is one that anticipates no decreases in the number of persons needing treatment for alcoholism over the short term but will instead program for expected increases in the numbers of persons needing treatment for the next decade.

14. There is little agreement in the literature about what combinations of prevention/control/treatment measures "work". Therefore, prevention, control, and treatment of alcohol abuse/alcoholism is an experimental enterprise.

15. Medicine, psychiatry, psychology, social work and sociology and other disciplines disagree about the etiology and treatment of alcoholism. Nevertheless there are generally accepted program and treatment practices which are reflected in the "Joint Commission on Accreditation of Hospitals" standards for alcoholism services, recently adopted by the State through the Alaska Administrative Code.

16. Alaska is in an early and traumatic stage of growth and organizational development. Therefore it is appropriate to view the work of the Inter-departmental Coordinating Committee as an early step in the development of logical policies containing recommended counter measures to a set of problems the causes of which are beyond the control of the Committee.

17. Therefore this document should not be viewed as a panacea but as a rational first building block in the development of long term conditions and systems designed to reduce and treat alcohol abuse and alcoholism.

18. Recommendations presented herein should be rooted in hard evidence when possible.

19. The political power attributed to groups with vested economic interests in current alcohol use patterns is not a consideration in the development of this document.

20. An effective State program to deal with alcohol problems in Alaska must be a balanced, comprehensive approach including components of education, control, and treatment.

II Sources of Policy Questions/Development of this Document

The policy questions addressed in this document were derived from members of the Interagency Coordinating Committee, staff to the Interagency Coordinating Committee, input from other state officials, input from the public and perusal of national and international publications. (See Appendix A)

These policy questions were refined and analyzed by a working group of staff to the Interagency Coordinating Committee to the extent that time permitted.

These policy questions and recommendations were tested, insofar as possible, against hard empirical data. However, hard data is an often scarce commodity in Alaska.

Therefore, many of these questions had to be addressed by policy recommendations which were rooted in an informal "collective agreement" in the absence of empirical data.

A more thorough empirical analysis of many of the same issues explicated in this report will be completed by December 31, 1976.

Many of the proposals included in this report should be re-examined with the benefit of the additional data to be available in December.

CHAPTER TWO

CONFIGURATION OF ALCOHOL PROBLEMS IN ALASKA

It is the purpose of this report to present indicators thus far identified on the extent and nature of alcohol-related problems in Alaska, to estimate alcohol-related costs borne by State government as compared with tax revenues unique to the liquor industry, and to recommend action by State government that should effectively reduce the incidence of such problems and place the associated tax burden on the appropriate source. In this report, an alcohol-related event is defined as one in which alcohol is judged to have been a significant contributing factor.

It should be remembered that many alcohol-related problems are not readily apparent to State government and are often beyond our ability to measure. This includes such problems as broken homes, the emotional suffering and economic loss of families, industrial accidents, lost man-hours of productive work, and a variety of health problems related either directly or indirectly to alcohol abuse.

Extent and Nature of Alcohol-Related Problems in Alaska
(Currently visible to and measurable by State Government)

A. Social Services

1. In August, 1975, the Division of Social Services began submitting reports to the American Humane Association (AHA) on each substantiated case of child abuse or neglect brought to the attention of State social workers. The reports contain the social worker's appraisal of major contributing factors in each case. Of 108 child neglect reports submitted to AHA in the latter part of 1975, 49 (45%) were judged to have involved "alcohol dependence". The Division estimates that it responded to approximately 380 substantiated neglect cases over the entire year.

2. Of 61 child abuse reports submitted to AIA in the latter part of 1975, 16 (26%) were judged to have involved "alcohol dependence". The Division estimates that it responded to approximately 150 substantiated abuse cases over the entire year. We have no figure for the actual incidence of child abuse and neglect - we know only the number of cases reported to the State. In addition, the above figures do not tell us how often drinking was involved in the incident, but rather how often "alcohol dependence" was later judged to be an overall contributing factor.

3. Though firm information is not now available on the extent of alcohol problems among the state's aged population, a conservative estimate concerning the Homemakers program is that 10% of their elderly clients would require significantly less assistance were it not for excessive drinking. This is supported by a sample of 40 elderly clients of the Homemakers program in Southeast Alaska, of which 4 have been judged by the regional coordinator to have significant alcohol problems.

4. The Director of the Division of Social Services estimates that approximately 50% of all social worker time spent on direct counseling and case management is concerned with clients for whom alcohol presents a "significantly complicating problem".

B. Public Assistance

Interviews with the Southeast Regional Manager of the State's public assistance programs and others in the Department of Health and Social Services (DHSS) familiar with the State's welfare recipients have yielded the following conservative estimates:

1. Approximately 15% of all AFDC cases are alcohol-related. In other words, in at least 15% of all cases, alcohol abuse is believed to have significantly contributed to such eligibility factors as income below a certain level and families with one parent absent or incapacitated.

2. Approximations to 20% of all Aid to the Disabled cases are alcohol-related; i.e., it is the opinion of the Division that alcohol contributes significantly to the disability or lowered income of 20% of the recipients.

3. By determining the number of individuals who qualified for a Medicaid payment by virtue of their eligibility for AFDC or Aid to the Disabled, and by then applying the above percentages to this group of individuals, it is estimated that at least 6% of the State's Medicaid patients find themselves in a position of dependency due in large part to excessive drinking.

C. Mental Health

A tabulation of discharge reports for Alaska Psychiatric Institute indicates that, in FY 76, 29.5% of all discharges had an alcohol-related primary or secondary diagnosis. A similar tabulation for out-patient discharges from community and State-operated mental health clinics indicates that 4% of these services are alcohol-related.

D. Public Health

The Public Health nurses estimate that 15% of the home accidents that they see and treat are related to alcohol abuse. The percentage varies according to region and bush versus urban setting. In the bush areas the percentage will range from 2% to 40% as some areas are "dry" areas, while others are unrestricted. In the urban areas the problem is not as noticeable as the nurses are not as intimately involved in the handling of cases, especially in Anchorage and Fairbanks.

E. Education

Though any quantification of alcohol-related problems among the state's school age population remains elusive, such information does exist for the State's Boarding Home Program. A tabulation of "termination reports" for Boarding Home students indicates that during the 1975-76

1975/76 year, 40 students were sent home early due to serious drinking problems (either drinking regularly or getting into trouble while intoxicated). A total of 1,026 children began the program, and 872 completed a full year. It is estimated by the former director of the program that an additional 10% of the Boarding Home students drink excessively but do not get into trouble serious enough to warrant their early dismissal from the program.

F. Fires

According to the State Fire Marshal, there were 31 fatalities from fire in Alaska in 1975. Of these 31, 10 were positively identified as alcohol-related. These 31 fatalities resulted from 25 fires, 8 of which have been positively identified as alcohol-related while 8 others are possibly related.

Thus far in 1976 (through July), there have been 15 fatalities from fire, 10 of which have been judged to have been alcohol-related. These 15 fatalities resulted from 10 fires, 6 of which were alcohol-related.

G. Boating Accidents

According to the Coast Guard Office of Boating Safety (OBS), there were 62 deaths from boating accidents in Alaska in 1975. Whether or not alcohol was involved is unknown for 15 of these fatalities. Of the remaining 47, OBS has judged 30 to be alcohol-related. It is felt that a similar proportion probably applies to the other 15 fatalities for which the possible involvement of alcohol remains unknown.

H. Traffic Safety

1. The Alaska Traffic Safety Bureau (ATSB) has determined that, in 1975, 45% of fatal accidents (46% of traffic fatalities) were alcohol-related.

2. The national average for OMVI arrest per 1,000 licensed drivers in 1975 was 9.1 (taken from Department of Transportation Highway Safety Report for Congress, 1975). This compares with an Alaska rate of 15.0 for the same year (figure compiled from state trooper and municipal police reports, and the Division of Motor Vehicle records). The Alaska rate for 1974 was 11.6, and for 1973 was 12.5.

3. OMVI recidivism - It has further been determined that, in 1975, 33% of all OMVI arrests in Alaska had been arrested on the same charge at least once before (taken from convicted driver files, Division of Motor Vehicles, Department of Public Safety).

4. The ATSB reports that the average Blood Alcohol Content (BAC) statewide at the time of an OMVI arrest is .177. In 71% of OMVI arrests, the BAC was determined to be .15 or over. Under current State law, an individual with a BAC of .10 or over is presumed intoxicated. This means that only the most serious offenders are currently arrested, and that Alaska's unusually high rate of OMVI arrests per 1,000 licensed drivers is not a result of unusually strict enforcement.

I. Criminal Justice

1. The administrator of the Violent Crime Compensation Board estimates that 50% of those cases for which a compensation grant was made in FY 76 were alcohol-related.

Information shown under #2 - #5 has been extracted from "Alcohol and the Alaskan Offender" by Judy Hill, Division of Corrections, 1975.

2. In 1969, a survey was conducted by the Office of Vocational Rehabilitation of one half the total inmate population at 12 Alaskan State and City jails and at 3 Federal prisons (Alaskan inmates only). Of 173 sampled, 62 had been charged with "Drunk in Public". Excluding

these 62, 68% of all others stated that they had been drinking at the time of the offense. (Including the 62 charged with Drunk in Public, the figure would be 80%.)

3. In a 1974 Division of Corrections random sample of District Court misdemeanor cases in Anchorage, 42% of the charges were directly alcohol-related (OMVI, Drunk on Roadway, Disorderly Conduct).

4. In a Division of Corrections sentencing study for 1974, it was found that 37% of all sentences in Anchorage during that year were directly alcohol-related (17% for OMVI, 10% Drunk on a Roadway, 10% Disorderly Conduct). These figures were taken from Commitment and Release cards in the Division of Corrections. In Fairbanks, Juneau and Ketchikan, data recorded for all offenders sentenced to time in jail during the last six months for 1974 indicates that 41% of all sentences were for alcohol-related offenses.

5. In a 1975 Division of Corrections study of 103 Anchorage offenders with sentences of 6 months or more, 84% stated on anonymous questionnaires that they had been drinking at the time of the offense. The following table summarizes the relationship in this sample between alcohol use and major violent and non-violent offenses:

Alcohol at time of offense, violent crime	44%
Alcohol at time of offense, non-violent crime	40%
No alcohol, violent crime	3%
No alcohol, non-violent crime	8%
Unknown	<u>5%</u>
	100%

J. Per Capita Alcohol Consumption

The table on page 2-8 gives per capita consumption comparisons among the states for 1972 (the last year for which we have comparative

data on this scale). Alaska ranks fourth behind Nevada, New Hampshire and Vermont. Factors contributing to high consumption in these three states include: Well established tourist industry; and/or low taxes/prices compared with neighboring states; and/or, in 1972, lower drinking ages than neighboring states (e.g., Massachusetts). The table is lifted from a booklet entitled Alcohol and Health by HEW, June, 1974.

An earlier booklet in the same series, prepared by HEW, offers the same kind of table for 1970. The 1970 figures permit us to make some international comparisons. Per capita consumption figures for a wide selection of countries in 1970 are available in a paper presented to the Education Commission of the States by Jan De Lint of the Toronto Addiction Research Foundation. One of the countries in the selection is the United States, for which a per capita consumption rate of 9.74 litres of absolute alcohol per year is given. The 1970 figures from HEW declare that the U.S. per capita consumption rate of absolute alcohol was 2.61 U.S. gallons, or 9.88 litres. In both cases, the population base used in the calculations are all residents 15 years old or older. Given the close similarity of these figures, we feel justified in converting the Alaska per capita consumption rate in 1970 given by HEW into litres, and then comparing Alaska with the other countries on De Lint's list. This is shown on the second table. Though France and Italy seem to be in a class by themselves, Alaska's per capita consumption rate appears to be quite high in comparison with the rest of the world.

TABLE 1
APPARENT CONSUMPTION OF SPIRITS, WINE, AND BEER, AND
OF ABSOLUTE ALCOHOL FROM EACH, AND OF TOTAL ALCOHOL,
IN U.S. GALLONS PER PERSON IN THE DRINKING-AGE
POPULATION, U.S.A. AND BY STATES, 1972

State	Distilled Spirits	Absolute Alcohol	Wine	Absolute Alcohol	Beer	Absolute Alcohol	TOTAL Absolute Alcohol	Rank Order
Alabama	1.86	0.80	0.63	0.09	16.93	0.76	1.65	48
Alaska	5.06	2.18	2.93	0.43	27.87	1.25	3.86	4
Arizona	2.61	1.12	2.46	0.36	34.70	1.56	3.04	9-10
Arkansas	1.38	0.59	0.95	0.14	17.66	0.79	1.52	50
California	3.17	1.36	4.66	0.68	26.60	1.20	3.24	6
Colorado	2.95	1.27	2.64	0.38	29.61	1.33	2.98	12
Connecticut	3.26	1.40	2.43	0.35	21.81	0.93	2.73	21
Delaware	3.79	1.63	1.87	0.27	28.15	1.27	3.17	8
Florida	3.69	1.59	2.36	0.34	28.99	1.30	3.23	7
Georgia	2.69	1.16	1.11	0.16	20.64	0.93	2.25	36
Hawaii	2.56	1.10	1.91	0.28	24.43	1.10	2.48	29
Idaho	1.80	0.77	1.94	0.28	30.65	1.38	2.43	32
Illinois	3.16	1.36	2.18	0.32	27.36	1.23	2.91	14-15
Indiana	1.72	0.74	3.88	0.13	22.76	1.02	1.89	41
Iowa	1.63	0.70	0.56	0.02	25.27	1.14	1.86	43
Kansas	1.59	0.68	0.57	0.03	21.32	0.96	1.72	47
Kentucky	1.93	0.83	0.70	0.10	22.39	1.01	1.94	39
Louisiana	1.04	0.88	2.20	0.32	28.11	1.26	2.60	30
Maine	2.35	1.01	1.68	0.24	29.92	1.35	2.60	26
Maryland	5.37	1.45	2.10	0.30	28.68	1.29	3.04	9-10
Massachusetts	3.18	1.37	2.54	0.37	26.50	1.19	2.93	13
Michigan	2.51	1.08	1.92	0.23	31.25	1.41	2.77	20
Minnesota	2.65	1.14	1.41	0.20	25.68	1.16	2.50	27-28
Mississippi	1.82	0.70	0.82	0.11	21.93	0.99	1.88	42
Missouri	2.18	0.94	1.34	0.19	25.66	1.15	2.33	35
Montana	2.52	1.08	1.14	0.16	34.95	1.57	2.81	18-19
Nebraska	2.42	1.04	1.10	0.16	28.81	1.30	2.50	27-28
Nevada	8.26	3.55	5.23	0.78	41.66	1.88	6.19	1
New Hampshire	7.41	3.19	2.67	0.39	40.93	1.84	5.42	2
New Jersey	3.14	1.35	2.90	0.42	25.32	1.14	2.91	14-15
New Mexico	2.38	1.02	2.42	0.35	32.08	1.44	2.81	18-19
New York	2.93	1.26	3.06	0.44	25.78	1.16	2.80	15
North Carolina	2.08	0.89	1.50	0.22	18.33	0.82	1.93	40
North Dakota	2.80	1.20	1.15	0.17	29.26	1.32	2.69	24
Ohio	1.84	0.79	1.40	0.20	30.33	1.72	2.71	22-23
Oklahoma	1.79	0.77	1.05	0.15	19.67	0.88	1.60	44
Oregon	2.13	0.92	3.29	0.48	28.15	1.27	2.67	25
Pennsylvania	1.88	0.81	1.50	0.22	28.66	1.29	2.32	34
Rhode Island	2.17	1.19	2.97	0.43	30.62	1.33	3.00	11
South Carolina	2.95	1.27	1.52	0.22	21.17	0.95	2.44	31
South Dakota	2.19	0.94	1.15	0.17	23.44	1.05	2.16	33
Tennessee	1.50	0.64	0.79	0.11	22.09	0.99	1.74	46
Texas	1.76	0.76	1.42	0.21	31.95	1.44	2.41	33
Utah	1.37	0.59	1.05	0.15	18.15	0.82	1.56	49
Vermont	4.41	1.50	3.15	0.46	34.78	1.56	3.92	3
Virginia	2.35	1.01	1.51	0.22	22.29	1.00	2.73	37
Washington	2.36	1.01	3.03	0.44	28.05	1.26	2.71	22-23
West Virginia	1.74	0.75	0.69	0.10	20.00	0.99	1.75	45
Wisconsin	3.04	1.31	1.87	0.27	39.73	1.79	3.37	5
Wyoming	2.81	1.21	1.36	0.20	32.10	1.44	2.85	17
District of Columbia	9.9	4.26	6.31	0.91	30.56	1.37	6.54	
U.S.A.	2.60	1.12	2.16	0.31	26.62	1.20	2.63	

Amounts calculated from tax-paid withdrawals only. The drinking-age population is taken as 15 years and older.

Source: Efron, Keller and Gurioli (20).

1970 TOTAL ALCOHOLIC BEVERAGE CONSUMPTION PER CAPITA

15 YEARS AND OLDER IN LITRES OF ABSOLUTE ALCOHOL

Country	1970
France	23.98
Italy	20.73
Spain	16.89
Luxembourg	16.21
W. Germany	16.04
Portugal	15.72
CSSR	14.55
Switzerland	14.52
ALASKA	14.23
Austria	13.29
Belgium	13.21
Hungary	12.95
Australia	11.68
N. Zealand	11.02
E. Germany	10.47
Yugoslavia	10.36
U.S.A.	9.74
Denmark	9.70
Canada	9.58
Gt. Britain	8.32
Sweden	7.94
Netherlands	7.81
Poland	7.52
Rep. Ireland	7.27
Finland	6.33
Norway	4.37

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CHAPTER THREE

DIRECT COSTS OF ALCOHOL USE AND
ABUSE TO THE STATE OF ALASKA

Cost to State Government

The following is an attempt to summarize direct alcohol related costs to State government. Only State general funds costs are given. The list is not exhaustive. For example, we are unable to estimate lost time, excess sick leave, and lowered productivity among State employees due to alcohol, and therefore, cannot translate these into dollar costs. We have not attempted to estimate overhead costs in agencies such as the Department of Administration and the Governor's Office incurred in relation to alcohol-related program activities. In the absence of alcohol, we have no idea how much less the State might pay for fire insurance on State-owned buildings around the State, and for employee benefits such as health insurance and workmen's compensation. Where "ballpark" figures have been used, they are conservative.

	<u>FY 76 General Fund Cost</u> <u>(Thousands of Dollars)</u>
1. <u>Office of Alcoholism</u>	1897.7
100% of General Fund Budget	
2. <u>Alcoholic Beverage Control Board</u>	263.4
100% of General Fund Budget	
3. <u>Division of Mental Health and</u>	1252.9
<u>Developmental Disabilities</u>	
29.5% of API, General Fund in FY 76=1203.7	
4% of Community and State-operated mental health	
clinics (GF)=49.2	
Total=1252.9	
4. <u>Division of Social Services</u>	1500.0
Derived from the following percentages applied	
against General Fund costs estimated by the	
Division in the areas of Foster Care, Institutional	
care, Protective Services and Social Work.	

- 45% of child neglect
- 26% of child abuse
- 50% of direct counseling and case management
- 35% of information and referral services
- 10% of Homemakers services

5. Division of Public Assistance 1706.3

Derived from following percentages applied against General Fund costs.

15% of AFDC =	902.9 GF
20% of Aid to Disabled =	324.8 GF
Approximately 6% of Medicaid =	<u>478.6 GF</u>
TOTAL	1706.3

6. Department of Law - Prosecution 777.2

A survey of professional staff in the Juneau District Attorney's Office revealed that 35% of staff time in that office was devoted to prosecuting alcohol code/use of alcohol violations. This does not include other offenses in which alcohol use may have been involved. 35% figure applied statewide against FY 76 budget to yield estimate of 777.2 GF.

7. Public Defender 830.8

Based on an informal survey of attorneys in the Public Defender agency, their office reports that approximately 60% of their staff time is spent on alcohol-related cases, including both direct violations of alcohol statutes and other offenses

in which excessive drinking was involved.

60% of Public Defender budget = 830.8 GF.

8. Court System 1476.6

The following estimates on the number of alcohol-related cases were obtained from the administrative office of the Court System. The respondents felt that these figures were conservative:

- 60% of traffic misdemeanors
- 80% of alcohol/drug law misdemeanors
- 30% of all misdemeanors involving violence
- 30% of all felonies involving violence
- 15% of all felonies against property

The resulting numbers of cases were multiplied by \$245/case for misdemeanors and \$735/case for felonies. Result = 1476.6 GF.

9. Department of Public Safety 3327.8

Percentage of alcohol-related cases given by the Court System were applied against the different categories of arrests made by State Troopers in 1975 as follows:

Part I crimes

- 30% of violent crime arrests
- 15% of property crime arrests

Part II crimes

- 30% of violent crime arrests
- 100% of OMVI, liquor law arrests
- 75% of Disorderly Conduct arrests

This resulted in a total of 2106 estimated alcohol-related arrests out of 6700 total arrests, or 31%. Of the 2106 estimated as alcohol-related, 1626 were for OMVI and liquor law violations. FY 76 GF cost for trooper detachments and CIB was 9036.5. Adding in the records section, lab, administration, and communications budgets, the total is 10,734.8. $31\% \times 10,734.8 = 3327.8$.

10. Division of Corrections 2941.9

The Division has thus far been unable to estimate the proportion of inmate days for alcohol related offenses to the total number of inmate days in the Correctional System. Therefore, based on the crime and alcohol data gathered by Judy Hill, (previously discussed) we believe it is certainly fair and quite conservative to add 20% of the Corrections GF budget to the list of costs. Excluding the Violent Crimes Compensation Board, the GF budget for the Division of Corrections in FY 76 was 14,709.3. $20\% \text{ of } 14,709.3 = 2941.9$.

11. Violent Crimes Compensation Board 70.0

Administrator of Board estimates that 50% of compensation grants are for alcohol-related crimes. FY '76 grant awards amounted to approximately 140.0

FY 76 General Fund Cost
(Thousands of Dollars)

12. Department of Revenue 53.9
Estimate from Department on employee time spent reviewing alcohol beverage tax returns and periodic audits of these taxpayers.
13. Education 100.0
Based on interview with Juneau school superintendent. Estimate of State general funds used statewide to buy school nurse and health education counseling time related to alcohol.
14. Division of Public Health 87.0
Division estimates that Public Health Nursing time for alcohol-related home accidents costs approximately 50.0. Family Health time spent counseling chronic alcoholic women during child bearing years (e.g., on fetal alcohol syndrome) costs approximately 15.0. Laboratory costs in FY 76 related to inspection of breath alcohol devices used in Public Safety for OWI determination = approximately 12.0. Total = 87.0.
15. Municipal Revenue Sharing 1521.7
The State distributes funds to municipalities for a variety of purposes, including police, fire protection and health facilities construction and operation. In FY 76, \$2,842,980 was distributed for municipal police. Using the 31% figure derived for the state troopers on the proportion of alcohol-

related activities, we estimate that 881.3 of this amount is alcohol-related (31% of 2843.0). For fire protection in FY 76, \$2,316,979 was distributed to municipalities. Based on our information from the Fire Marshal, we believe it to be both fair and conservative to estimate that 20% of these costs are alcohol-related. 20% of 2317.0 = 463.4. Finally, the Department of Community and Regional Affairs has determined that 177.0 was distributed for direct alcohol-related health facilities operation and construction.

	881.3	
	463.4	
	<u>177.0</u>	
TOTAL	1521.7	
Total General Fund alcohol-related costs listed above (1975-76 fiscal year)		<u>17,807.2</u>

State Taxes Unique to Liquor Industry

For calendar year 1975, the Department of Revenue reports that the liquor industry paid \$6,597.2 in alcohol excise taxes and \$854.9 in liquor license fees. The sum of these two is \$7,452.1. The Distilled Spirits Council of the United States (DISCUS), an organization of the liquor industry, states in its publication "Public Attitudes & Economic Progress" that the industry contribution to Alaska state revenues in 1974 was \$6,489.0.

The difference, then, between identified alcohol-related costs in FY 1975-76 and tax revenues from the liquor industry in calendar year 1975 is:

$$\$17,807.2 - \$7,452.1 = \$10,355.1$$

A number of comments are appropriate here: (1) Assuming that total alcohol consumption has been increasing in Alaska over the past several years, if only as a reflection of population increase, we expect that tax revenues from the liquor industry during Fiscal Year 1975-76 are somewhat higher than revenues for calendar year 1975, for which we have data. (2) Some unknown downward adjustment should be made to the identified State costs due to the fact that alcohol cannot be held solely responsible for many of these problems and associated State activities. We have defined an "alcohol-related event" as one in which alcohol is judged to have been a significant contributing factor -- but not necessarily the only contributing factor. (3) We have presented the deficit of costs to revenues for one year only, but have ignored the cumulative deficit the State has been covering with other revenues for years past. If the State were to increase liquor taxes and fees to cover an agreed upon cost in FY '76, this would in no way repay the state for past deficits nor would it prevent future deficits from occurring. State costs rise, at a minimum, with inflation -- however, excise taxes are a flat dollar amount on gallonage and do not rise with inflation. (4) As noted earlier in this report, there are a number of significant alcohol-related costs in State government (lowered productivity, higher benefit rates, higher insurance rates, overhead costs), which have not been included in our list due to our present inability to quantify them. (5) We believe our estimates to be conservative, particularly for the criminal justice system. Informal estimates concerning the proportion of alcohol-related cases in the Court System, the Division of Corrections, and the Department of Law are considerably higher than those used in this report.

(b) The Office of Alcoholism to be reviewed by the Committee in the near future concerning State funded rehabilitation services would cost roughly \$3 million additional per year. If approved by the Committee, the Governor and the legislature, this additional expenditure should be covered by liquor industry taxes.

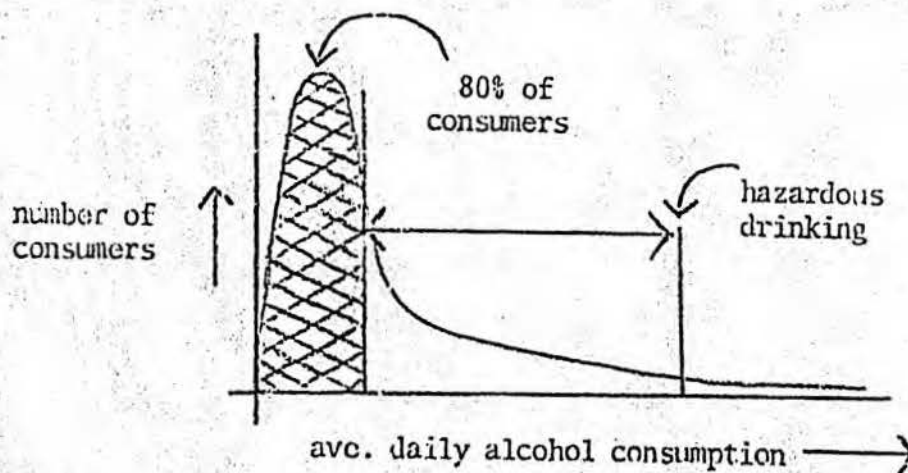
Taking all these factors into account, we believe it is quite justifiable for the State to raise an additional \$10 million per year from liquor taxes and fees. Our recommendation on excise tax increases, presented in the next section, would raise approximately \$9.7 million additional revenue per year.

CHAPTER FOUR
PREVENTION AND CONTROL

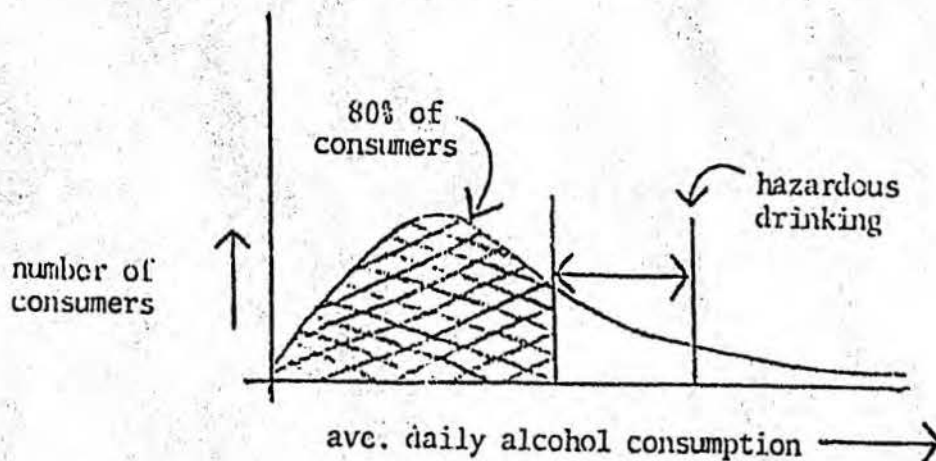
It is a reasonable goal for the State of Alaska to attempt to reduce the incidence of alcohol related problems as expressed in the first part of this report. It is suggested that the most effective, and probably the only, means to accomplish this goal is to reduce the incidence of excessive drinking within the State. To this end, it is helpful to know whether excessive drinking in Alaska involves substantial deviance from prevailing drinking patterns or whether it instead differs primarily in degree from the accepted norm and is therefore more a function of societal drinking levels than of individual difficulties.

There have been numerous studies of the frequency distribution of alcohol use in various societies*, which have yielded the following relationship between per capita consumption in a society and patterns of use:

In a society with low per capita consumption:



In a society with high per capita consumption:



* Jan Delint, "The Prevention of Alcoholism," Preventive medicine 3

Excessive drinking in a low-consumption population implies a major departure from prevailing drinking customs, while excessive use in a high-consumption population differs from prevailing custom primarily in degree. Consumption statistics presented earlier define Alaska as a high-consumption society.

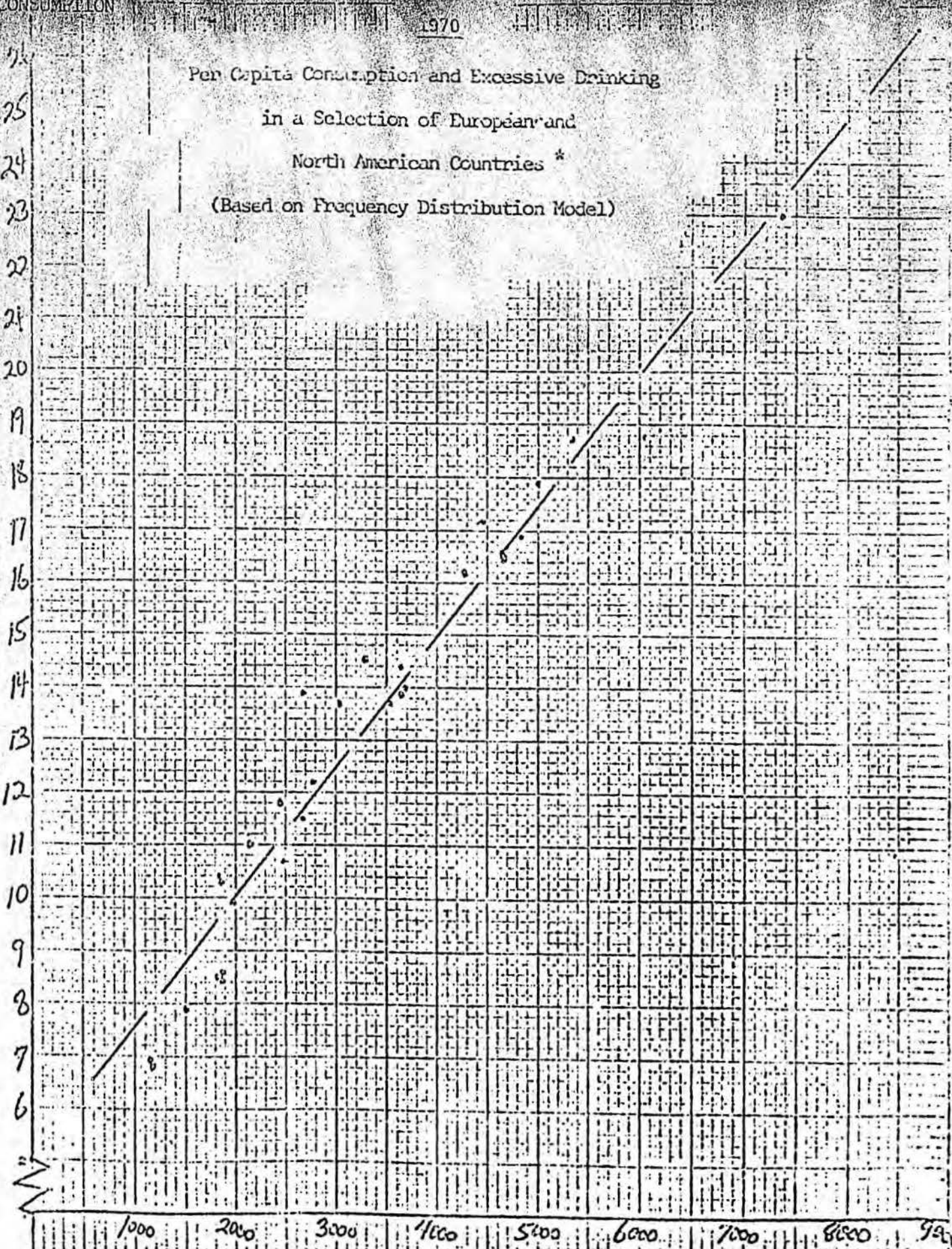
Using frequency distribution curves as outlined above, Jan DeLint of the Addiction Research Foundation in Toronto has estimated rates of excessive drinking in a selection of countries based on per capita consumption data. The graph on the next page demonstrates that, if the frequency distribution curves postulated above are indeed valid, then excessive drinking increases and decreases in direct proportion to per capita consumption in the society at large. Studies on the relationship between liver cirrhosis death rates and per capita alcohol sales (Popham 1970) support this conclusion. Though we are not in a position to prove or disprove this relationship, we are persuaded that, in Alaska, the custom of comparatively heavy drinking in the society at large is the most important determinant of excessive drinking and its undesirable effects within the State. One implication of this is that it is extremely unlikely that a reduction in excessive consumption can be accomplished without a reduction in per capita consumption, i.e. without a lowering of general drinking levels. Another implication is that Alaska's alcohol-related problems are not traceable to a distinct group of cultural deviants but rather to those who, either often or only occasionally, embrace our Alaskan drinking ethic more than most.

It is therefore the conclusion of this committee that State policy should be directed towards a deliberate reduction in per capita alcohol consumption in Alaska, with the expectation that the incidence of excessive drinking will decline as a result. In other words, it is our opinion that, without a significant change in prevailing drinking customs in Alaska, efforts to

Per Capita Consumption and Excessive Drinking
 in a Selection of European and
 North American Countries *
 (Based on Frequency Distribution Model)

liters absolute alcohol
 per person (drinking age) per year

26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6



Rate of Excessive Alcohol Use per 100,000 population
 (15 cl absolute alcohol or more daily)

reduce the rate of excessive consumption, though well-intentioned, will almost assuredly be futile. The question, then, is how can and how should State government attempt to reduce per capita consumption.

A. Price Increase

The following table from the Finnish Foundation for Alcohol studies, 1974, summarizes the investigations thus far conducted on the price elasticity of alcoholic beverages. The price elasticity values shown in the far right column indicate the percentage decrease in consumption that would result from a 1 per cent increase in price. Though obviously there are wide variations in these figures, all of the studies have concluded that some decrease in consumption should be expected given an increase in price. In this respect, alcohol behaves on the market like other commodities. The following chart on price and consumption in Ontario lends further support to this view. To be sure, a price increase will not directly deter most individuals from getting drunk if such is their strong desire. However, we do assert that a price increase will have a lowering effect on overall consumption levels; and since we believe the overall levels to be the prime determinant of excessive drinking, such a lowering of prevailing consumption levels should, in turn, reduce the incidence of excessive drinking. The obvious mechanism to increase price is the State excise tax. The table on p. 4-9 shows the current Alaska excise tax rates as compared with 30 other license States as of January, 1975.

Although Alaska's excise tax rates are already comparatively high, so is per capita disposable income (see p. 4-10). Though these income levels have not been adjusted for cost-of-living, neither have the tax rates. The table on p. 4-10 estimates Alaska's per capita disposable income in 1975 to have been \$7,437. Georgia, with the highest excise tax rate on wine, had per capita disposable income of \$4,306 in the same year. South

INCOME AND PRICE ELASTICITIES OF DEMAND FOR DIFFERENT ALCOHOLIC BEVERAGES IN A NUMBER OF COUNTRIES*

Author	Country and time period	Beverage	Income Elasticity**	Price Elasticity**
Malmquist	Sweden 1923-1939	Spirits	0.3	-0.3
		Wine	1.2	-0.9
Malmquist	Sweden 1923-1939	Liquor	0.3	-0.37
		Wine	1.32	-0.72
Sundström & Ekström	Sweden 1931-1954	Spirits	0.9	-0.3
		Wine	2.0	-1.6
Tryding & Rydman	Sweden 1920-1951	Spirits	0.6	-0.4
		Wine	0.9	-1.6
		Medium Beer	0.6	-1.2
Mitfeldt & Forner	Sweden 1956-1962	<u>Off-sales:</u>		
		Vodka	0.0	-0.9
		Other spirits	1.4	-2.9
		Fortified wines	0.2	-0.7
		Light wine	-	-0.6
		Strong beer	1.8	-3.0
		Spirits	0.4	-1.2
		Wine	(0.9)	-0.7
		Spirits + Wine	0.7	-1.0
		<u>On-sales:</u>		
		Vodka	1.0	-0.3
		Other spirits	0.2	-0.5
		Strong beer	2.0	-0.1
		Johberg	Finland 1959-1962	Vodka
Other spirits	1.30			-0.95
Wines	0.97			-0.83
Malt beverages	0.23			-0.49
Total off-sales	1.05			-1.17
Total on-sales	0.94			-0.99
Total sales	1.01			-1.11
Stone	United Kingdom 1920-1938	Spirits	0.6	-0.6
		Imported wine	1.4	-0.6
		Domestic wine	1.7	-0.3

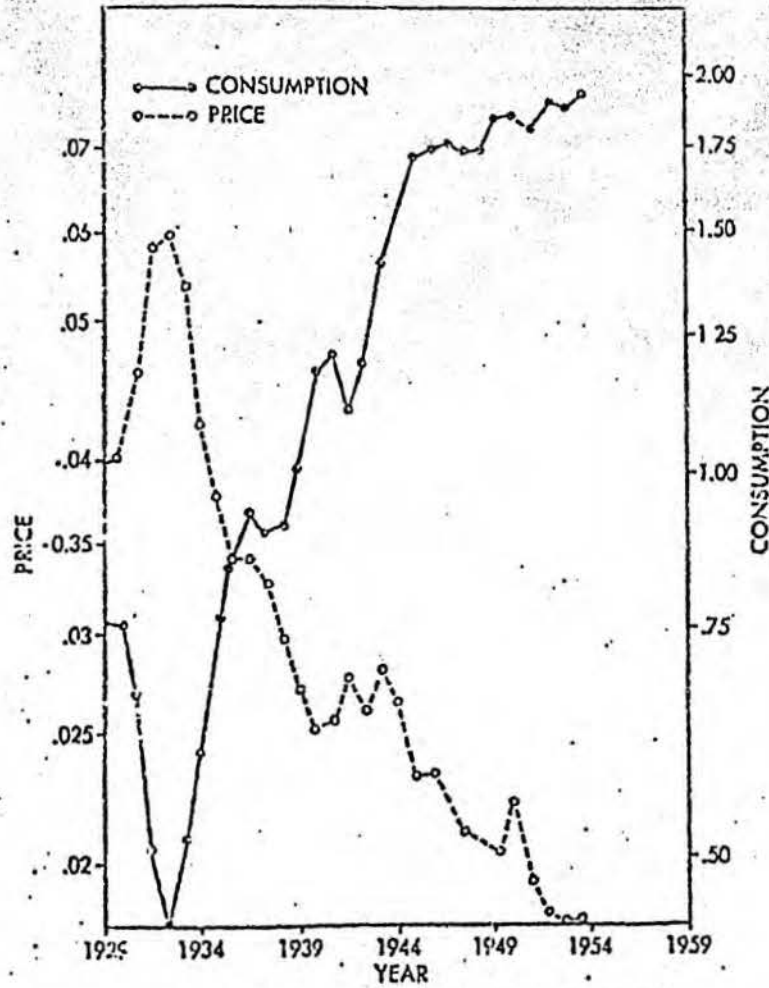
Author	Country and time period	Beverage	Income Elasticity **	Price Elasticity ***
Stone	United Kingdom 1920-1938	Spirits	0.54	-0.72
		Beer	0.14	-0.73
Walsh & Walsh	Ireland 1953-1967	Spirits	1.94	-0.57
		Beer	0.78	-0.17
Simon	United States 1955-1961	Spirits	-	-0.97
Canen	United States 1934-1954	Spirits	-	-1.74
Riskanen	United States	Spirits	-	-1.42
Riskanen	United States 1934-1941, 1947-1960	Spirits	-	-2.0
Schweitzer	Canada	All alcoholic beverages	0.88	-0.19
Lau	Canada 1949-1969	Spirits	0.68	-1.45
		Wine	-1.43	-1.65
		Beer	0.20	-0.03

Österberg, E. The pricing of alcoholic beverages as an instrument of control policy, Finnish Foundation for Alcohol Studies, Helsinki, 1974.

*The income elasticity values indicate the percentage increase in consumption that would result from a 1 per cent increase in income.

**The price elasticity values indicate the percentage decrease in consumption that would result from a 1-per cent increase in price.

ALCOHOL PRICE AND CONSUMPTION IN ONTARIO



Price = the price of an average gallon of absolute alcohol expressed as a fraction of an average disposable income
 Consumption = the consumption in gallons of absolute alcohol per person 20 years and older

As of January 14, 1975

(11-24-75)

Distilled Spirits		Table Wine		Dessert Wine		Beer	
State	Rate Per Gallon	State	Rate Per Gallon	State	Rate Per Gallon	State	Rate Per Gallon
1	2	3	4	5	6	7	8
Ak. proposed	\$6.22	Ak. proposed	\$1.93	Ga.	\$2.50	Ak. proposed	.88
Minn.	\$4.39	Ga.	\$1.50	Ak. proposed	\$1.93	S. Car.	.768
Alaska	4.00	Fla.	1.15	Fla.	1.60	Ga.	.322
Okla.	4.00	Tenn.	1.10	Tenn.	1.10	La.	.322
Tenn.	4.00	S. Car.	1.08	S. Car.	1.08	Okla.	.322
Fla.	3.75	Ark.	.75	Okla.	1.00	Fla.	.320
Ga.	3.75	Neb.	.75	S. Dak.	.95	S. Dak.	.267
Mass.	3.36	Alaska	.60	Minn.	.79	Alaska	.250
N. Y.	3.25	Ky.	.50	Ark.	.75	Ark.	.234
S. Dak.	3.05	N. Dak.	.50	Neb.	.75	Texas	.165
N. J.	2.80	Okla.	.50	Alaska	.60	N. Dak.	.160
S. Car.	2.72	Mass.	.46	Ill.	.60	Kansas	.150
Wisc.	2.60	Ind.	.45	N. Dak.	.60	Minn.	.129
Ariz.	2.50	Ariz.	.42	Kans.	.50	Tenn.	.110
Ark.	2.50	Del.	.40	Ky.	.50	Neb.	.100
Conn.	2.50	Md.	.40	Nev.	.50	Ind.	.095
La.	2.50	N. Mex.	.40	Mass.	.46	Md.	.090
N. Dak.	2.50	R. I.	.40	Ind.	.45	Mass.	.088
R. I.	2.50	Mo.	.30	Ariz.	.42	Conn.	.081
Ind.	2.28	Nev.	.30	Del.	.40	Ky.	.087
Del.	2.25	N. J.	.30	Md.	.40	Ariz.	.080
Calif.	2.00	S. Dak.	.30	N. Mex.	.40	N. Mex.	.080
D. C.	2.00	Minn.	.27	R. I.	.40	D. C.	.073
Ill.	2.00	Conn.	.25	Wisc.	.39	Ill.	.070
Mo.	2.00	Ill.	.23	Texas	.34	Del.	.065
Neb.	2.00	Colo.	.20	D. C.	.33	R. I.	.065
Texas	2.00	Kans.	.20	Colo.	.30	Wisc.	.065
Ky.	1.92	Wisc.	.195	Mo.	.30	Colo.	.060
Nev.	1.90	Texas	.17	N. J.	.30	Mo.	.060
Colo.	1.80	D. C.	.15	Conn.	.25	Nev.	.060
Kansas	1.50	La.	.11	La.	.21	N. Y.	.044
Md.	1.50	N. Y.	.10	N. Y.	.10	Calif.	.040
N. Mex.	1.50	Calif.	.01	Calif.	.02	N. J.	.032
Median of State Taxes	2.50		.40		.455		.089
Average of State Taxes	2.60		.51		.60		.152
Fed. Tax	10.50**		.17		.67		.29**

*Hawaii, the only other license state, levies an excise tax on alcoholic beverages of 20 percent of the wholesale price.

**Per proof gallon if withdrawn from bond at over 100° proof and per wine gallon if withdrawn from bond at not over 100° proof.

***Actual rate is \$9.00 per 31 gallon barrel.

Table 3—Total Number, Capital, Disposable Personal Income by States and Regions

State and region	Total									Per capita						
	Millions of dollars					Avg. annual growth (Percent)				Dollars					Avg. annual growth (Percent)	
	1959	1960	1973	1974*	1975*	1959-60	1960-73	1971-75	1959	1960	1973	1974*	1975*	1959-60	1960-73	1975*
United States	325,938	635,599	503,320	950,896	1,011,257	6.6	9.1	9.5	1,905	3,162	4,393	4,643	5,041	5.2	8.0	
New England	21,463	21,760	51,037	53,707	61,101	6.4	8.0	9.2	2,051	2,354	4,451	4,512	5,235	5.1	7.1	
Midwest	5,970	11,639	15,305	16,932	18,425	6.9	7.4	5.9	2,329	3,650	5,031	5,452	5,253	5.1	6.7	
South	1,559	2,629	3,805	4,231	4,498	5.5	9.4	6.2	1,627	2,680	3,662	4,015	4,217	5.1	5.1	
New England	10,533	17,079	23,652	25,011	30,613	6.1	7.9	9.3	2,029	3,277	4,561	4,830	5,263	5.1	7.2	
Midwest	1,101	2,158	3,163	3,462	3,747	7.1	9.7	8.2	1,815	3,022	3,970	4,299	4,580	5.0	7.2	
South	1,631	2,921	4,010	4,217	4,750	6.3	7.6	11.5	1,504	3,212	4,115	4,532	5,121	5.4	6.4	
Vermont	601	1,260	1,620	1,818	2,093	7.2	8.8	10.5	1,533	2,747	3,709	3,769	4,265	5.9	7.0	
Midwest	52,616	117,802	193,115	211,190	233,411	6.0	7.5	9.0	2,767	3,510	4,611	5,039	5,413	5.0	7.2	
Delaware	591	1,911	2,707	2,656	3,183	6.5	9.7	10.1	2,217	3,439	4,632	5,039	5,417	5.0	7.2	
District of Columbia	1,620	3,013	4,011	4,325	4,747	5.0	7.4	9.5	2,413	3,961	5,454	5,435	6,030	5.0	8.4	
Maryland	6,026	12,429	18,469	20,049	22,032	7.7	9.9	9.9	1,955	3,265	4,519	4,577	5,379	6.2	8.5	
New Jersey	1,085	25,611	26,318	33,355	42,352	6.6	8.1	7.5	2,319	3,751	4,829	5,361	5,789	6.8	7.9	
New York	31,712	66,211	113,254	92,733	103,851	5.8	6.5	8.9	2,922	4,723	5,116	5,525	5,925	5.9	8.7	
Pennsylvania	21,912	37,507	40,254	51,858	60,211	5.5	7.8	9.8	1,923	3,178	4,243	4,628	5,091	5.0	7.3	
West Lakes	73,833	133,882	184,423	198,077	216,435	6.1	8.3	9.3	2,956	3,355	4,515	4,517	5,252	5.0	7.7	
Illinois	22,676	40,092	51,671	59,044	64,793	5.8	8.1	9.7	2,211	3,621	4,857	5,395	5,515	5.0	7.6	
Indiana	8,600	16,119	22,413	23,434	25,709	6.4	8.7	9.7	1,577	3,132	4,215	4,307	4,811	5.3	7.9	
Michigan	15,697	30,374	42,799	48,093	49,929	6.8	8.7	9.2	2,022	3,422	4,667	4,822	5,353	5.5	7.5	
Ohio	19,447	31,560	46,561	50,460	51,600	5.9	7.7	8.6	2,011	3,222	4,331	4,709	5,073	5.0	7.3	
Wisconsin	7,394	12,503	18,144	20,135	22,142	5.8	8.3	10.0	1,895	2,913	4,053	4,410	4,669	4.5	8.4	
Midwest	26,748	45,653	73,302	75,001	82,603	6.2	10.5	10.1	1,760	3,002	4,467	4,495	4,570	5.5	10.1	
Ohio	4,731	8,599	13,327	12,681	11,697	6.0	11.7	11.2	1,735	3,032	4,623	4,507	5,117	5.7	11.1	
Indiana	6,035	6,888	10,263	10,711	11,711	5.5	10.5	9.5	1,863	3,000	4,311	4,701	5,156	5.1	10.1	
Minnesota	5,871	11,331	17,667	17,900	19,267	6.8	10.7	7.6	1,715	3,070	4,317	4,572	4,508	5.6	10.1	
Wisconsin	7,557	13,534	20,295	20,624	22,311	5.9	8.0	8.2	1,615	3,697	4,110	4,517	4,684	5.0	8.1	
Nebraska	2,422	4,542	6,814	6,909	8,241	6.2	10.7	12.9	1,751	3,051	4,417	4,519	5,399	5.6	9.6	
North Dakota	660	1,622	3,203	3,129	3,216	6.6	13.1	3.8	1,304	2,615	3,517	3,603	5,112	6.5	15.3	
South Dakota	898	1,710	3,051	2,657	3,065	7.0	11.6	7.3	1,311	2,650	4,476	4,457	4,488	7.0	11.0	
Midwest	51,775	112,715	173,355	189,840	205,324	7.5	11.2	8.2	1,437	2,894	3,721	4,017	4,234	6.1	9.5	
Alabama	4,391	8,601	11,568	12,540	11,353	6.5	10.2	10.5	1,342	2,351	3,354	3,642	3,922	6.5	9.3	
Arkansas	2,237	4,449	6,592	7,592	5,215	7.0	12.1	8.2	1,271	2,394	3,421	3,681	3,882	6.1	10.3	
Florida	8,210	16,361	31,591	37,611	40,289	9.0	11.5	7.1	1,714	2,946	4,337	4,609	4,811	8.6	10.2	
Georgia	5,615	12,229	18,189	19,769	21,213	8.1	10.5	7.5	1,432	2,683	3,775	4,030	4,327	6.3	8.9	
Kentucky	4,193	7,922	11,571	12,660	13,791	6.6	9.9	7.2	1,379	2,477	3,477	3,631	4,071	6.0	8.6	
Louisiana	4,775	9,154	13,597	14,503	15,639	6.7	9.0	9.3	1,450	2,829	3,451	3,588	4,153	5.9	8.1	
Mississippi	2,400	4,717	7,259	7,767	8,314	7.0	11.2	7.7	1,123	2,136	3,132	3,317	3,567	6.0	10.0	
North Carolina	6,177	13,061	19,899	21,276	22,859	7.8	10.6	7.4	1,365	2,600	3,605	3,667	4,191	6.5	9.2	
South Carolina	2,887	6,170	9,211	10,285	11,075	7.9	10.5	7.7	1,220	2,401	3,352	3,664	3,979	6.9	8.9	
Tennessee	4,977	9,905	14,934	16,309	17,634	7.1	10.8	7.8	1,413	2,812	3,667	3,667	4,211	6.0	9.4	
Virginia	6,211	12,373	18,602	20,065	21,000	7.7	10.8	9.2	1,568	2,876	4,131	4,494	4,819	6.1	9.5	
West Virginia	2,654	4,132	6,192	6,265	7,890	4.6	10.6	12.2	1,434	2,333	3,463	3,773	4,210	5.2	9.3	
Midwest	21,462	46,049	61,317	76,119	81,581	7.0	10.7	11.1	1,694	2,422	3,919	4,222	4,617	5.1	8.6	
Ohio	2,161	4,517	8,594	9,537	10,435	8.6	11.7	8.9	1,714	2,505	4,133	4,465	4,665	5.2	9.7	
New Mexico	1,530	2,442	3,603	4,663	4,485	4.9	10.5	12.0	1,665	2,415	3,353	3,568	3,910	3.9	8.2	
Alabama	3,732	6,131	9,661	10,761	11,822	6.2	9.7	9.9	1,630	2,695	3,710	3,972	4,329	5.2	8.3	
Florida	16,039	31,827	47,681	51,848	57,900	7.1	10.3	11.7	1,705	2,852	3,951	4,333	4,732	5.4	8.4	
Appalachian	7,555	13,823	22,023	21,285	26,661	6.1	12.4	9.8	1,511	2,796	4,021	4,266	4,692	4.1	9.5	
Colorado	3,268	6,459	10,636	11,647	12,704	7.1	13.3	9.1	1,911	2,942	4,310	4,466	5,013	4.6	9.6	
Idaho	1,691	1,839	2,912	3,429	3,561	5.7	11.7	3.3	1,661	2,073	3,172	4,263	4,819	4.9	9.1	
Montana	1,181	1,809	2,919	3,643	3,491	4.8	11.9	13.2	1,765	2,595	4,084	4,195	4,667	4.4	10.1	
Wyoming	1,491	2,641	4,694	4,206	5,017	5.9	11.5	15.0	1,519	2,530	3,561	3,819	4,154	4.0	8.9	
Wyoming	671	911	1,411	1,600	1,820	4.2	10.8	13.6	1,920	2,670	3,997	4,437	4,914	3.9	8.6	
West	45,391	90,365	124,359	144,573	151,915	7.1	8.3	11.1	2,273	3,530	4,631	5,070	5,572	4.7	7.0	
California	35,681	71,211	97,421	105,372	120,334	7.2	8.1	11.0	2,907	3,613	4,711	5,119	5,626	4.6	6.9	
Arizona	553	1,067	2,643	2,962	3,789	9.8	12.2	13.2	2,332	3,477	4,797	5,067	5,566	4.0	8.4	
Nevada	3,264	6,013	9,646	10,138	10,969	6.4	10.6	8.2	1,872	2,947	4,095	4,671	4,791	4.6	8.6	
Washington	5,159	11,410	15,269	17,163	19,321	7.0	7.4	12.6	2,032	3,413	4,433	4,638	5,432	5.2	6.5	
Alaska		1,035	1,639	1,917	2,415		12.9	31.5		3,453	4,067	5,775	7,437		9.2	
Hawaii		2,513	3,792	4,136	4,550		10.5	10.0		3,423	4,571	4,931	5,311		7.5	
By Census Regions																
New England	21,463	21,760	51,037	53,707	61,101	6.4	8.0	9.2	2,051	2,354	4,451	4,512	5,235	5.1	7.1	8.4
Midwest	73,170	133,882	172,910	186,931	203,487	5.8	7.3	8.9	2,171	3,356	4,621	5,015	5,417	5.0	7.6	8.2
South	13,851	25,611	36,426	40,017	43,819	6.1	8.3	9.3	2,029	3,277	4,561	4,830	5,263	5.0	7.7	8.9
West	26,748	45,653	73,302	75,001	82,603	6.2	10.8	10.1	1,760	3,002	4,467	4,495	4,570	5.5	10.1	10.1
Mountain	40,751	55,591	131,573	145,023	157,067	7.8	11.3	8.3	1,515	2,855	4,045	4,267	4,654	3.9	9.4	6.2
West South Central	15,871	30,629	45,672	49,976	51,126	6.8	10.5	8.3	1,305	2,401	3,434	3,733	4,025	6.0	9.1	7.1
West North Central	26,785	51,250	76,560	81,709	91,745	6.9	10.2	10.7	1,698	2,731	3,795	3,915	4,297	3.4	8.5	9.1
Mountain																

Carolina, with the highest excise tax rate on beer, had per capita disposable income of \$3,930, again in 1975. Given these observations, and keeping in mind our earlier proposal that the State exact approximately \$10 million additional revenue from the liquor industry, the following is proposed:

1) Raise the excise tax on beer from \$.25/gallon to \$.88/gallon. Current wholesale price of a gallon of beer, excise tax included, is approximately \$2.89/gallon. With a tax increase to \$.88/gallon, the wholesale price of beer should rise to approximately \$2.52/gallon. This would therefore entail a 22% increase on the wholesale level.

2) Raise the excise tax on wine from \$.60/gallon to \$1.93/gallon. Current wholesale price of a gallon of wine, excise tax included, is approximately \$8.89/gallon. With a tax increase to \$1.93/gallon, the wholesale price of wine should raise to approximately \$10.22/gallon. This would entail a 15% price increase on the wholesale level.

3) Raise the excise tax on distilled spirits from \$4.00/gallon to \$6.22/gallon. Current wholesale price of a gallon of distilled spirits, excise tax included, is approximately \$22.22/gallon. With a tax increase to \$6.22/gallon, the wholesale price of distilled spirits should rise to approximately \$24.44/gallon. This would entail a 10% price increase on the wholesale level.

The additional State revenue to be realized from such measures would be as follows:

	Proposed Tax Per Gallon	Current Tax Per Gallon	Proposed additional tax x Per Gallon	(000's) Alaska Total Consumption 1975 (gal)	(000's) = Additional Revenue
Beer	\$.88	\$.25	\$.63	8880.3	\$5594.6
Wine	1.93	.60	1.33	873.3	1161.5
Distilled Spirits	6.22	4.00	2.22	1359.4	<u>3017.9</u>
TOTAL					\$9774.0

Since the excise tax is not a percentage rate on sales but rather a flat dollar amount on gallonage, there has been no corresponding increase in tax for increases in retail price (i.e., inflation) over the last 15 years. As a consequence, it is reasonable to assume that the price of beverage alcohol has been declining in proportion to disposable income in recent years. Though we believe the excise tax increases recommended above to be a necessary first step for purposes of 1) implementing State policy aimed at reduction of per capita consumption, and 2) collecting revenue from the liquor industry sufficient to offset current State costs identified as alcohol-related; we further believe that a new tax structure should eventually be implemented that will 1) prevent the price of alcohol from declining as a proportion of disposable income, and 2) ensure that tax revenue from the liquor industry will at least rise with inflation to help maintain a balance between alcohol-related costs and revenues in the future.

Concerning the structure of the excise tax increase we recommend, the following comments are offered:

1) We have found no conclusive research evidence to indicate which alcoholic beverage tends to be most often associated with the incidence of alcohol-related problems. Does beer drinking typically precede incidents of concern to the public and to State government, or are such incidents more often preceded by the consumption of hard liquor? We do not know.

2) In at least two countries, Canada and Ireland, studies have shown the price elasticity of beer to be considerably less than that of distilled spirits. In other words, it was shown that beer sales are much less responsive to changes in price than are sales of distilled spirits in those two countries. We do not know if the same would be true in Alaska. If it is true, however, we would then have to decide whether an appropriate response would be (a) disregard the price availability of beer as an element of the State's program of counter measures, and concentrate price increases on distilled spirits, or (b) put the highest price increase on beer, with the idea that beer may require a higher price increase than other alcoholic

beverages to bring about a given reduction in consumption. Were the State to choose option (a), we believe that the probable consequence would be to shift some portion of total drinking from distilled spirits to beer and wine.

Though at first this would seem beneficial, we repeat that research evidence has not determined that beer drinking leads to fewer alcohol-related problems than does consumption of distilled spirits.

(3) The total consumption figures for beer, wine, and distilled spirits, given in the chart on page 4-11, can be played with in a number of ways. The first observation one can make is that many more gallons of beer are consumed than any other alcoholic beverage. We do not know whether or not this indicates that beer is the beverage of choice on the greatest number of drinking occasions. The total consumption figures can be translated into gallons of absolute alcohol, yielding the fact that the greatest volume of absolute alcohol is consumed from the drinking of distilled spirits. We do not know whether or not this indicates that the greatest amount of excessive drinking involves the consumption of distilled spirits. In short, we cannot interpret the total consumption figures in a way that proves useful in structuring the tax increase to respond best to the State's alcohol-related problems.

(4) Although we have attempted to analyze alcohol-related problems, costs, and proposed counter measures in relative disregard for current practice here or in other states, the Committee feels that current practice does impose some operational upper limits on what the Administration can successfully propose, especially as first steps. The chart on page 4-9 shows current and proposed Alaska excise taxes compared with 30 other license states. To our knowledge, no other State has succeeded in identifying alcohol-related costs borne by State government and then matched revenues to cover the costs. Nevertheless, we feel that resistance to tax changes we propose will increase sharply if the tax proposals are too far out

of King will. The rest of the pack. Finally, we feel that our proposal to raise the excise tax on distilled spirits to \$6.22/gallon already presses the limits of political acceptability, even though this would only entail a 10% price increase on the wholesale level.

These were the primary considerations discussed in structuring our excise tax increase proposal. The tax rate increases are high compared with current rates in Alaska and in other license states. The wholesale price increases we expect from such measures are as follows: 22% for beer, 15% for wine, and 10% for distilled spirits. It is assumed that wholesale price increases will be passed on directly to the consumer. By way of comparison, it might be remembered that the State budgeted 10% inflation for FY 1977, and approximately 10% inflation for FY 76.

B. Local Sales Tax on Alcohol

It is further recommended that State law be changed to allow municipalities to levy a special tax on the sale of alcoholic beverages. This has been requested previously by the Alaska Municipal League, and we concur with the request for the following reasons: 1) Should a municipality decide to further raise the price of alcohol as a means of reducing consumption, we see no good reason for State law to prevent them from doing so. On the contrary, we believe that such action should be encouraged. 2) The demand for funds to expand alcohol abuse prevention and treatment programs is strong throughout the State. We believe that local communities should be responsible for funding such programs to the extent they are able. We have stated our belief that State costs attributable to alcohol consumption should be paid by alcohol consumers, in this case through the mechanism of the state excise tax passed on to the consumer as a portion of the retail price. Just as the State is reluctant to increase or draw more heavily upon general revenues to cover alcohol-related cost increases, municipalities are reluctant to increase property taxes in order to fund

judgment of the State. They believe that local funding is analogous to state funding in this regard, and that therefore municipalities should be enabled to tax alcohol consumers to cover local alcohol-related costs. It is expected that such a provision in State law will eventually yield more money on the local level which may be used to increase funding of local alcohol-related programs.

C. Advertising

We are not aware of any studies that have specifically tried to measure the impact of alcohol advertising on per capita consumption. There seem to be two major types of alcohol advertising: 1) national or regional advertising that promotes a particular name brand of alcoholic beverage, and 2) local advertising that promotes drinking at a particular establishment or package sales from a particular outlet. It is often argued that "type 1" advertising does not increase total consumption, but is rather a battleground of corporate competition for an increased share of the existing market. The removal of cigarette ads from radio and TV is cited as a fitting analogy, for cigarette sales did not decline as a result. We do not know what cigarette sales would have been had radio and TV ads continued. Also, it does not seem reasonable to us that the repetitive portrayal of cigarettes and/or alcohol as a natural accompaniment to the good life is wholly without effect on acceptance of drinking and smoking, and on total consumption. From the perspective of the individual advertiser, it would seem easier to woo part of the existing market from other brands than to attempt to increase total consumption and win the allegiance of the new market. This may well be the intent of "type 1" advertising, though we are not convinced that total consumption is not increased in the process.

"Type 2" ads generally consist in direct appeals to come in to a local bar, restaurant, or liquor store and buy alcohol. Such appeals take a number of forms, such as advertising reduced sale prices, convenient shopping hours

and with promotion in liquor stores, "happy hours" and the like in bars and restaurants, convivial settings for watching football games, friendly conversation over your favorite beverage, etc. It might be argued that the intent of "type 2" ads is similar to the intent of "type 1," i.e., to compete for market share rather than to increase total consumption. The intent of "type 2" ads may be to maintain the visibility of one's establishment in the minds of those who frequent such establishments, just as the intent of the Schlitz beer ads may be to maintain visibility of their product name in the minds of existing beer drinkers. However, we are concerned with effect, not intent. The Committee members felt that they were much more likely to drink more than they otherwise would in response to "type 2" ads ("stop by tonight for our two-for-one sale") than in response to "type 1" ads ("Schlitz is the beer of successful athletes"). It is the opinion of the Committee that "type 2" ads in particular probably stimulate sales of alcoholic beverages in Alaska above the level sales would otherwise reach.

Since our objective is to reduce per capita consumption in Alaska, and since it is preferable to do so without imposing direct restrictions on what the general public can or cannot do, we are led to recommend that a law be enacted to prohibit advertising by licenses of alcoholic beverages, bars, and liquor stores for all in-State programming on radio and television, and in all newspapers and magazines published within the State. It is probable that the State could survive in the absence of such repetitive suggestions from the media. To attempt to restrict such advertising imported on national networks and publications seems quite unrealistic, and the relationship of such advertising to per capita consumption seems shrouded in greater uncertainty.

The local media will not welcome the loss of advertising revenue from the liquor industry. Either new advertisers will be found, existing advertisers might have to pay higher prices, or else media activities will decline in

proportion to the loss of advertising revenue from the liquor industry. If we assume the latter to be a probable, if temporary, adjustment to our suggested restriction on advertising, the State must determine whether or not this is an acceptable trade-off. It is our belief that the extra increment of programming or publication funded by liquor industry ads is not worth subjecting ourselves to regular appeals to drink. The restriction we propose would limit the aggressiveness of the seller, not the purchasing options of the buyer, and is similar to putting up a "No Soliciting" sign in an apartment building.

D. Drinking Age

Though very little information is available on the effect of lowering the drinking age on the consumption levels of young people, there is considerable evidence on the concurrent increase in traffic accidents involving young drivers. In a report from MIT entitled "The effect of the 18-year old drinking age on auto accidents" in Massachusetts, it was found that the lowered drinking age led to a 50% increase in fatal accidents for young drivers. Another study* comparing three jurisdictions that lowered the drinking age (Michigan, Wisconsin, and Ontario) with three others that did not (Indiana, Illinois, and Minnesota), found significant increases among drivers under 21 in the rates of fatal crashes, especially single car crashes at night, in areas that changed the drinking age as compared with areas that did not. A third study** on the effect of lowered drinking age, this time in London, Ontario, found that alcohol-related collisions among 18 and 19 year old male drivers increased by more than 340% after the change in drinking age, and that the corresponding rates for 20 year olds increased 156%. It was also found that rates of alcohol-related collisions among 16 and 17 year olds increased by 162%. Though the lowered drinking age was not the only factor contributing to the increase, it is believed to have had a sizeable independent effect. Similar "before and after" data is not available for Alaska.

*Williams et al. "The Legal Minimum Drinking Age and Fatal Motor Vehicle Crashes," 197

**Whitehead et al. "The Impact of the Change in the Drinking Age on the Collision

Based on these various findings, we believe there is little question that lowering the drinking age in Alaska from 21 to 19 has resulted in increased consumption by those under 21; i.e., lowering the age did more than legalize the drinking already going on - it resulted in an increase. There is equally little doubt that raising the drinking age back up to 21 would result in decreased consumption, and presumably fewer auto accidents among this group of drivers. We do not presently have the data to estimate how much of a decrease might, at a minimum, be expected.

In spite of these various findings, the following table on the incidence of OMVI arrests by age group should give pause to any movement to raise the drinking age back to 21.

AGE AND OMVI ARRESTS IN ALASKA, 1975

<u>Age</u>	<u>No. of OMVI Arrests*</u>	<u>No. of Licensed Drivers**</u>	<u>OMVI Arrests Per 1000 Licensed Drivers</u>
18	77	6003	12.8
19	91	6266	14.5
20	92	6945	13.2
21	97	7779	12.5
22	110	7962	13.8
23	100	8247	12.1
24	94	8302	11.3
25-29	433	39072	11.1
30-34	387	30906	12.5
35-39	342	23767	14.4

*From Uniform Crime Report, 1975

**From Division of Motor Vehicles, effective 12/31/75

It appears that the proportion of licensed drivers under 21 arrested for OMVI in Alaska is not significantly different from the proportion of drivers over 21 who get into similar trouble. Though we would expect that raising the drinking age to 21 would result in a significant lowering of consumption and OMVI arrests for the affected age group, the same argument could be used to raise the drinking age to 23, 25, or 35. Our information, sparse though it is, does not indicate that people under 21 in Alaska are abusing alcohol significantly more or less than any other age group.

In addition, it should be remembered that 18 year olds are voters, serve in the armed forces, are held accountable in adult courts for crimes committed, can legally marry without parental permission, etc. In view of this and the information currently available, the Committee recommends that no change be proposed regarding the legal drinking age in Alaska.

E. Closing Hours

It is often assumed that, by limiting the hours of sale for bars and liquor stores, per capita consumption can be reduced. This may or may not be true - we can find very little evidence on the subject. One relevant study was performed in Victoria, Australia, concerning the extension of closing time for bars from 6 p.m. to 10 p.m. The overall total of personal injury accidents did not change, though the peak shifted from 6 - 7 p.m. to 10 - 11 p.m. This is hardly conclusive, though it leads one to suspect that, allowing for a period of adjustment, limiting closing hours may change patterns of consumption but not be effective in reducing total consumption.

The chart on the next page, showing prohibited hours of sale in other license states, is offered for comparison.

The "gut reaction" of the Committee was that further limitations on hours of sale in Alaska would probably result in some lowering of total consumption, some modification of attitude concerning the wide open acceptability of drinking in Alaska, and at least might serve to punctuate more effectively some of the round-the-clock, continuous drinking that occurs among some fraction of the drinking population; i.e., that there might be some benefit in encouraging a longer "drying out" period each day. For these reasons, the Committee considered proposing that statewide closing hours for bars and other establishments of "on-premise" consumption be changed to 3 a.m. to 10 a.m., and that closing hours for package stores be changed to 1 a.m. to 10 a.m. Current closing hours for all retail outlets are 5 a.m. to 8 a.m.

However, we believe that if policy is to be based on "gut reaction" in the

PROHIBITED HOURS OF SALE FIXED BY STATE LAWS*

License States	On-Premise Consumption (Bars, Restaurants, etc.)	Off-Premise Consumption (Package Stores)	No. Hours Closure On-Premise	No. Hours Closure Off-Premise
Alaska	5 am - 8 am	5 am - 8 am	3	3
Arizona	1 am - 6 am	1 am - 6 am	5	5
Arkansas	1 am - 7 am	1 am - 7 am	6	6
California	2 am - 6 am	2 am - 6 am	4	4
*Colorado	2 am - 7 am	Midnight - 8 am	5	8
*Connecticut	1 am - 9 am	8 pm - 8 am	8	12
Delaware	1 am - 9 am	1 am - 9 am	8	8
*D.C.	2 am - 8 am	9 pm - 10 am	6	13
Florida	Midnight - 7 am	Midnight - 7 am	7	7
Indiana	3 am - 7 am	3 am - 7 am	4	4
Kansas	11 pm - 9 am	11 pm - 9 am	10	10
Kentucky	Midnight - 8 am	Midnight - 8 am	8	8
Louisiana	None	None	0	0
*Maryland	2 am - 6 am	Midnight - 6 am	4	6
*Minnesota	1 am - 8 am	10 pm - 8 am	7	10
*Mississippi	Midnight - 10 am	10 pm - 10 am	10	12
Missouri	1:30 am - 6 am	1:30 am - 6 am	4 1/2	4 1/2
Nebraska	1 am - 6 am	1 am - 6 am	5	5
Nevada	None	None	0	0
New Mexico	2 am - 7 am	2 am - 7 am	5	5
*New York	3 am - 8 am	Midnight - 8 am	5	8
North Dakota	1 am - 8 am	1 am - 8 am	7	7
Oklahoma	10 pm - 10 am	10 pm - 10 am	12	12
South Carolina	Sundown - Sunrise	Sundown - Sunrise	12	12
South Dakota	2 am - 7 am	2 am - 7 am	5	5
*Tennessee	3 am - 8 am	11 pm - 8 am	5	9
*Texas	2 am - 7 am	9 pm - 10 am	5	13
*Wisconsin	2 am - 8 am	9 pm - 8 am	6	11
Wyoming	2 am - 6 am	2 am - 6 am	4	4

Average of States
Listed Above

6 7

Other License States				
Georgia	Fixed Locally	Midnight - 8 am	-	8
Hawaii	Hrs. Set By Counties	Hrs. Set By Counties	-	-
Illinois	Fixed Locally	Fixed Locally	-	-
Massachusetts	Fixed Locally	Fixed Locally	-	-
New Jersey	Fixed Locally	Fixed Locally	-	-
Rhode Island	1 am - 6 am	Fixed Locally	5	-

*States requiring closure of package stores prior to closure of on-premise outlets
**Excluding Sundays and holidays

absence of useful, empirical information, such reaction should come directly from the people of the State. We therefore recommend that the question of further statewide limitations on hours of sale be included in the public survey to be conducted within the next year by the Criminal Justice Planning Agency. (The survey will focus on standards and goals of the criminal justice system.) Results of the survey will be presented to the Governor, who may then wish to sponsor a referendum on the subject of statewide closing hours at the next general election.

F. Alcohol in the Push - Mail Order and Telephone Sales

Bethel voted to go dry two years ago. The Police Chief of Bethel has stated that his department was averaging 600 calls per month before the dry vote, almost all alcohol-related and with a high incidence of violence. After going dry, calls dropped to approximately 150-200 per month but have since climbed slowly back almost to pre-dry levels, still almost all alcohol-related. It is believed that bootlegging is the major contributor to the re-emergence of alcohol as a destructive influence in the community.

It is against State law to sell liquor without a license. However, it is legal for an individual to purchase up to 20 wine gallons of liquor per order by mail (there is no limitation on the number of orders), have it sent to Bethel (or any other community) on scheduled airlines, pick it up and take it home. Once the liquor disappears into the community, neither the local police, the State troopers, nor the ABC Board investigators are able to trace its possible progress into eventual resale. This means that State law against bootlegging liquor is largely unenforceable under current conditions. However, it is unlikely that a town, having taken the major step of voting itself dry, intended simply to substitute ready availability from a bootlegger for ready availability from a licensed outlet. The idea of going dry is to seriously reduce availability. It is unlikely that the measures thus far proposed in this report would have a

significant effect in those areas where bootlegging is currently common.

Our first recommendation to address this problem is that a law be enacted to prohibit retail licenses from accepting any orders by mail or by telephone. This is predicated on the definition of alcohol as a potentially dangerous drug. This would be effective in reducing consumption in areas where a liquor outlet does not exist, for the only legal means of procurement for either a resident or a bootlegger would be to carry in his own supply.

The Committee considered a variation of this proposal which would specifically prohibit retail licensees from accepting telephone or mail orders originating from a dry community. This was rejected in favor of the general ban due primarily to the administrative and enforcement problems the "variation" would entail. In order for the ban to apply only to those orders originating in a "dry" community, the ABC Board would have to ensure that 1) all retail licenses in the State were in possession of an updated list of dry communities, and 2) that only those telephone and mail orders originating from "wet" communities were being honored by the licensees. In addition, it would seem relatively easy for a bootlegger to place orders from a nearby "wet" community and then transport his supply to the "dry" community for resale. The Committee was opposed to recommending any law that 1) would be difficult to administer, 2) would be much more difficult to enforce, and 3) would still leave ample opportunity for its intent to be subverted.

The general mail order and telephone sales ban that we propose will involve greater inconvenience and expense in the purchase of alcohol even in those bush locations that are not formally "dry" but lack a local outlet. However, there are costs and benefits of living in the bush, and we believe that adding reduced availability of alcohol to the cost side of the ledger does not outweigh the benefit of shutting off this source of alcohol flowing into a community that does not want it.

We believe that this proposal will help considerably in seeing to it that,

if a bush community really wants to be "dry" and votes accordingly, conditions in the town really will resemble "dry" more closely than "wet." There are at least two problems related to this proposal which are addressed in the next two sections of this report. First, although a telephone and mail order ban should significantly curtail bootlegging, it would be foolish to think that this alone will somehow put an end to it. One or a few local residents in a "dry" town could quite easily and legally hop in a plane, scheduled or non-scheduled, fly to the nearest licensed package store, purchase and fly back with any number of cases, and take them home. Eventual resale in the "dry" community would be as difficult to trace as it is now. Though the incidence of bootlegging should go down and the price of bootlegged liquor should go up as a result of the proposal, there is no question that a significant amount of bootlegging will still occur. Second, we are told that those residents of a "dry" town who order alcohol by mail for their own personal consumption are much less likely to be involved in alcohol-related problems than are those who buy from the bootlegger, who may have secured his "inventory" through mail orders. In the context of a mail order and telephone sales ban, the condition "dry" may be perceived by these residents to be too inconvenient or "too dry" to gain their support. Our proposal may therefore make it less likely that some villages will vote "dry" in the first place. Though we believe our proposal is a necessary step in bringing about a genuinely "dry" condition in those communities that desire it, we believe that a workable middle option should be provided for those communities that wish to reduce their alcohol problems but are unwilling to vote "dry" in the context of a general telephone and mail order ban.

G. Limitation on Possession in a Dry Community

Bootlegging will continue to some extent in "dry" communities. It is extremely difficult at present to "catch" a bootlegger and successfully prosecute him. Though enforcement officers may know who the individuals are, it is extremely

rare for them to actually witness the money changing hands, difficult to find other willing witnesses to the transaction, and therefore nearly impossible to enforce the law against selling without a license as the laws are currently written. However, the intent of the law is clear and the need to make that intent enforceable, especially in "dry" communities, is equally clear.

We therefore recommend that it be illegal for an individual to possess more than two wine gallons of alcoholic beverages in a "dry" community. (Two wine gallons translates into ten fifths of liquor.) It is the judgment of the Committee that possession of more than that amount in a "dry" community indicates an intent to sell. Ten fifths of liquor does not seem to be an intolerably low ceiling on possession for personal, or even social, consumption, particularly in a "dry" community. However, we expect that those bootleggers who do the most business must keep more than that on hand. We have no doubt that such a law would be far easier to enforce than is the current law against selling without a license by itself.

In addition, we recommend that this proposal be forwarded to and reviewed by the Bush Justice Conference, which will meet from October 7 to October 9 this year. Their input should be useful and will be appreciated.

II. Middle Option - "Semi-Dry"

We recommend that the following option be available for an incorporated community to adopt by majority vote:

When the "middle option" has been chosen by a community, all private licenses will expire within a maximum of 3 months after the election (liquor license fees to be refunded in proportion to the time remaining on the license at the end of this period). At the end of three months, the State will issue the community a "community liquor license" for package sales only, defined as follows: The community liquor outlet will operate on a non-profit basis (i.e., charging only what is needed to cover expenses) and will subscribe to at least

two operational rules: (1) All liquor orders must be placed at least two weeks in advance of being picked up, and (2) no more than two (as opposed to twenty) wine gallons of liquor may be ordered on any one day. A third rule that might be considered would be a limitation on the number of orders allowable within a week. However, it may be that such a rule would be unnecessary and might simply involve confusion and paperwork. The fewer rules the better - thus we suggest holding off on the third until experience is gained. (This definition would place the current "community liquor license" concept already on the books.)

This would accomplish several objectives: (1) Time-lag sales from government outlets were first instituted in Frobisher Bay, Canada, in 1962. (Frobisher Bay had a population at that time of approximately 2,000, including 900 Eskimo and 1,100 whites, and is located in the Canadian arctic). It was demonstrated there that time-lag sales can be very effective in reducing total consumption, excessive drinking, and related social problems*. (2) The Frobisher Bay experience indicates that time-lag sales are particularly effective in reducing the incidence of highly spontaneous "binge drinking." (3) If the public outlet were run for profit and used as a source of revenue for the town, we feel there may be a tendency to encourage sales. A local sales tax on alcohol, as discussed previously, would be a more appropriate means of generating revenue. Also, it is expected that a non-profit operation, even with a local sales tax added to the price of retail sales, would effectively under-price bootlegged liquor. (4) This arrangement still allows individuals to order up to two wine gallons of liquor at a time at going prices, which again seems more than sufficient for personal consumption and not too inconvenient for a town that has voted to seriously reduce its alcohol problems.

It is further recommended that the two wine gallon limit on possession

*Honigman, "How Baffin Island Eskimo Have Learned to Use Alcohol"

apply to towns choosing the "middle option" as well as towns that have voted dry. Finally, we suggest that the law provide that the "middle option" remain in effect for at least one year after the community outlet begins operation, in order to give the new system a chance to function for a sustained period.

I. QMWI Statutes

1. Medical evidence exists to demonstrate the validity of blood alcohol concentrations as an index of level of impairment due to alcohol. Further, both medical and associated scientific research information demonstrates the reliability of the blood, urine, and breath testing procedure to ascertain blood concentrations.
2. According to research tests, the risk of a person becoming involved in an automobile accident begins to increase at .05% BAC. At .10% a person is approximately seven times more likely to be involved in a crash than if sober, and at .15% BAC the risk of accident involvement is increased 25 times.*
3. Additional research findings and demonstration programs show that persons identified as problem drinker-drivers as a result of conviction for QMWI and presentence investigation are primary candidates for alcohol treatment and rehabilitation systems as well as for the criminal justice system. Further, recent treatment rehabilitation evaluation information shows that the recovery rate for persons treated as problem drinker-drivers is much higher than the conventional treatment rate for voluntary self-admissions to treatment programs. This result is considered to be due to the increased potential of treatment when problem drinker-drivers are identified early in the progressive cycle of alcoholism. The important contribution of screening all convicted drunk drivers is the early identification of

*U. S. Dept. of Transportation, National Highway Traffic Safety Administration

problems drinkers and early intervention into the progressive cycle of alcoholism.

Our first and, at this point, our only recommendation is to change statutes to make it illegal to drive with a blood alcohol concentration of .10 or higher (see chart on next page). Currently, a BAC of .10 constitutes evidence of intoxication, but by itself is insufficient to ensure an OMVI conviction. We believe this aspect of the law should be strengthened as suggested above.

Additional recommendations on this subject are still being developed. Specifically, the costs and benefits of establishing mandatory presentence investigations for all OMVI offenders, and the costs and benefits of increased police enforcement, are still under review. The idea of presentence investigations would be to screen the pool of persons convicted of OMVI, for early identification of problem drinker-drivers, and possible referral for treatment or rehabilitation in lieu of traditional court sanctions.

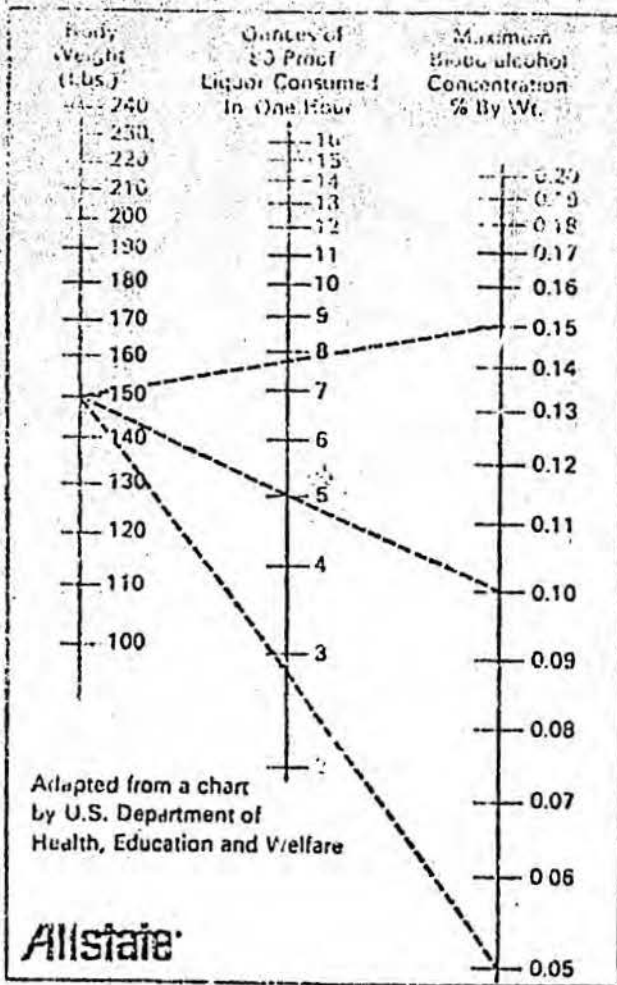
J. Public Education

A recommendation on public education will be made later. The Department of Education will present specific proposals for the Committee to review in early October.

**ESTIMATED AMOUNT OF 80 PROOF LIQUOR NEEDED TO
REACH APPROXIMATE GIVEN LEVELS OF ALCOHOL IN THE BLOOD**

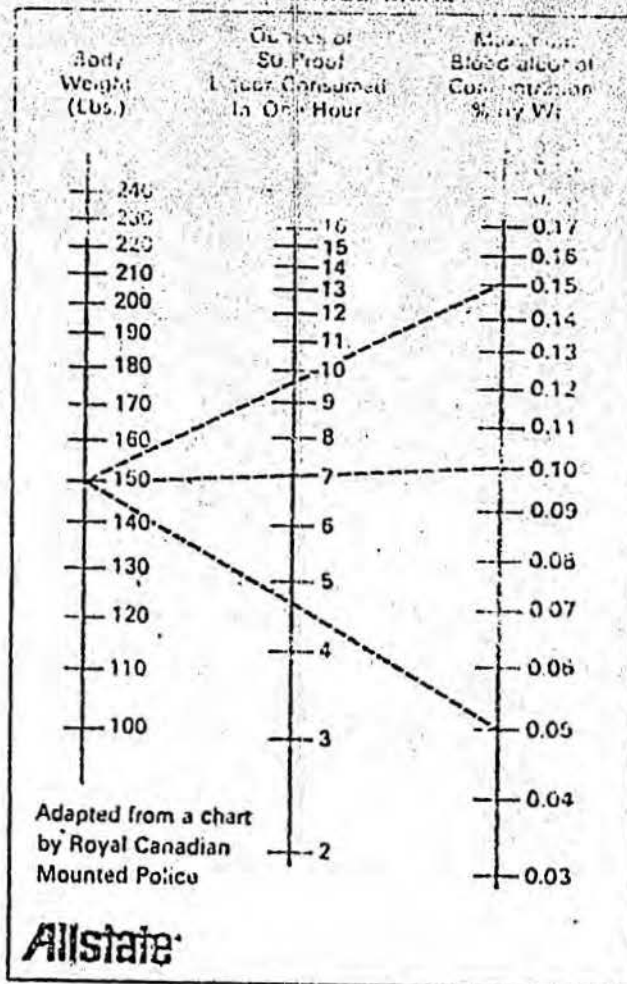
"EMPTY STOMACH"

DURING A ONE-HOUR PERIOD* WITH LITTLE
OR NO FOOD INTAKE PRIOR TO DRINKING



"FULL STOMACH"

DURING A ONE-HOUR PERIOD* OCCURRING
BETWEEN ONE AND TWO HOURS AFTER
AN AVERAGE MEAL



The examples above show the approximate average amount of 80 proof liquor a 150-pound person would have to consume in a one-hour period to reach 0.10%, the percent weight of alcohol in the bloodstream that is presumptive of intoxication.

To determine the approximate average number of ounces of 80 proof liquor needed in a one-hour period to reach 0.10%, draw a line from BODY WEIGHT to 0.10%. The line will intersect the average number of ounces needed to produce 0.10%. Follow the same procedure to determine the amount of liquor needed to reach other

blood-alcohol concentrations, such as 0.05%, 0.15%, etc. Charts show rough averages only. Many factors affect the rate of alcohol absorption into the bloodstream. Amount of food consumed, kind of food and drink consumed, and percentage of fatty tissue in the body, for examples, can vary blood-alcohol concentration values. *The rate of elimination of alcohol from the bloodstream is approximately 0.015% per hour. Therefore, subtract 0.015% from blood-alcohol concentration indicated on above charts for each hour after the start of drinking.

REPORT OF THE
I.C.C. SUB-COMMITTEE ON THE
PRIMARY PREVENTION OF ALCOHOL-ASSOCIATED
PROBLEMS THROUGH EDUCATION

October 14, 1976

4.29

GOAL

The reduction of the incidence of alcoholism and alcohol-related social problems in Alaska through programs of preventive education.

CONSIDERATIONS

- "Primary Prevention" has been defined as those strategies or efforts which are directed at the totality of a population and designed to reduce the unquestioned use and the social acceptance of a substance which has been demonstrated to be harmful to a significant proportion of that population. It differs from secondary and tertiary prevention efforts in that the latter are more expressly directed at the treatment of the alcoholic and the detection of cases in their earlier and more manageable stages.

Primary preventive education, then, is essentially concerned with the formation of realistic attitudes and the consequent creation of a climate of acceptance among all groups and levels toward whatever steps may be taken by a concerned public to reduce the prevalence of the substance or disfunctional social situation in question.

The concerned public in general and the educators in particular must be totally aware that educational (information-bearing) programs operating unilaterally can never be as effective as they might be conceived to be. Preventive programs are expected to function as a strong spur to community action; there must be brought into existence simultaneously some systems or avenues of action that the citizenry may utilize for the carrying into effect the value-changes which result from the introduction of the new concepts.

- Past programs of alcohol and drug education have been relatively ineffective due in part to the use of scare tactics, the exclusive use of objective information, and concentration on the disease alcoholism. New programs should be broader in scope, including the promotion of alternative and healthier lifestyles.

- An effective prevention programs must not only impart objective information, it must also lead to the development of positive attitudes about and skills for working with the problems surrounding alcohol use and abuse.

- The sub-committee recognizes that for maximum effectiveness, any educational program must be flexible and appropriate for the various social groups with differing and sometimes opposing needs and special interests that exist in Alaska.

- An educational program of professional design which is broad enough in scope to address all sectors of the Alaskan public and which can be carried forward over a sufficient time-span to achieve effectiveness in depth, will require re-allocation of existing resources and the addition of new resources.

- The outcome of prevention efforts through education which attempt to create lasting changes of social attitudes, customs and values, must be assumed to require continued effort over a considerable period of time.

RECOMMENDATIONS

Therefore, the Sub-Committee on Education recommends that consideration be given to the formulation and implementation of all of the following projects, for both the education of the general public and those in the schools.

I. TOWARD THE EDUCATION OF THE GENERAL PUBLIC

GOALS

1. The public will be made aware of the true extent of the socio-economic problems at State, community, family and individual levels, which emerge from the current levels and patterns of alcohol consumption use.
2. The public will be aware of the concept that alcohol is a drug in the true sense of the definition, that intoxication means being functionally incapacitated to some degree, and that such a state is not to be approached with impunity or humor.
3. The public will be disabused of the traditional misconceptions associated with alcohol.
4. The public will be aware of alternatives to drinking which are more rewarding and less physically dangerous.
5. The public will be aware of the purpose and direction of counter-media campaigns originated by the alcohol beverage industry.
6. The general public will sustain a measurable decrease in over-all consumption of alcoholic beverages.

Project A

To develop and implement a long-term on-going program of public information and education, utilizing all available media. The focus will be concerned with the above goals.

To insure the maximum efficiency of such a media program, the committee recommends that materials be developed which are appropriate to the needs of age and interest groups (i.e., urban/rural, native/non-native, aging/ young adults, etc.).

1. TIME FRAME

Twelve months will be necessary to effectively design and begin to implement the complete public education program. This program should be assessed at definite intervals, and its continuation based on objective evaluation.

2. RESPONSIBILITY BASE

The Department of Health and Social Services should be responsible for designing and operating the public education program. Within this department, responsibility might be assigned to The Office of Alcoholism and/or The Health Education Section of Public Health. State Departments must coordinate efforts with non-state agencies (e.g., National Council on Alcoholism/Alaska Region; ANCADA, etc.) so that duplication and gaps in public education do not occur. The Department may elect to fill temporary positions and/or sub-contract for the 12 months of some segments of the project, rather than establish permanent professional positions and personnel to accomplish this task.

3. FUNDING SOURCE

Those expenditures which are necessitated should be, as directly as possible, derived from an increase in revenue generated by additional taxes imposed on the sale and distribution of alcoholic beverages. It is recognized that such taxes may not be specifically dedicated, but the additional revenue which may accrue to the State General Fund should be borne in mind as a potential funding base.

4. LEGISLATIVE BACK-UP

Support budget requests of involved State Departments.

Project B

To promote within communities, their development of affirmative action plans for preventive education, by providing technical assistance on possible alternative programs and funding sources.

Professionals knowledgeable in community organization skills; types of preventive education programs; and planning, funding and evaluation strategies would use their skills by motivating and assisting local communities in developing and implementing affirmative action plans and programs for identifying causes and solutions to preventing their alcohol problems through educational means. One funding source for communities to use for the programs they design would be made available by creating a new category for this purpose in the Municipal Revenue-Sharing Act.

1. TIME FRAME

A pilot program, involving several communities, should be accomplished and evaluated for effectiveness within 2 years. The total effort in community education will become an on-going service.

2. RESPONSIBILITY BASE

Community guidance and support for alcohol education should be the duty of a Community Preventive Education Specialist located in each of the three Health Service Areas. Community Preventive Education Specialists may be based in either the Department of Health and Social Services or Community and Regional Affairs.

3. FUNDING SOURCES

From the increased revenue which may be generated into the State General Fund by additional taxes on alcoholic beverages, an alcohol-abuse prevention categorical base for municipal revenue-sharing

request (under AS 43.18.010.050) should be formulated, which will provide funds by which the concerned community may implement alcohol education on a local level. A minimum of \$2.00 per capita may be sufficient. Follow-up analysis should be useful in determining whether a different dollar amount is necessary. Unincorporated areas should receive funds by special legislation. State General Funds will be needed for three new positions.

4. LEGISLATIVE NEED

- a. Legislation which will provide authorization for a new category for alcohol education under the municipal revenue-sharing plan.
- b. Legislation which will provide State personnel positions and funding for three community preventive education specialists.

Project C

To design a program of public education which will provide information, elicit public response and issue feedback to the public, concerning all proposed alcohol related legislative measures and considerations.

This section of the total program, in addition to the formulation, implementation and analysis of public opinion polls and surveys, may utilize the Alaska Public Forum, the TV program "Alaskan Advocates" and other existing media channels.

1. TIME FRAME

This project is expected to be employed each time significant legislation on alcohol is proposed. This project should commence with the Governor's projected legislation resulting from the I.C.C. report.

2. RESPONSIBILITY BASE

The program will stem basically from the Office of the Governor, which will provide material on projected legislation and coordinate information-gathering and dissemination.

3. FUNDING SOURCES

The Office of the Governor.

4. LEGISLATIVE NEED

Favorable budgetary review of requests for expanded services, if necessary, which may arise as a result of needed support.

Project D

To promote the establishment of an informed policy on alcohol use by the leadership of government, business, industry and labor, and the dissemination of such policies to the general public.

The committee feels that the leadership of Alaskan government and industry are in a position, by the use of public statements and by the force of example, to become a strong influence toward setting the tone of public acceptance of preventive efforts in the field of alcohol-use.

1. TIME FRAME

The elicitation of supportive statements and policies should begin immediately and become a permanent factor.

2. RESPONSIBILITY BASE

The Department of Health and Social Services, working with individual business leaders and union officials, will be responsible for the elicitation and public dissemination of policy.

3. FUNDING SOURCES

Department of Health and Social Services.

4. LEGISLATIVE NEED

The passage of a Joint Resolution by the State Legislature, accompanied by a strong statement of support from The Office of The Governor (see Appendix).

II. TOWARD A SYSTEM AND POLICY OF EDUCATION IN THE SCHOOLS

GOALS

By completion of the elementary grades:

1. Students will know and demonstrate the importance of asking a responsible adult before eating or drinking anything unknown; and know dangers of putting foreign objects into mouth or other body orifices.
2. Students will be able to identify substances commonly used by individuals that may modify mood and behavior (e.g., candy, soft drinks, tea, coffee, cigarettes, alcohol); and know there are differences between alcoholic beverages and other beverages.
3. Medicines are helpful for maintaining health and should be treated with respect.
4. Medicines and other substances that are commonly used can be harmful if misused; know a variety of conditions which contribute to the misuse of medicines; are able to identify substances that can be harmful if misused; know dangers resulting from use of combinations of drugs.
5. Misuse of drugs often starts early in life. Individuals react differently to alcohol and other drugs. One can live a normal, full and happy life without misusing drugs. Personal goals and practices established early in life (e.g., self-respect for one's body, healthy standards of behavior and sound personal decisions) can help one to avoid the misuse of drugs. A positive self-image can be a factor in finding alternatives to the abuse of alcohol and other drugs.
6. Students will know some sources and results of authoritative research concerning the effects of alcohol use on the body; identify reasons individuals drink or refrain from drinking and ways that drinking can affect the performance of an athlete, hunter or fishing person, and know some of the ways alcohol advertising contributes to the use of alcohols.

7. Well-adjusted individuals are able to interact with others in a variety of situations. Various behaviors can produce various good and bad feelings in others. People react in different ways to various situations. Other people can affect one's self-image.
8. Students will be able to identify the qualities in themselves which they appreciate and those they would like to change; will be able to analyze their own feelings of pride; and will be able to describe ways to improve qualities and how to maintain those they value.
9. Students will be able to recognize and discuss effects of emotions on behavior; will be able to identify alternative methods of dealing with stress in one's own culture.

By the completion of junior high:

1. Students will know general physiological and psychological effects of drugs; know about alcohol, its history, nature, uses and abuses, and physical effects on the individual, the family and society; know reasons why individuals refrain from drinking; and can identify cultural similarities and differences in our society and how this pertains to alcoholism. Students can identify dynamics of decision making concerning use of alcohol and are able to list sources of social pressures which affect decisions; are able to evaluate alternate solutions to such problems and to name legal, psychological and physical consequences of given incidents involving use and abuse of alcohol. Students will know methods of discouraging illegal alcohol and other drug suppliers and ways in which individuals can be influential in the control of alcohol and other drug usage.
2. Alcohol and other drugs may cause immediate and harmful long-range effects. Many major health problems may be aggravated by misuse of these substances. Students know effects on pregnant women and new-born infants. Students know some social and economic problems resulting from substance misuse.
3. Students know basic physiological and psychological needs of human beings and are able to list ways substances have been used and misused to meet basic needs; know ways of avoiding alcohol and other drug abuse.
4. Students will understand that anxiety, fatigue, frustration and mild depression are normal tolerable parts of everyday life; know ways in which pressures can help or hinder behavior; know ways that the effects of pressure can be re-channeled; know ways in which trust in one's self and in others can serve as relief from anxiety; know how a crisis situation may affect the individual; and that individuals vary in their abilities to adjust to the demands of living.

5. Self-acceptance and acceptance of one's cultural framework is fundamental to sound health; know socially appropriate ways of meeting one's own emotional needs that will be well regarded by others, both within immediate peer or cultural group and within the larger society, and ways of meeting those needs that will not be so regarded. Self-respect is built upon complex factors, including the concept of self in relation to "important others" and is related to the ability to accept success, failure and/or criticism.
6. Students will demonstrate basic steps in dealing with a problem; know ways in which feelings such as anger and fear may affect an individual's ability to cope with problems; will be able to identify acceptable ways in society to release and deal with hostility and anxiety; and know local resources that can assist individuals in solving complex problems.
7. Students will know ways in which self-discipline helps to adjust behavior and regulate emotions in a manner acceptable to oneself and to one's own culture.

By the completion of high school:

1. Students will know the historical background, characteristics and scope of the substance abuse problem in their immediate family, village or city, state, nation and world.
2. Various treatments and sources that are available for substance abuses will be known.
3. Students will be able to analyze alcohol and drug advertising for such qualities as subtle inferences, scientific accuracy and emotional appeal.
4. The essences of major state, federal and international laws and regulations relating to alcohol and other drugs will be known.
5. Students will be able to identify defense mechanisms which they and others use in adjusting and adapting to situations and experiences; will identify defense mechanisms which may be used in maladjustive behavior.
6. Values include the beliefs, ideals, rules and standards which guide one's actions. Influences in one's physical or social environment which help shape one's values are recognizable. Values influence human behavior in many ways.
7. Vocational and avocational interests and activities can fulfill psychological and creative needs.
8. Students will know ways in which major changes (e.g., changing jobs, marrying, having children, death in the family) can affect the individual's overall well-being.

Project 7

To formulate an elementary and secondary school alcohol education curriculum package, which, while having as its central focus objective information about the substance, its use and abuse, will achieve its goal through helping young Alaskans learn to understand their values, needs and desires; to resist peer pressures; control impulses; make rational decisions; and learn problem-solving skills.

Such a program must be designed with great sensitivity to the variation in need and the capacity to assimilate that exists in any student body and particularly in Alaska. It must be constantly borne in mind that the youngest students are not so much in need of objective information about the substance as they are in need of the development of personal skills and ego-strengths to enable them to cope with the decisions and evaluations that they will face at later levels of socialization. Learning from drug education programs in the past, it must be recognized that as the older students arrive at the point of decision, they must also be armed with objective and factual information concerning alcohol and other drug substances which neither contains any element of coercion nor attempts to promote unrealistic goals or elicit unreasonable decisions. Such a program must be developed in a manner that is conducive to integration into a school's comprehensive health education curriculum.

1. TIME FRAME

An effective academic curriculum package which will address the specific demands of students as they progress from one level of need to another, will take one year to design and another year to field test, evaluate and adjust.

2. RESPONSIBILITY BASE

The State Department of Education may designate and assign appropriate experienced personnel to devise, test and evaluate the curriculum

guide, which will necessitate a temporary expansion of their present personnel and budgetary structure or funding allowing for such services to be performed on a contractual basis.

3. FUNDING SOURCES

Total cost of design, testing, evaluation and implementation of a curriculum package will be approximately \$100,000 (includes the make-up and distribution of teaching and resource kits for each of the 52 school districts). The funds should derive from State General Fund monies.

4. LEGISLATIVE NEED

Budgetary support for this special-purpose project.

Project B

To develop and implement a program for training teachers, school administrators and school counselors in the purposes and methodologies of the alcohol education curriculum package.

There is a need to provide teachers with training courses which will provide them with up-to-date information and teaching skills, and will assist them in arriving at sound personal attitude-bases from which to operate. 4.

The University of Alaska is the natural place to develop and offer courses which will meet both these needs of teachers and school counselors. The Sub-Committee on Education strongly recommends that the Department of Education and the University give consideration to establishing a minimum of a three credit-hour course in alcohol education as a requisite to teacher certification or re-certification in this state.

1. TIME FRAME

This course (or courses) should parallel the development of and be aligned with the curriculum package. The Sub-Committee recommends that the Governor's Office recommend to the University of Alaska that this project be undertaken, in cooperation with the Department of Education, no later than September 1, 1977.

2. RESPONSIBILITY BASE

The responsibility should lie with a tri-partite cooperative group consisting of the Department of Education, Health and Social Services (e.g., Office of Alcoholism) and the University of Alaska (e.g., Departments of Education and Center for Alcohol and Addiction Studies).

3. FUNDING SOURCES

Cooperative State Departmental funding.

4. LEGISLATIVE NEED

Budgetary consideration to the requests of the University of Alaska, the Department of Education and Department of Health and Social Services, for additional funds for this training effort.

Project C

To develop a promotional program, directed to school boards and school administrators, which will insure the use of the alcohol education curriculum package.

1. TIME FRAME

persons, This effort should be continuous in time-span with the projects for curriculum package development and training efforts.

2. RESPONSIBILITY BASE

The Department of Education should be the lead agency, requesting and utilizing the services of others as may be indicated.

3. FUNDING SOURCES

No special funding is necessary.

4. LEGISLATIVE NEED

No special legislative back-up is foreseen presently.

SUMMARY

The seven projects outlined above are designed to reach the general public through top-quality media programs; community programs promoting self-responsibility; and the publicity of examples set by government, business, industry and labor policies; and they will reach the school-age population through the development of an appropriate curriculum package and the motivation and training of school personnel who will implement it.

None or very few of the necessary mechanisms (fiscal capacity or personnel) presently exist to a near-requisite degree in the Alaskan governmental structure or in Alaska itself. Even allowing for an extensive cooperative effort that may be extended by the involved state agencies, it will be necessary to allocate, to an extent not now fully determined, money and specialized personnel in order to implement this total set of projects.

① It is the Sub-Committee's recommendation that in addition to the above, that at least twenty percent of all future state funding for the State Office of Alcoholism be specifically designated to be used in educational activities or primary prevention. This ^{would} ~~will most likely~~ require that the State Office of Alcoholism receive additional funds. ② The prevention activities currently on-going through the State Office of Alcoholism are concentrated at the secondary level of prevention. The Sub-Committee members believe that a shift toward the direction of education and primary prevention will be more effective in the long term.

In order to successfully carry out this total program, there must be demonstrated a high standard of cooperative effort among involved inter- and -intra state and community agencies at all levels, in order to avoid duplication and dilution of effort and to offer necessary understanding and support. All preventive education projects must be ultimately coordinated with a central agency in order that this occur. That the State Office of Alcoholism be the coordinating body for preventive education is a possibility.

SUMMARY OF PROGRAMS FOR THE PREVENTION OF
ALCOHOL-ASSOCIATED PROBLEMS THROUGH EDUCATION

APPROACHES	TIME FRAME	RESPONSIBILITY BASE	FUNDING	LEGISLATIVE NEED
I. Education of the General Public				
A. Public Information and Education through the media	on-going	HSS; coordinate with non-state agencies	State General Fund	Support budget requests
B. Community affirmative action	on-going	HSS or CRA	State General Fund	a. New revenue-sharing category b. 3 new state positions
C. Public involvement in legislation	on-going	Office of the Governor	Office of the Governor	-
D. Government, business industry and labor policy on alcohol use.	on-going	HSS	HSS (no new funds)	Joint Resolution
II. Education in the Schools				
A. Development of Curriculum Packages	2 years	DOE	State General Fund	Support budget requests
B. Training teachers, school administrators and school counselors	on-going	University of Alaska, DOE and HSS	University of Alaska, DOE, and HSS	-
C. Promotional program for school boards and school administrators	on-going	DOE	None	-

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I. Problems

A. The Uniform Act

The Uniform Alcoholism and Intoxication Treatment Act (A.S. 47.37.010-.270) establishes:

1. The State's policy concerning alcoholism and public intoxication;
2. The Office of Alcoholism and its functions;
3. The elements of a comprehensive program for treatment;
4. Regulations for committment of alcoholics for treatment.

However, the Uniform Act (Sec. 47.37.010) does not distinguish between the alcoholic and the alcohol abuser (or publicly intoxicated person) for the purposes of treatment.

It is essential for planning and implementation of treatment and rehabilitation programs that an adequate distinction be made between alcoholics and alcohol abusers.

The requirements for effective intervention for each of these groups are of a very different nature. The addicted individual is afflicted with a psychological, physiological and social problem which requires the attention of skilled professionals applying established treatment principles and methods. The individual referred to here as the "alcohol abuser", the "alcohol-related offender", the publicly intoxicated individual, the OMVI offender, etc., may or may not be suffering from a demonstrable addictive condition and may therefore, not need all the services appropriate to the treatment of alcoholism. Though treatment and rehabilitation, and the present discussion of these areas, primarily addresses the alcoholic, there are some areas in the range of treatment components that may appropriately be geared toward dealing with the alcohol abuser, for example emergency medical crisis intervention sleep-off services and educational outpatient counseling.

There is insufficient data upon which to formulate a complete, definitive plan for:

1. the distribution of monetary resources;
2. the selection and location of alcoholism treatment components; and
3. the success of treatment programs in meeting the assumed or verified need for treatment services.

The types of data which may be relevant to #1-3 above include the following:

1. Population distribution by region, district and local community.
2. Size of target population (number of alcoholics and alcohol abusers).
3. Existing alcoholism treatment resources in the region, district and local community.
4. Unit cost of care for each treatment component.
5. Maximum amount of State, Federal and local dollars available for alcoholism services.
6. Cost effectiveness of existing alcoholism services.
7. Number of clients successfully completing the program.
8. Long-term reduction in alcohol-related impacts (e.g., arrests and convictions, deaths, child abuse, emergency room services).
9. Client recidivism rates for alcoholism treatment programs.
10. Demographic profiles of geographical districts, local communities and target population.

Current efforts to acquire and analyze potential relevant data include the Office of Alcoholism's "Systems Analysis of Alcohol Problems" project, the Interdepartmental Coordinating Committee Task Force, the computer analysis of Client Data Base Forms and Monthly Program Activity Reports, and Office of Alcoholism program evaluations.

C. The Grant-in-Aid Funding Mechanism

We believe that grants-in-aid, unless used principally as initial seed money for limited periods of time, are counter-productive in the effort to develop and maintain quality alcoholism treatment and rehabilitation services. This view is supported by the statements and experiences of the Directors of Valley Hope Treatment Center (Norton, Kansas) and Chit-Chat Foundation (Wernersville, Pennsylvania). The Valley Hope and Chit-Chat alcoholism treatment programs are widely recognized as two of the oldest and most successful alcoholism rehabilitation services in the United States.

Third-party (insurance) reimbursements and client fees account for approximately 70% of the revenues generated by these two programs. Both of these programs generate sufficient income to not only meet their operational cost but also to expand their services and facilities.

The grant-in-aid statute, A.S. 47.30.475-477 as amended (1975) requires that grants be awarded in a ratio of 75% State money to 25% community money, except for those communities officially designated as poverty areas. The required ratio for these poverty areas is 90% State money to 10% community money. The current poverty areas as determined by the Department of Community and Regional Affairs are as follows:

Ariak	Bettles	Ft. Yukon	Kotzebue
Barrow	Cold Bay	Galena	McGrach
Bethel	Dillingham	Glennallen	Nome
			Tok

The grant-in-aid regulations (7AAC 10.050) provide for the use of in-kind contributions in meeting the non-State sharing of project costs. It should also be noted (AS 47.30.475 d) that other non-State (e.g.,

Federal) grants may be used to meet the required match:

Therefore, it can be seen that the grant-in-aid statute places the burden of financial support for program operation on the State. In other words, a project is eligible for and may receive State grant-in aid for an indefinite number of years at the 75:25 or 90:10 State/local ratio. This is in contrast to most Federal grants (NIAAA staffing, special projects, and public inebriate grants), which generally provide funding in decreasing yearly amounts for from three to five years.

This mechanism provides the opportunity for the Federal government to assist in establishing a greater number of alcoholism treatment programs. It also provides an incentive for existing programs to develop alternative financial resources and achieve a greater degree of self-sufficiency.

Decreasing, time-limited funding recognizes and encourages the local community's and the consumer's responsibility and authority in selecting and maintaining health care services. It also provides sufficient time for a program to establish the relevance and viability of its services and allows for an opportunity to develop the financial resources which will be required for its continuing existence.

Evidence for the contention that State grant-in-aid funding passively or actively encourages programs to rely on State monies may be deduced from the following table (FY 76):

<u>Project location</u>	<u>State funds</u>	<u>Other Cash or In-Kind</u>	<u>Ratio State/Non-State</u>
Nome	85,430	40,697	2.09
Dillingham	22,100	9,405	2.35
Kotzebue	36,507	15,719	2.32
Juneau	90,360	233,864	0.39
Wrangell	26,860	8,980	2.99
Unalaska	33,800	66,110	0.51

Seward	27,600	9,200	3.00
Petersburg	27,070	9,023	3.00
Yakutat	13,875	4,625	3.00
Anchorage	767,978	724,682	1.06
Fairbanks	309,546	156,740	1.97
Tok	13,700	114,900	0.12
NCA-AR	78,484	656,580	0.12
Bethel	93,500	38,714	2.42
Galena	14,000	4,667	3.00
Sitka	78,388	26,071	3.00
Kodiak	119,548	29,666	4.03
Ketchikan	74,474	84,046	0.89

The contention that the State's grant-in-aid mechanism discourages funding of new programs is reflected in the following tables.

<u>Fiscal year</u>	<u>Number of Programs/ Number of Communities</u>	<u>Total State-administered dollars</u>
1974	18/14	1,762,100
1975	20/18	1,958,300
1976	18/17	2,170,000
1977	17/16	2,056,700

<u>Program</u>	<u>FY 74</u>	<u>FY 75</u>	<u>FY 76</u>	<u>FY 77</u>
University of Alaska	X	X	--	--
City/Borough of Juneau	X	X	X	X
Rural Alaska Community Action Program	X	--	--	--
Yukutat	X	X	X	X
Petersburg	X	X	X	X
GAAB/Municipality of Anchorage Health Department	X	X	X	X
Seward	X	X	X	X
Bethel	X	X	X	X

Kodiak	X	X	X	X
Sitka	X	X	X	X
Nome	X	X	X	X
Kotzebue	X	X	X	X
Fairbanks	X	X	X	X
National Council on Alcoholism Alaska Region	X	X	X	X
Upper Tanana Regional Council on Alcoholism (Tok)	--	X	X	X
Unalaska	--	X	X	X
Wrangell	X	X	X	X
Gastineau Council/ Gastineau Manor	--	X	X	X
Alaska Native Commission on Alcohol and Drug Abuse	--	X	--	--
Dillingham	--	X	X	X
Fort Yukon	--	X	--	--
Calena	--	X	X	--

X = Funded

-- = Not Funded

D. Other Problems

1. Manpower and Staff development

Program evaluations conducted by the State Office of Alcoholism during FY 76 consistently identify the need for improvements in the level of alcoholism programs staff training and expertise. Staff training has also been consistently cited as a high priority need by the program staff themselves. The University of Alaska Center for Alcohol and addictions studies does not have resources sufficient to allow it to address the alcohol-related training needs in the State.

2. Administrative and Fiscal Management of Programs

State Office of Alcoholism program evaluations and DHSS fiscal audits

identify significant problems in the administration and financial management of local alcoholism treatment programs. These problems (e.g., improper billing, over and under-expenditure of line item budgets, inadequate bookkeeping and accounting systems, improper intermingling of funds) have resulted in numerous audit exceptions and program instability resulting from past due accounts, delayed billings and late payroll payments.

3. Public attitude and awareness

Little or no public survey data is available which measures community attitudes toward alcoholism or alcoholism treatment programs. However, there appears to be a variety of public concerns and misconceptions which impact on the funding and effectiveness of alcoholism treatment programs.

These concerns and misconceptions center around the following issues:

- a. The acceptance of alcoholism as a treatable illness.
- b. The success of alcoholism treatment programs in reducing the number of visible alcoholics.
- c. The fundamental nature, limitations and capabilities of treatment programs for the alcoholic.
- d. The distinction between the alcoholic and the alcohol abuser and the treatment modalities appropriate to each.

11. Basic treatment and rehabilitation components

The following definition of treatment is quoted from the Uniform Alcoholism and Intoxication Treatment Act (AS 47.37.270 (12)):

"Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological and social service care, vocational rehabilitation and career counseling.

Emergency, inpatient, intermediate and outpatient care may be further elaborated according to the Joint Commission on Accreditation of Hospitals' suggested Standards for Alcoholism Programs, as follows:

- A. Emergency care: Shall provide for twenty-four hour availability of the following services to all persons and their families with problems related to alcohol use and abuse: (1) immediate medical evaluation and care; (2) supervision of persons by properly trained staff until they are no longer incapacitated by the effects of alcohol; (3) evaluation of medical, psychological, and social needs, leading to the development of a plan for continuing care; and (4) effective transportation services.
- B. Inpatient care: Shall provide twenty-four hour supervised care under the direction of a physician in a hospital or other suitably equipped medical setting designed for the diagnosis and/or treatment of medical and/or psychiatric illnesses derived from or associated with alcohol abuse and/or alcoholism.
- C. Intermediate care: Shall be designed to facilitate the rehabilitation of the alcoholic person by placing him in an organized therapeutic environment in which he may receive diagnostic services, counseling, vocational rehabilitation and/or work therapy while benefiting from the support which a full or partial residential setting can provide.
- D. Outpatient care: Shall be designed to provide a variety of diagnostic and primary alcoholism services on both a scheduled basis and nonscheduled basis in a nonresidential setting to alcoholic persons and their families whose physical and emotional status allows them to function in their usual environment.

Additional treatment components may be designated as outreach, information and referral, drop-in, sleep-off, crisis center, halfway house or quarter way house.

The following services (or facilities) represent a comprehensive continuum of care for the alcoholic, according to the structure provided

Above (A-D).

A. Emergency Care

1. Emergency Medical Services

The State currently provides for emergency medical services through the federally funded EMS program.

These services are typically provided on an as-needed basis by local community hospitals. It is important to note that most alcoholism programs do not have contracts or working arrangements with these hospitals to provide services necessary for their client population. The level and extent of emergency medical services for either the alcoholic or non-alcoholic, intoxicated individual appear to be inadequate.

2. Sleep-Off Center

Sleep-off centers should provide for the immediate care and custody of those individuals who are intoxicated and/or incapacitated by alcohol. These units should address themselves to acute problems that would require clients to stay no longer than 72 hours and should also provide triage, crisis intervention, case planning and disposition, motivation counseling and referral--particularly as a primary stage in the court commitment process. The staffing of such units would be provided by personnel trained in the acute care of alcohol (and/or alcohol/drug) problems. Sleep-off centers should not be confused with medical or non-medical detoxification services (see B below).

At present, comparable centers exist only in Juneau, Anchorage, Fairbanks, and Kodiak.

B. Inpatient care

1. Medical detoxification describes the hospital procedures applied in the treatment of alcoholic or intoxicated person required for the withdrawal from the physio-chemical presence and effects of alcohol in the system. The process of detoxification requires an average of from three to five days treatment. This treatment may require the administration

of sedatives, tranquilizing drugs, anti-convulsive medications, and therapeutic vitamin prescriptions.

There are at present no hospital-based or medical detoxification programs in the State. For the most part detoxification is offered by hospitals only for patients suffering from delirium tremens or purely medical problems incidental to addiction or intoxication. The State Office does provide funding for a number of programs which have been notably unsuccessful in obtaining third-party payments, client fees or other reimbursement for services. They have also been plagued by a variety of problems and dangers associated with the inability to provide medical coverage for clients needing such services. In addition, these non-medical detoxification programs have unfortunately had considerable difficulty in maintaining distinct client populations and distinct treatment components.

C. Intermediate Care

1. Thirty-day residential rehabilitation and treatment services.

This short-term, intensive treatment program is designed to provide education about alcohol and alcoholism and group and individual counseling or therapy within a highly structured and supportive environment. This type of service is designed to provide maximum exposure to the principles and practices required for the maintenance of sobriety.

The following chart lists those programs presently providing short-term residential treatment services.

<u>Program location</u>	<u>Number of available beds</u>
Fairbanks	29
Anchorage	30
Sitka	7 (Mt. Edgecumbe IHS Hospital program)
Ketchikan	12
Kodiak	6
	<u>84</u> Beds

2. Halfway house services

A halfway house unit is a community-based intermediate residential

care facility. It provides room and board, informal counseling, and referral services to the recovering alcoholic in a sober environment. The average length of stay should be 90 days for halfway house clients. Since the major goal is the successful transition to fully independent community living, clients are encouraged and assisted to obtain employment and to arrange for medical, vocational, counseling, and other services as provided in the community (rather than in the halfway house unit itself.) It is expected that the halfway house will not attempt to duplicate the efforts of inpatient rehabilitation or outpatient counseling services.

The list of existing halfway house programs is as follows:

<u>Program Location</u>	<u>Number of available beds</u>
Anchorage	
Studio Club	15
Phoenix House	17
Fairbanks	8
Juneau	15
Ketchikan	7
Kodiak	10
Sitka	10
Total	<u>82 Beds</u>

D. Outpatient care

1. Outpatient services

Outpatient services typically include client evaluation and referral, individual and group counseling or therapy, after-care, family counseling, crisis intervention, consultation, and court-related programs such as Driver Alcohol Information Schools.

Most of the programs funded by the State Office, and the majority of its funding, is devoted to programs offering a combination of outpatient, information and referral, and education services. Reliance on State grants

has been and continues to be even more typical of these programs than of those already mentioned. This relates to a number of factors, including the current limitation of Blue Cross and other medical insurance coverage and the problems associated with the State grant-in-aid mechanism as elaborated earlier.

2. Information and Referral services

Information and referral may be distinguished from outpatient services in that the former responds to requests for information about alcoholism, alcohol abuse, and alcoholism treatment services available in the community.

3. Education

Education activities have been a service traditionally offered by alcoholism treatment programs although such activities may be more appropriately considered to fall within the category of prevention or preventive education.

Alcoholism education efforts may be classified generally as one of three types:

1. Alcoholism education as part of the public school curriculum
2. Special lectures to interested groups within the community.
3. Communications media presentations.

E. Long-term Domiciliary Care

There are a variety of individuals requiring either long-term care or an indefinite period of care in a facility other than those already mentioned. These individuals include the older and/or severely debilitated, chronic alcoholic with serious organic and/or social impairment who has not responded favorably to other forms of treatment or care. Some of the individuals appropriate for placement in a long-term care facility are those with a very poor prognosis for recovery or for the ability to maintain themselves independently in the community and those who are chronic public inebriate

committed by the courts. This facility would also be appropriate for individuals with a better prognosis, but requiring a more extended length of stay (6-12 months) in a structured environment then is available in a rehabilitation program.

Applying the formula used in the "Allocation of Adult Alcoholics in Alaska", a 1973 study conducted by the State Office of Alcoholism, 9.2% of the state's adult population are alcoholics. Based on 1975 census figures of 404,000 total state population, we can estimate that there are 20,800 alcoholics in Alaska. According to accepted national standards, the chronic, "skid row", alcoholic constitutes 3-5% of the alcoholic population. It is primarily this group (approximately 1,000 persons) that would be appropriate for placement in a long-term care facility.

There is no long-term residential care facility for alcoholics currently operating in the State of Alaska.

Essential elements of such a program would include the following: work therapy (for example an institutional industrial program, production contracts, etc.); vocational rehabilitation including work evaluation, skill, training, vocational testing, and job placement; resocialization; referral to group or foster homes; physical therapy and rehabilitation; and affiliation with service and treatment resources in the community such as Vocational Rehabilitation, mental health, Alcoholics Anonymous, alcoholism treatment agencies, social services, etc.

Services emphasizing resocialization and physical and vocational rehabilitation are of primary importance for a client population whose occupational skills and general health and adjustment have deteriorated to a marginal level.

III. Recommendations

A. Based on the preceding elaboration of needs, problems, available treatment resources and the services necessary for the prevention and treatment of alcoholism and alcohol abuse, the following policy recommendations are offered.

* Amend the Uniform Alcoholism and Intoxication Treatment Act (AS 47.37.010-270)

for the purposes of: distinguishing more adequately between the alcoholic and intoxicated individual (alcohol abuser); establishing separate policies for the alcoholic and the alcohol abuser; defining the responsibility of the State Office of Alcoholism and the service providers with whom the office contracts with regard to the treatment of the alcoholic and the alcohol abuser; and simplifying the court procedure for involuntary commitment of alcoholics to inpatient treatment for 30 to 180 days after sleep-off.

(The present Uniform Act contains provisions which are far too costly, cumbersome and unwieldy with regard to involuntary commitment. Consequently, there have been considerable problems with implementation of this provision by the Courts.)

* Continue and complete the "Systems Analysis of Alcohol Problems" project in the Office of Alcoholism.

* Continue and augment the State Office of Alcoholism's program evaluation and data collection/analysis efforts.

* Amend the State Grant-in-aid Statute, AS 47.30.475-477, for the purposes of: establishing a progressively decreasing state/non-state funding ratio for grants, limited to a four year period from the date of program inception, establishing a reimbursement for services contract mechanism to provide funding for those alcoholism treatment services which fail to qualify for or have exhausted the grant alternative (such reimbursement should be provided for those services for which alternative funding or reimbursement is available); requiring that all match contributions be in the form of cash.

- * Recommend use of local sales taxes (either current possible or raised from a special tax) to provide increasing amounts of local support for programs.
- * Require that communities receiving revenue-sharing money from the Department of Community and Regional Affairs for "alcoholism program beds" match their SGF Office of Alcoholism Grant with an amount of cash equivalent to that revenue sharing support.
- * Allow an amount equivalent to 10% of the State's grant as "in-kind" match, for all years of State Grant-in-Aid financial support to local programs, to help offset local indirect cost expenses for local management of grants.
- * Alter existing Title XIX, Private Insurance and Vocational Rehabilitation regulations, to provide coverage for treatment of alcoholism.

B. The following Grant-in-Aid schedules are recommended:

- * Fund programs, already in existence, beginning in FY 78 at the following schedule:

FY 78	60% State; 40% Other (cash)
FY 79	40% State; 60% Other (cash)
FY 80	25% State; 75% Other (cash)
FY 81	State fee for service support only for those patients not covered by other resources.

- * Fund new programs at the following schedule:

Year 1	75% State; 25% Other
Year 2	60% State; 40% Other
Year 3	40% State; 60% Other
Year 4	25% State; 75 % Other
Year 4	State "fee for service" support only for those patients not covered by other resources

C. Emergency Care

1. Emergency Medical Services

The present Uniform Act requires that persons be afforded a continuum

of treatment beginning with Emergency Care. The required resources are not available to adequately provide that care. The Uniform Act also implies that severe medical emergencies induced by the abuse of alcohol will be treated by physicians in hospitals; yet physicians and hospitals are often reluctant to provide care for these persons.

* Amend state law that physicians and hospitals are required to meet their obligations to provide emergency care to those individuals with acute medical conditions.

* Recommend that alcoholism treatment agencies or community health authorities establish work agreements or contractual arrangements with public or private hospitals for the provision of emergency medical services.

2. Sleep-off Center Services

The public safety, health & welfare risks and costs associated with alcohol intoxication, alcohol abuse, and alcoholism in Alaska are so great that adequate measures must be taken to protect the community and the individual from those present and recurring behaviors which represent immediate and long-term threats.

* Amend the Uniform Act (AS 47.37) to allow sleep-off facilities to hold "intoxicated persons" and/or "incapacitated persons" for up to 72 hours involuntarily.

* Provide the funds to operate a statewide network of sleep-off facilities of the kind described.

* Require all sleep-off facilities to employ at least one person with Emergency Medical Training on each shift seven days a week.

* Require an initial medical examination within 24 hours.

* Require hospitals and physicians to admit intoxicated persons to hospitals if they also present other severe complicating medical problems.

* Require sleep-off facilities to conduct an evaluation for the purpose of disposition and referral of the patient prior to his release at the end of 72 hours.

* Sleep-off centers are recommended for the following communities:

Juneau	Wrangell	Cordova
Ketchikan	Petersburg	Kotzebue
Valdez	Seward	Barrow
Yakutat	Unalaska	Kenai

Sitka, Kodiak, Anchorage, Fairbanks, Bethel, and Nome have facilities suitable for a sleep-off service.

Capital expenditure estimates are based on the approximate purchase and installation price for new double-wide trailers for Ketchikan, Juneau and Valdez and for new single-wide trailers in the remaining locations.

The smaller units should be able to accommodate up to 10 beds and the larger units up to 15 beds. An estimate covering the cost of furnishing and equipping these units are included in the following figures:

Capital Expenditures = \$439,050 (estimated)

Operating expenses (per annum) = \$2,193,750 (estimated)

(includes total staffing of 117)

* Sleep-off centers might be recommended for Dillingham, Galena, Fort Yukon and Glennallen-Copper Center depending upon the results of a needs assessment and the availability of funds. Estimated capital expenditures for these four additional units would be \$119,275 and the estimated operating expenses would be \$675,000.

It can be anticipated, or conservatively assumed, that the probable levels of need, utilization, and/or required resources in most rural villages would not justify or allow for the establishment of sleep-off centers at this time. There probably would be, therefore, a number of communities with some level of need, which would have to depend upon the use of local jail or transportation to the nearest community with a sleep-off center.

* Encourage communities without jails or sleep-off centers to develop statistics which could be used by the State to assess the need for and the

probable utilization of a sleep-off facility.

Source of funding

* The proposed sleep-off programs should be funded in the following manner:

A. For Capital Expenditures: State General Fund

B. For Operating Expenses:

1. Poverty area communities: renewable yearly grant-in-aid, 90/10

State to local cash ratio.

2. Non-poverty area communities: progressively decreasing State/
local grant-in-aid for four years (75/25; 60/40; 40/60; 25/75)

and "fee for service" reimbursement starting at year five for
those clients not covered by other resources.

* The Division of Corrections should provide sleep-off capability through
existing rural jails where feasible and necessary.

* The Division of Corrections should keep records of the degree of association
between crimes of which their inmates were convicted and a history of alcohol
abuse and/or alcoholism.

* The Division of Corrections should provide treatment for alcoholism within
the Corrections system.

* The Division of Corrections should provide a counseling program for
alcohol abusers within the Corrections system.

* The Division of Corrections should ensure that appropriate after-care
and follow-up are provided for all alcoholic inmates upon their parole.

* Referral for after-care and follow-up should be made available to those
inmates who have completed their full sentence.

These recommendations are made in view of the following considerations:

An alcoholic is, by definition, a person physically and/or psychologically
addicted to ethyl alcohol. (A person who cannot control his drinking
behavior).

A person who is alcoholic and commits a serious crime because of his

alcoholism, will be a continuing recidivism risk.

An alcoholic offender will be less of a continuing recidivism risk if, while in custody, he received treatment for his alcoholism.

A paroled alcoholic offender must be afforded some protection from his addiction at least during the initial stages of his parole. This should continue until he has successfully re-integrated into society. Otherwise, the chances are great that he will relapse into his former active addictive condition.

Alcohol abuser offenders, upon parole, will most likely not need protective rehabilitative care but should be provided continuing outpatient counseling for a period of time.

2. Inpatient Care

A. Medical detoxification

There are a variety of potential medical problems such as cardiovascular arrest, convulsions, respiratory failure, diabetic coma, delirium tremens, or other severe withdrawal symptoms associated with the process of detoxification. Because these medical risks and the difficulties with attendant liability are greatest with the operation of a nonmedical service by para-professionals.

* The State should encourage establishment and participate in the funding of medical detoxification services whenever possible.

* Medical detoxification services should be located in a hospital or in a facility that has the capability of responsible medical management. A major advantage of medical (rather than nonmedical) detoxification, in addition to quality patient care, is the potential for reimbursement through Title XIX, social security, and private medical insurance.

3. Intermediate Care

A. Thirty day residential treatment services

There is evidence nationwide that many of the most viable and most effective rehabilitation programs (for example Chit-Chat, Valley Hope, Hazelden) are those that do not use government grants for funding but which

rely primarily on reimbursement for services given.

The size and stability of currently existing rehabilitation programs in the state are not adequate to meet the needs of this type of service. Patients who can pay and/or who have insurance coverage for this kind of care are typically transported "outside". It would be a functional and economic benefit to the State to have such a facility/program available within Alaska. It would afford existing smaller local programs with an inpatient resource within the State. It would also keep the money paid for treatment within the State.

It should be noted that the cost of care for approximately 70% of those clients participating in the Valley Hope and Chit-Chat treatment programs is provided by private health insurance payments and the cost of care for the remaining 30% is provided by other third-party payments (Veterans Administration, Medicaid, etc.) or absorbed by the program at no cost to the client (approximately 10% of all clients.)

* The State should provide funding for the establishment of a quality, short term residential, intensive treatment program which is directed primarily toward those rural and urban clients who are covered by public or private insurance or able to pay their own way.

* This facility should be centrally located but not directly adjacent to a large metropolitan area. There is ample evidence nationwide that far from being necessary to locate such a program in an urban area, it is a decided advantage to have this type of program situated at some distance from a major population center.

* This facility should not exceed 70 beds and should have an average patient stay of 30 days.

* This program should be available to residents from throughout Alaska and serve both urban and rural populations.

* This program should also serve as a practicum training center for alcoholism and other professionals.

The Valley Hope and Chit-Chat alcoholism treatment programs, which are located in relatively remote rural areas, report that they have experienced no problems relating to referral or physical accessibility because of their location. To the contrary this location provides an attraction for those clients wishing to minimize the visibility of their being in treatment. Moreover, such location decreases the temptation and potential for leaving the program prior to the completion of treatment. It has also been the experience of Valley Hope, Chit-Chat and other comparable programs, that the independence from local government control considered to be essential for maintaining program integrity can be assured only by being located outside the boundaries of a large municipality.

The set of needs and conditions that a program of this size is designed to meet and the therapeutic modalities which are necessary for meeting these needs determines that;

* 30 day residential treatment services should be provided exclusively for the alcoholic and for the cross-addicted individual. The necessary goals and therapeutic functions required for the treatment of drug addicts drug abusers, the mentally ill and the emotionally disturbed who may require inpatient treatment are not the same as those required for the treatment of alcoholism.

Those 30-day treatment programs (Valley Hope, Chit-Chat, etc.) which have attempted to include drug addicts who have experienced a significant lack of success in working effectively with these clients. They report that the subcultural background, the life style, and the greater incidence of sociopathic pathology were not at all amenable to the kind of treatment they were able to provide. In addition, the drug addicted client was consistently found to disrupt the rest of the client community.

Residential treatment programs for drug addicts and abusers (Day Top Village; Freedom House, Inc.; Synanon; etc.) support this contention that distinct residential programs are required for the drug addict.

It would be inappropriate to include the mentally ill or the emotionally disturbed for the following reasons: 1) The average length of stay in an inpatient facility for psychiatric patients (e.g., at Alaska Psychiatric Institute) is at least fifty days, as opposed to thirty days. 2) The administration of psychoactive drugs (tranquilizers, anti-depressants, amphetamines, barbituates, etc.) is the most prevalent therapy of choice or therapeutic adjunct used by inpatient psychiatric programs. Chemotherapy, and the principles underlying its application, are antithetical to and/or incompatible with the drug-free environment of alcoholism treatment programs. 3) Most psychiatric patients requiring hospitalization suffer from acute (and often chronic) and severe mental and emotional disorders (e.g., paranoid schizophrenia, manic-depressive psychosis, and other diagnoses associated with symptoms of gross disorientation and dysfunction, e.g., hallucinations, delusions, and thought disorder). Most alcoholics, however, are well-oriented and psychologically unimpaired beyond the context of their addiction. 4) Successful thirty-day alcoholism treatment programs rely heavily on a variety of treatment modalities such as educational lectures on the nature of alcohol and alcoholism, the principles of recovery, and an orientation to the principles and methods of Alcoholics Anonymous. These modalities are inappropriate and irrelevant for the treatment of psychiatric disorders. Moreover, the traditional approach of in-depth psychotherapy views behavior as a symptom of underlying intrapsychic phenomena. This approach is greatly in contrast to the prevailing and accepted view that for the alcoholic, psychological (intrapsychic phenomena) and behavioral dysfunctions are symptoms of the underlying addiction.

* State support for this particular program should be provided on the following basis:

FY 78 75% State; 25% Other

FY 79 50% State; 50% Other

FY 80 25% State; 75% Other

FY 81 0% State; 100% Other

The annual operating expense for this 30-day treatment program is estimated at \$894,250. This figure is based on a \$35/day cost at full occupancy (70 beds) and includes rental expenses estimated at approximately \$7,000/month.

If new construction were required, the Department of Health and Social Services estimates the costs at approximately \$100,000/bed for a nursing-home type facility located in areas adjacent to the greater Anchorage vicinity. Additional cost estimates will be made, however, in an attempt to discover a less costly alternative.

The construction cost based on this figure for a 70-bed facility would amount to \$7,000,000. Purchase of an existing facility of adequate size and design might well reduce the necessary capital investment by one-half.

Halfway House Services - It is possible to determine, on the basis of available data, which communities need to establish halfway house facilities.

* The projected number of clients and the availability of resources should be evaluated in order to determine the locus and extent of State financial support required to provide appropriate numbers and types of halfway house services.

Outpatient Care:

A. Outpatient Services - The Division of Mental Health's July 1975,

Mental Health Service "Provider Survey" study reports that alcoholism (in terms of "additional services needed" and "most pressing problem") accounts for 62.3% of all areas of programmatic concern.

Because of the predominance of alcoholism problems in rural communities, because of the limitation on available resources in rural communities, and because of the importance of skilled help for the alcoholic:

* It is recommended that the primary direction and identity of the Community Mental Health outpatient program be that of an alcoholism treatment service.

* Rural alcoholism, drug abuse, and Mental Health professionals and para-professionals should be cross-trained in all three areas.

There is insufficient information at this time upon which to determine the justification for combined versus separate outpatient units for each program area (alcoholism, drug abuse, and mental health) in larger (nonrural) communities. There are a number of considerations, however, in favor of combining these program areas or collocating the separate services wherever appropriate and feasible. For example, the inclusion of alcoholism, drug abuse, and mental health professionals within a single physical setting should facilitate and improve effective screening, case assignment and client referral. Continuing education across disciplinary lines and the availability of specialized consultation should also result from this arrangement.

* It is our recommendation that rural alcohol, drug abuse and mental health outpatient services maintain their separate identities and budgets but that they collocate in order to facilitate cooperation in patient care and facilitate cross-training for personnel in all three areas.

Information and referral services

* The major responsibility for the local dissemination of information about alcoholism and alcoholism services should be in the hands of volunteer organizations (i.e. Local NCA affiliates).

- * The State should function as a clearing-house for research, treatment, and training information pertinent to alcoholism.
- * Existing local community alcoholism programs should provide information and referral services on an ongoing basis as part of their normal activities.
- * Existing local community alcoholism programs should be required to develop formal referral networks with all health, social services, judicial and law enforcement agencies in their local catchment area.

Long Term Care

- * The State should fund, and initially operate, a long-term domiciliary care and rehabilitation facility for the chronic public inebriate.
- * The primary client population for this program should be the court committed chronic public inebriate and/or those addicted individuals in need of long-term in-residence care who chose to commit themselves voluntarily for a period of 90 days or longer.
- * The State should initiate and operate this facility for a period of at least five years.

RATIONALE:

The major purpose of this program would be to care for those who are presently a public burden. State operation would ensure quality control and close supervision of the organization of the facility and the program and personnel necessary to implement this recommendation.

1. Trained management personnel will have to be recruited.
2. Other personnel will have to be trained.
3. Close cooperation will have to be maintained with the Alaska

Court System. A state operated facility could more easily accommodate court referrals.

- * The program should have the capacity to care for at least 70 persons initially.

* A decision should be made at the end of five years of operation as to whether the program should be contracted to the private sector.

RATIONALE:

This decision should be based upon projections, information and statistical data relating to such considerations as the following:

1. The availability of third-party reimbursements for cost of care for a program of this sort.
2. The direct and indirect costs likely to be incurred by various state agencies (e.g., Vocational Rehabilitation, Public Safety, Corrections, Judicial System) in using the services of this facility.
3. The willingness and capability of a community agency to effectively operate such a facility and to provide the required administrative and fiscal management.

* It is recommended that this long-term facility be operated exclusively for the alcoholic.

RATIONALE:

There are different and distinct medical needs of the chronically mentally ill (chemotherapy, psychotherapy, etc.), and the State currently operates a facility capable of meeting these needs. The population of drug addicts requiring or suitable for this kind of care is minimal.

* It is recommended that this facility be located in close proximity to a major metropolitan area.

RATIONALE:

This facility would serve as a statewide resource and might require the services of various community vocational, health, and social service agencies available only in the larger population centers.

The annual operating expense for this 90 day treatment program is estimated at \$894,250. This figure is based on a \$35/day cost at full occupancy (70 beds) and includes rental expenses estimated at approximately

\$7,000/month.

The Department of Health and Social Services estimates construction costs at approximately \$100,000/bed for a nursing home facility located in areas adjacent to the greater Anchorage vicinity.

The construction cost based on this figure for a 70-bed facility would amount to \$7,000,000. Purchase of an existing facility of adequate size and design might well reduce the necessary capital investment by one-half. Additional cost projections will be made in order to determine the least expensive alternative.

REVENUE PROJECTIONS FOR LOCAL COMMUNITY ALCOHOLISM PROGRAM

With the implementation of annually decreasing state grant support to local alcoholism programs, local programs will be required to provide an increasing percentage of total project costs. Traditionally, project income when available has been used to reduce the total project costs to a net project cost upon which the required local match is determined. Funds used to meet the required match have been federal grant funds, local government contributions, and community donations. Matching requirements have allowed for either hard cash or in-kind contributions.

A. Project Income: Project income is basically divided into client fees for services and third party reimbursement for services provided to eligible clients. The most generally available sources for third party reimbursement are Veterans Administration (VA), Bureau of Indian Affairs (BIA), Vocational Rehabilitation (V-R), Blue Cross/Blue Shield (BC/S), and Medicaid (Title XIX). However, the amount of income available from these sources is represented in general by an inverse relationship to program size and services offered. Therefore, generally only those programs sufficiently large to provide a comprehensive range of services recoup third party payments. Such payments are not available to those programs offering only sleep-off information, referral, educational, and preventive services. Outpatient counseling, intermediate

care (halfway house and short term rehabilitation), and long-term care generate this type of income. It is established that reimbursement for outpatient and long-term care is more limited (restrictive) than for intermediate care.

The charts below reflect the total amount of project income payments received by state-funded alcoholism programs in FY 76, amount by program projected for FY 77, and the projected FY 78 income based upon a minimal 10% increase.

<u>Income Source</u>	<u>FY 76</u>	<u>FY 77</u>	<u>FY 78 (10% Inc.)</u>
Client Fees	\$83,000	\$ 65,000	\$ 71,500
Third Party	83,000	223,500	245,850
Miscellaneous	19,000	23,000	25,300

Based on the second quarter information available from the VA, we can estimate that a substantial dollar investment is already being made in third party payment to various Alaska alcoholism treatment providers. The VA indicates a total of \$358,673 was spent on alcoholism treatment services in Alaska during the second quarter of FY 76. The VA estimates that 50 to 60% of these payments have gone for medical care, including doctors' visits and hospitalization for alcoholics. The current VA policy is to pay for 30-day alcohol rehabilitation services.

The Blue Cross of Washington and Alaska only reimburses for treatment in a state approved treatment facility or hospital. Since state licensure will be a reality in FY 78, we can anticipate that a portion of the money now going to hospitals will be used for treatment in State licensed alcoholism facilities. Blue Cross was unable to provide cost estimates for the amount of reimbursements made to hospitals for physicians for alcoholism treatment in Alaska. The State Division of Vocational Rehabilitation was unable to provide us with cost estimates for expenditures made in alcoholism treatment services.

B. Local Matching Funds: Local matching funds are generally comprised of federal grants, local government contributions, and contributions from the community itself. The following chart compares FY 76 and FY 77 contributions and projects a minimal 10% increase for FY 78.

<u>Funding Source</u>	<u>FY 76</u>	<u>FY 77</u>	<u>FY 78</u>
Federal Grants	\$ 483,190	\$ 607,821	\$ 668,603
Local Govt.	502,076	693,522	762,874
Community	10,000	122,753*	135,028
Sub-Total	995,266	1,424,096	1,566,505
In-Kind	383,244	252,410	277,651
Total	1,378,490	1,676,506	1,844,156

* Includes \$111,150 contributed by Salvation Army which was not contributed last year.

The availability of federal grants, local community donations and in-kind contributions to local community alcoholism programs might be expected to increase in the amount of funding available to local programs in many communities would be substantially greater if local community governments would utilize more substantial portions of the local retail alcohol beverage sales tax revenues to defray costs of their local alcoholism programs.

The following chart shows the estimated amount of locally taxed retail sales in 1975:

VOLUME/SALES (1975)*			
	Consumption No. of Gals.	Wholesale Sales (Millions)	Retail Sales (Million) (EST.)
Liquor	1,236,976	27.5	66.7
Wine	801,665	5.9	14.9
Beer	<u>8,451,841</u>	<u>24.4</u>	<u>59.2</u>
	10,490,482 Gals	\$57.8	\$140.8

*(from: "Economic Benefits of Sale and Consumption of Beverage Alcohol"-
SAAP Report, 1976)

No study has yet been able to determine the actual amount of retail beverage sales tax revenues realized by local communities for 1975. The following chart displays possible amounts based upon the assumption that local communities collectively may be taxing up to the local limit of 3%

	1975 Gallons Volume	Est. 1975 Retail Sales (Millions)	Local Sales Tax Revenues (Projected in Millions)		
			1%	2%	3%
Liquor	1,256,976	\$66.7	0.670	1.330	2.001
Wine	801,665	\$14.9	0.149	0.298	0.447
Beer	<u>8,451,841</u>	<u>\$59.2</u>	<u>0.592</u>	<u>1.184</u>	<u>1.776</u>
Total	10,490,482	\$140.8	\$1.411	\$2.812	\$4.224

In other words, local communities collected somewhere between \$1.4 million and \$4.224 million from local retail sales taxes on beverage alcohol in 1975. Local community General Fund cash contribution to alcoholism program grants for FY 76 by contrast was \$366,186.

Based on distribution increases during 1974-75/1975-76 for Liquor (21%), Wine (32.7%), and Beer (22%) projected revenues for 1976 from sales taxes, if adjusted, become:

	%Inc	Est. 1976 Gallons Volume	Est 1976 Retail Sales (Millions)	Sales Tax Revenues (Projected in Millions)		
				01%	02%	23%
Liquor	(21%)	1,496,741	\$81.07	0.8107	1.609	2.420
Wine	(32.7%)	1,063,809	19.8	0.198	0.395	0.593
Beer	(22%)	<u>10,311,246</u>	<u>72.2</u>	<u>0.722</u>	<u>1.444</u>	<u>2.167</u>
		12,871,796	\$173.07	\$1.7307	\$3.448	\$5.180

In 1976 therefore, local communities will collect somewhere between \$1.730 million and \$5.18 million in local retail sales taxes on beverage alcohol. Total local General fund cash contribution to local alcoholism programs for FY 77 is \$501,484.

We therefore recommend that the deficits created by our proposed decreasing schedule of SGF grant support be made up locally in the following ways:

* An attempt should be made to alter the 3% sales tax limitations so that local communities could tax beverage alcohol at a higher rate.

If local communities had been able to tax retail sales at 4% or 5% during FY 75 or FY 76, the total revenue locally available would have been:

<u>1975</u>		<u>1976</u>	
4%	5%	4%	5%
\$2.668	\$3.335	\$3.230	\$4.04
0.560	0.745	0.743	0.99
<u>2.368</u>	<u>2.960</u>	<u>2.888</u>	<u>3.61</u>
\$5.596	\$7.04	\$6.861	\$8.64

* In the meantime, local communities should be encouraged to tax retail alcohol sales at the 3% level allowed by law.

* In either case, local communities should be expected to utilize a portion of their local general fund revenue realized from local retail sales on beverage alcohol to maintain their alcoholism programs during and after state support declines at the rates proposed earlier in this paper.

E. Troubled Employees Program

* The State of Alaska should immediately design and implement a Troubled Employees Program for state employees. This program would assist in the early identification, evaluation, referral, and treatment of state employees experiencing social, health, and behavioral problems. The program should concern itself solely with problems in the employee's work performance. The program should be designed to reduce turnover of personnel, maintain productivity, and reduce the use of sick time.

Similar state programs have been demonstrated to be of major importance in terms of employee retention, morale, and productivity and have been proven to result in a net cost savings in those organizations in which they have been

implemented.

Data from existing troubled employee programs indicate that over 50% of all clients referred into the programs have alcohol or alcohol-related problems. The National Institute of Alcohol Abuse and Alcoholism estimates that 95% of the individuals who are alcoholic or who have alcohol-related problems are family centered and employed. Until recently most of the help and attention in the area of alcohol abuse has been given to those visible alcoholics who are unemployed and have chronic drinking problems. The national trend is now shifting toward prevention and early identification for the employed and family centered population.

Since it is within the job function of the personnel department to concern itself with the development of policies and procedures, administration of fringe benefits, employee relations programs, and the maintenance of personnel records.

* The Division of Personnel should develop and administer the troubled employees program.

Since the emphasis of a troubled employees program is in the recognition, prevention, and treatment of alcohol and other social and health problems, it would be unrealistic to limit a troubled employees program solely to the area of alcohol abuse. It should also be emphasized that this program is not designed to "keep alcoholic individuals on the job". It is a program to assist employees with problems that cause job impairment and loss of efficiency in job performance. Unfavorable changes in work habits or behavior should be the indicator to the supervisor that the employee has problems that warrant attention.

It is essential when discussing the development and implementation of a troubled employees program that there be a clear understanding of the provisions of the group health insurance policy within the agency or agencies considering a program.

* The State should provide insurance coverage that ensures that treatment of alcoholism and other social health problems receive the same coverage provided any other illness.

* The treatment services covered by insurance should be all-inclusive, so that treatment can be provided on an outpatient as well as inpatient basis.

The following elements are basic to any sound troubled employee program:

1. Constructive Confrontation

The key to any successful troubled employee program is the supervisor's confrontation with his employee regarding unsatisfactory job performance. Evidence of the sub-standard job performance should be substantiated and serve as the sole criteria of an employee's referral to the program. The confrontation should be structured by the supervisor to be constructive rather than punitive. The supervisor should make known to the employee experiencing difficulties that a program of specialized referral for treatment is available.

If the supervisor's confrontation corrects the employee's deficient work performance, no further action is needed. But if the confrontation fails to restore performance to its previous level, the supervisor may feel that it is time for the intervention of a professional Employee Assistance Counselor.

The troubled employees program is not a "witch hunt" to identify alcoholics nor is it designed to make detectives or diagnosticians out of supervisors. The program relies on the supervisor's managerial skills and his ability to confront his subordinates with evidence of poor job performance. The supervisor should not be expected to investigate or analyze the cause of the impaired performance. This is the responsibility of the Employee Assistance Counselor and the community treatment resources. Although an inherent advantage of this program is its ability to structure and direct the employee's referral for treatment, it should be emphasized that a troubled employees program in

no way prevents the employee from going directly to the treatment resource of his choice.

2. Employee Assistance Counselor

The Employee Assistance Counselor is the professional individual who is responsible for counseling the troubled employee. He receives the referral from the employee's supervisor, counsels the employee, and may refer that employee into an existing treatment resource within the community. He should serve as the coordinator between employee, supervisor, and treatment resource. He must be familiar with the community treatment resources in order to make knowledgeable referrals. The Employee Assistance Counselor monitors the employee's progress during his treatment and maintains contact with the supervisor regarding the employee's job performance. If ongoing treatment is necessary, he is responsible for making appropriate arrangements with the employee's supervisor. He is also responsible for follow-up and coordination of inter-agency referrals.

It is essential that the Employee Assistance Counselor be adequately trained in the human relations field. In selecting this individual, consideration should be given to the following elements:

- A. Academic background - basic course work in the social sciences.
- B. Area of experience - social work pastoral counseling, counseling psychology, personnel counseling, and experience in a public or

private occupational program.

- C. Ability to relate to others and to conduct oneself in a professional manner, be objective, non-judgemental, maintain professional distance, and be experienced in the area of evaluation of behavioral problems including alcoholism.

The Employee Assistance Counselor should have the ability to conduct short-term counseling with employees and understand current treatment techniques and modalities. Confidentiality must be guaranteed to the troubled employee. He must view the counselor as an empathetic person and have confidence in his ability.

3. Community Resources

Each community will have some, if not all, of the social and health services needed to implement a troubled employee program. One of the initial steps in program development is the coordination of these services to serve as referral sources. Utilization of existing community resources eliminates the need for adding treatment personnel to the staff.

4. Policy Statement

Any bureau or agency, whether at the state or municipal level, should have a policy statement explaining their troubled employee program. The policy

statement is the nucleus and the framework of the program. It establishes the guidelines from which the program operates.

The following concepts and ideas present some general principles to be considered when an agency is developing a policy statement:

--That alcoholism and other social, health-related problems affect employee work performance.

--that these conditions are treatable and that there is help available for the troubled employee.

--that the agency's concern is limited strictly to an employee's job performance and that there is no intent to intrude upon the employee's private life.

--that the agency will not penalize any employee for seeking help for social health problems which are affecting his job performance and that he will receive the same consideration given an employee with any other illness.

--that management is responsible to initiate and implement the policy. Management has the responsibility to protect the confidentiality, job security, and promotional opportunities of the employee.

--that management is not responsible for diagnosis, but is responsible for making appropriate referral of an employee with deteriorating job performance.

--that the responsibility of the employee is to comply with the referral and make necessary corrections in his job performance and his behavior. Failure to do so may result in appropriate corrective or administrative disciplinary action, including dismissal.

--that alcoholism and other social health problems should receive the same insurance coverage provided for other illnesses.

--that the agency encourages an enlightened attitude and realistic acceptance of alcoholism and other social/health problems to motivate the employee to voluntarily seek help.

A State Troubled Employees Program would require the hiring of a counselor and secretarial position in the regional personnel offices in Fairbanks, Juneau and Anchorage. If the counselor were hired at range 20 and the secretarial position was a Clerk Typist II, the costs including \$10,000 travel for each counselor would total \$170,884 per annum. A \$10,000 travel budget for each regional counselor would allow for travel to outlying areas in their respective region to conduct supervisory training sessions and to consult with clients.

The possibility exists that an additional expense might be charged by Blue Cross for increased insurance coverage. This cost in other states has been minimal and

would depend upon the amount of coverage, length of stay, and re-admission stipulations. The present alcoholism treatment group coverage insurance plan for employees in the State of Washington costs 35¢ per month per family group and 15¢ per month for an individual. Blue Cross reimburses 80% of total cost to a maximum of \$1,000 for residential alcoholism treatment. This is the total amount of treatment allowable for one calendar year. The relatively low cost of residential alcoholism treatment cost in Washington results from the use of alcoholism treatment facilities rather than hospitals for the majority of alcoholism treatment. The State of Washington also has a law that requires all group health insurance plans to include alcoholism treatment.

* The State should provide funds through the Office of Alcoholism for the establishment and operation of a statewide in-service training program on alcoholism and its treatment and prevention.

RATIONALE:

An in-service training program on alcohol abuse and alcoholism should be established for all judges, prosecutors, law enforcement officers, social workers, physicians, nurses, related health professionals, teachers, psychologists, counselors, and other human services personnel currently practising in the State of Alaska. This training program should focus on: the psychology, physiology, sociology, and pharmacology of alcoholism and alcohol abuse; the manner in which alcohol abuse and alcoholism impact upon the law enforcement, judicial, health, mental health, social services, and corrections,

systems in Alaska; appropriate intervention, treatment, support and rehabilitation roles that can be assumed by persons currently employed in these fields.

* A program of higher education, leading to degrees in and/or a major emphasis on alcohol abuse and alcoholism, should be established through the Office of Alcoholism in negotiation with the University of Alaska Center for Alcohol and addiction studies. This program should be funded by the State.

The thrust of this program would be to provide students with incentives to enter the field of alcoholism rehabilitation/treatment upon graduation, and to provide them with legitimate academic credentials for future certification as professionals in the area of addictions.

Counselor Training and Counselor Certification

* The Offices of Alcoholism and Drug Abuse working with the University of Alaska Center for Alcohol and Addictions Studies, should develop an "Alcohol and Drug Dependency Counselor Competence and Assessment Program."

Because of the unique problems posed by Alaska's geography of scattered, remote and small native villages and since there are but a few population centers spread hundreds of miles apart, counselor training and counselor certification procedures and standards are most difficult to establish.

The problem is two fold: (1) what standards should apply to counselors serving in various capacities throughout the state? and (2) how is training to be accomplished?

The counselor training and certification plan would be as follows: It is the responsibility of the State Office of Alcoholism along with the Office of Drug

Abuse to establish and operate through the University of Alaska and its community colleges the degree training program which provides the range of skills, knowledge, and attitudes demanded of the various people providing all levels of alcoholism and drug abuse services in the greatly divergent areas of the State. As an integral part of this degree program, the Office of Alcoholism and the Office of Drug Abuse working through the University of Alaska will develop an "Alcohol and Drug Dependency Counselor Competence Assessment Program" which provides state recognition of (1) individuals trained in and demonstrating competency in counseling alcohol and drug dependent persons and also (2) other individuals without prior formalized training but demonstrating "entry-level competency" in counseling alcohol and drug-dependent persons. Such a combination training program and counselor competency assessment program would be designed similar to the plan developed and implemented by the Minnesota Department of Public Welfare and State Merit System through Metropolitan State University.¹ Standards for training and for counselor certification would be agreed upon by a consortium of alcoholism and drug abuse professionals and certain other health care and social service providers working in various parts of Alaska and in consultation with certain professionals who have developed training and certification programs in other states with bicultural constituencies. Such standards would include an inventory or list of about ten major areas of competency (knowledge, skills, attitudes) that graduates of the training program should possess in order to function adequately in entry-level positions in the field. These professional

1. Metropolitan State University Chemical Dependency Competence Assessment Program, Minnesota Department of Welfare, December 1975.

entry-level competencies having been identified, the Counselor Competency Assessment Program would provide a mechanism whereby persons who had attained the same professional competencies through a variety of work and life experiences could be appropriately assessed, granted university recognition, and thereby be qualified under State certification standards. The ten major areas of competency would focus around the following:

1. Knows the interrelated physical, psychological, social, and spiritual dynamics of addiction-alcoholism and drug dependency as they relate to individual clients and the family social structure, and general approaches to the tasks of prevention and treatment.
2. Knows the "continuum of care" concept as a prevention and treatment strategy for addressing the problems of addiction and substance abuse in the community and in the overall State system, including specific treatment modalities, and is committed to using and expanding his knowledge.
3. Knows and can apply the basic principles and techniques of intervention, assessment (diagnostic) interviewing, and referral within the "continuum of care".
4. Knows the legal, ethical, and confidentiality considerations involved in the treatment of alcohol-(and drug) dependent clients and the processes relating to same.

5. Knows and can apply the principles and techniques of individual and group counseling within the alcoholism (and drug-dependency) treatment program.
6. Knows and can apply the principles and techniques of family (significant other) counseling.
7. Knows and can apply interpersonal communication principles and techniques in relation to bicultural (Eskimo, Indian, and Aleut) populations.
8. Knows and can apply written communication principles and skills in relation to developing client treatment plans, progress notes, and discharge summaries.
9. Knows and can apply oral communication principles and skills in relation to clients and other human service professionals.
10. Knows one's personal attitudes in relation to the alcoholism and drug-dependency treatment system and the clients it serves; knows how to develop effective attitudes and approaches and is committed to being an effective worker.²

Each of the ten major areas of competency would include a breakdown of those specific skills, knowledge, and attitudes (at least five in each area) required in order to demonstrate competency in that major area.

2. Minnesota Department of Welfare, "Chemical Dependency Specialist Competencies," December 18, 1975. Provided by Art Deegan, Ph.D., Management by Objectives, an approach to hospital management.

The assessment mechanism would follow the following procedure: The counselor candidate seeking recognition for life-work experiences and demonstrated competencies is asked to take the list of the ten major competency areas and for each area describe the significant life experiences (including work, volunteer activities, independent reading, workshops, papers, etc.) in which the candidate has engaged that have provided the opportunity for the candidate to obtain the competency. Then for each competency the candidate is to propose two persons (approved by the University training program) to evaluate the candidate in relation to the competency. The candidate is also asked to propose assessment procedures (measurement techniques) to be used by the evaluators. Such procedures may include any of the following: observation of the candidate in the work setting, simulation or role-playing exercises, oral examinations or interviews, reviews of reports by the candidate, objective or essay tests, etc. At least two assessment techniques should be offered for each of the specific skills cited under each of the ten major competencies.

Once the assessment procedures are approved, the candidate proceeds with the collection of evidence to support his claim to each of the ten competencies. Many candidates will be able to verify some but not all of the ten competencies. In such cases diagnostic feedback will be provided so that the candidate will be able to engage in appropriate training activities. At first it will be difficult to insure consistency in the objectivity of evaluators, but as the training and assessment program matures, a pool of expert evaluators will evolve who will meet periodically to discuss the standards and assessment procedures which

they are employing. In like manner the ten major competency area statements will be refined by the State Office of Alcoholism and by the State Office of Drug Abuse as a result of feedback offered by the training program teachers, the counselor competency evaluators, and the program evaluators from these two offices. Within two years, efforts to develop an advanced level of competencies for Alaska's alcoholism and drug abuse programs including supervisory competencies will be realized, and certification along these levels will be instituted.

Information about the training program and the Counselor Competency Assessment Program will be distributed widely in the small villages as well as in the larger population centers in order to attract a wide range of individuals into training and into jobs providing direct services in the local communities.

The framework of the University of Alaska training program would provide for training in three parts: (1) All alcoholism and drug-dependency workers would receive some training at one of the University of Alaska community colleges and at the two centralized treatment facilities: the inpatient intensive treatment facility and the long-term care facility. (2) In-service training would be provided in the local programs by program training staff. (3) Local program directors who have been intensively trained would take responsibility for providing certain levels of training for alcoholism and drug-dependency service providers in their local areas.^{3,4}

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3. Training program of State of Colorado Alcohol and Drug Abuse Office, which includes training for Indian counselors serving in a large number of Indian communities throughout Colorado.
 4. The local alcoholism services program in Nome, Alaska, administered by the Norton Sound Health Corporation provides for ongoing training for counselors serving a network of fifteen small Eskimo villages plus Nome on such a training program framework with favorable results reported.

VI. POLICY RECOMMENDATIONS FOR MANAGEMENT

A. MANAGEMENT PROBLEMS

I. There is currently no state mechanism in place which will allow us to routinely continue to monitor alcohol related costs in increasingly more sophisticated and reliable ways or to determine the reasonableness of costs either as a whole or in individual Budget Request Units (BRU's).

However, the State's "PPBS" budgeting system does hold potential for more sophisticated and continual cost - revenue comparisons.

It is apparent that the state's alcohol related "cost center" have never been considered as parts of a programmatic or budgetary whole, nor have they been realistically related to the annual revenue available from the sale and distribution of beverage alcohol, federal funds, local contributions, private third party payments, public third party payments or other potential sources of revenue.

There is no overall budget policy for alcohol related programs. There is no set of budget directives reflecting that policy. Individual alcohol related BRU's are treated as discrete units and not as a programmatic whole, reflective of an overall policy. Therefore, there is no routine and accurate way for the state to measure its alcohol related costs/revenues, nor the efficacy and interrelation of its countermeasures.

This state has been not unlike many others in that it has suffered from a severe deficiency in both baseline and operational data from which to derive adequate and accurate measures of "where it is" and "where it's going" in the area of alcohol abuse and alcoholism.

The Executive Budget Act (AS 37.07.080) attempts to set up a rational data base and planning mechanism for the development of state programs. We are given to believe that it is largely not functioning as intended.

All departments and division with alcohol related ERU's are required to submit annual budgets in compliance with the Executive Budget Act which requires statements of "Public Needs To Be Addressed", "Agency Goals and Objective" (to meet those needs), "Agency Activities" (to execute the goals and objectives) and "Progress measures which show whether the need is in fact being met by the execution of goals and objectives at the projected levels of accomplishment and within the projected costs. In fact, this system does not appear to ensure that alcohol related agencies are working toward the accomplishment of a policy, through agreed upon goals, in a cooperative and coordinated manner. Hardly any reliable base-line or management information (M.I.S.) data is available to or generated by agencies that would allow them to make this system function.

In addition to the data needed by agencies to properly execute the state budgetary system, individual alcohol related agencies frequently have to develop non-comparable data sets to comply with different federal reporting requirements [there are both base line data planning requirements and MIS data reporting requirements mandated in different forms and contents by different federal agencies for; Social Services Division, Office of Alcoholism, Corrections, Traffic Safety, Criminal Justice Planning, Medical Assistance Division, Office of Drug Abuse, the Judicial System, Comprehensive Health Planning (Office of Planning and Research), and others.]

Baseline data for these plan requirements is often incomplete to the degree that it is useless for realistic planning and programming

purposes. M.I.S. data collected by various agencies is non-comparable and incomplete and therefore of limited value for program monitoring or cost evaluation purposes. Annual and Quarterly Performance Reports required of each BRU are usually useless for the purpose of measuring program effectiveness, mutual support toward agreed upon goals, or cost efficiency.

II. The field of "health planning" is no more chaotic anywhere than in Alaska. Much of the chaos is the result of various federal laws and activities which have created disparate organizations, mutually independent, but each with some level of health planning authority and responsibility. Trying to make sense of the current situation is a trying task.

For example, the following federally mandated agencies, over which the state has very little, if any, control, have alcohol-related health planning and/or programming responsibilities: The Alaskan Area Native Health Services; The Alaskan Federation of Natives (Health Affairs Division); The Veteran's Administration; The Regional Health Corporations (non-profit branch of AFN); The Regional Emergency Medical Services Systems and the Regional Health Services Agencies (areas and boards).

The Federal Government funds directly, through its National Institute on Alcohol Abuse and Alcoholism grant-in-aid program, the following: The Alaskan Native Commission on Alcoholism and Drug Abuse, The National Council on Alcoholism - Alaska Region, local alcoholism treatment programs in Anchorage, Juneau, Ketchikan, Fairbanks and Tok and the Center for Alcohol and Addictions Studies at the U. of A. in Anchorage. There are local boroughs and municipalities in Alaska which have either assumed health powers, (planning and programming)

within their domain under Alaska State Law, or developed into the principal managerial agency for alcoholism treatment programs (as in Anchorage and Juneau).

Finally, the State, through the Department of Community and Regional Affairs, the Office of Alcoholism, the Office of Drug Abuse, the Division of Mental Health, the Division of Traffic Safety, the Division of Corrections, the Criminal Justice Planning Agency, the Manpower Office and the Division of Social Services and Medical Assistance, fund local community alcoholism programs either directly or indirectly through grants-in-aid and/or reimbursable fee payments.

III. There is no state organization at present with sufficient resources and authority to coordinate the activities of the disparate organizations within Alaska that will plan for, fund, or provide alcohol - related services.

Given the conditions described above, the management problems inherent in coordinating the thrust and direction of alcohol related programming in Alaska are relatively complex. Additional complexity inherent in Alcoholism programming is added by the heavy involvement of the Judicial and Enforcement Systems of both the State and local communities, considerable involvement of the private medical profession and hospitals who provide most of the emergency and trauma care

Management Recommendations:

* Adopt the policy that alcohol abuse and alcoholism are inextricably linked to the per capita consumption of beverage alcohol, the sales and distribution of beverage alcohol and public attitudes toward its use.

A. Require that an annual state plan be developed that recognizes these relationships and addresses each of them an its proposed countermeasures.

* Retain an identifiable state "lead agency" for the coordination of prevention treatment and control of alcoholism and alcohol abuse for at least five more years. (Either the Office of Alcoholism or an Office of Substance Abuse)

* Alter the composition of the Interdepartmental Coordinating Committee:

The following persons should be members:

Commissioner of Health and Social Services

Director of Division of Policy Development and Planning

Director of Budget and Management

Commissioner of Administration

Commissioner of Public Safety

Commissioner of Community and Regional Affairs

Commissioner of Education

Commissioner of Revenue

Commissioner of Labor

Director of Criminal Justice Planning Agency

Department of Law

Representative from the Alaska Court System

* Charge the Interdepartmental Coordinating Committee with monitoring responsibility for all alcohol-related state government efforts.

A. Monitor the preparation and content of an Annual State Alcohol Abuse Countermeasures Plan.

B. Ensure interdepartmental and interdivisional cooperation and coordination in the implementation of the Annual State Alcohol Abuse Countermeasures Plan.

* Require all affected State BRU's to develop a combined annual alcohol abuse countermeasures plan through the annual budget process.

A. In those Division and Department where significant levels of activity related to alcohol abuse have been identified, budgets

Should be developed which specifically address those problems and coordinate with related activities in other Divisions and Departments.

B. The ICC, DPDP, and Budget and Management should review annual alcohol-related budgets and plans as a programmatic whole.

* Implement a centralized management information system that allows the State to measure the volume, effectiveness, costs and benefits of all its alcohol-related activities through time.

A. Develop and implement a centralized data system that can gather, analyze and synthesize reports on all alcohol-related activities and problems affecting State government. (Could pull together data from Revenue, AJIS, Corrections, Department of Health & Social Services, Traffic Safety, etc., on a routine basis.)

* Amend the Uniform Act (AS 47.37) to create a permanent "Federal-State Coordinating Council for Alcohol Abuse:

A. Council to provide liaison between the State and Federal agencies for the purpose of coordinating alcohol-related policy development, planning, and program implementation statewide.

B. Membership to include members of the ICC, a representative from the National Institute of Alcohol Abuse and Alcoholism, Director of the VA, Director of IHS, representatives from the Military (Coast Guard, Army, Air Force), AFN, NCA-AR, ANCAD, The Regional HSA's and The State Health Coordinating Council (SHCC).

* The State should provide the ABC Board with staff and dollar resources sufficient to allow it to fulfill its regulatory mission.

A. Budget and Management should immediately review the ABC Board budget request for FY 78 and ensure that appropriate resources will be provided to upgrade the ABC Board function.

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Alaska State Legislature

SENATOR MIKE COLLETTA



SENATE FLOOR LEADER

Senate

MEMORANDUM

TO: CITIZENS LEGISLATIVE BILL PARTICIPANTS

FROM: MIKE COLLETTA

RE: STATUS REPORT ON LEGISLATIVE RECOMMENDATIONS
January 5, 1978

The first phase of activities in writing a citizens bill are now complete. Although we encountered some technical problems in setting up the statewide public hearing, it was a good first attempt to involve everyone in the process.

One of the contributing factors to the difficulties we had was that you did not have a copy of the summary points of items to be included in the Citizens Bill. The summary is attached to this memorandum. It includes those items most often mentioned by the public as important.

The next phase of our project now involves taking these items and "fitting" them into a comprehensive package for legislative and administrative implementation. As you know, each of the various sections must be coordinated in order to be effective. Education, enforcement and treatment activities must complement each other in the local setting.

The legislature will convene next week and I intend to personally tell each legislator about our special project. It would be beneficial for you to communicate your interest and views to your district representative. With everyone involved in a full scale attack on alcoholism and alcohol abuse I am confident we can solve Alaska's greatest human needs problem.

Best Wishes

education- prevention

- primary alcoholism education curriculum in the public school system, grades K through 12
- basic alcoholism education and in-service type training for persons with a main-line contact with alcoholics: police officials, judges, social workers, doctors, nurses, village health aides, etc.
- accredited training for state certified teachers involving workshops or seminars
- training for persons dispensing alcohol as a pre-requisite to licensing
- provision for a statewide alcoholism education and training resource center to provide coordination, education materials, and training for local programs to draw upon
- specialized training for coordination and joint operations in liquor law enforcement by Alcoholic Beverage Control Board and other police agencies

enforcement

- increase penalties for all convictions involving alcohol and a motor vehicle (NOTE: several separate pieces of legislation already before legislature addressing this provision. The very strong public comment about this will be relayed)
- licensing of bartenders, cocktail waitresses and others who dispense alcoholic beverages
- increase Alcoholic Beverage Control Board personnel with a particular emphasis on patrolmen and investigators
- require no more than one liquor beverage to be served to a single patron at a time.
- establish strict guidelines for the sale of alcohol beverages by telephone or mail order

alternatives. treatment

- Mandatory alcoholism counseling referrals by judges whenever an individual becomes involved in the judicial process and alcohol is a contributing factor. Requirements for case histories to be a part of the court record, with provisions for confidentiality, to enable the court to make an appropriate length and type of treatment referral. Medical and alcoholism evaluations would be a part of the history.

- Series of detoxification centers such as funding a local hospital to establish a separate alcoholism ward, or if the local community determines a greater need, a complete and separate detox facility.

- Establish guidelines and criteria for para-professionals in outlying areas and enable non-profit health corporations to act as primary contractors for providing alcoholism services.

- Make available low interest loans to community corporations similar to other special areas such as economic development, minorities, veterans and student loans. This low interest loan would be for design and construction of recreation, sports, or adult social gathering places with the condition that alcohol would be prohibited in the facility.

local option

- Establish uniform certification procedures for local alcoholism programs providing for a maximum of local self-determination in the structure and method of operations and objectives. The single goal for each is the reduction of alcohol abuse. Funding for local programs will be on a need basis without requirements for competing with other communities for grants.
- Require certification of alcoholism programs.
- Encourage development of third party funding sources such as veterans administration, employer participation and insurance coverage.
- Authorize tax credit for contributions to certified alcoholism programs similar to political deductions.
- Eliminate annual grant applications requirements for alcoholism programs and provide for longer periods of funding.
- Establish "program revenue sharing" for local communities with funding based upon need. Formula for determining need may be any quantifiable data relative to alcohol abuse:
 -court proceedings involving alcohol as a contributing factor,
 -police activity reports relative to alcohol,
 -medical statistics,
 -social services records,
 -other

Revenue sharing under this section will be for a "time certain" period
Example: documentation by local community that DWI or OMVI records show alcohol abuse problem and need to solve--funds are requested for a 2 year program, after which time no further funds for this program will be granted if the DWI or OMVI statistics did not reveal a decline.

All monies now collected by the state from alcohol related industry would be available for this new local program approach. By re-directing revenue currently being raised, together with the excise tax now awaiting action in the State House, costly duplication and competition by different state agencies and administrative overhead would be reduced, Current grant program funding to alcoholism programs now total approximately 3 million dollars. Under the revenue sharing proposal, approximately 12 million dollars would be made available directly to local communities for alcoholism programs.

