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A WORKABLE MODEL FOR AN INDIAN ALCOHOLISM PROGRAM IN SE ALASKA

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I. INTRODUCTION

A prevalent opinion among alcoholism professionals as well as community residents in SE Alaska is that alcoholism and/or the abuse of alcohol are serious "problems" affecting a large percentage of the SE Indian population. While there are very little "facts" to substantiate this opinion (i.e. formal data, research studies, etc.), the feeling still remains. Most individuals that I have talked to during the course of this project substantiate their opinion by accounts of alcohol abuse either by themselves, their immediate families, or observed community incidents that have caused severe family and community disturbances. A needs assessment survey completed in 1975 by SECAP under the auspices of ANCADA documented the prevalence of this opinion, and recommended the need for locally based Indian alcoholism counselors in all 20 communities.

Before one designs and implements an alcoholism program, however, it becomes absolutely essential to refine these personal statements of opinion into a more factual presentation based on hard data. In the alcoholism field, this becomes extremely difficult as reliable data practically does not exist. There are methods of refinement, however, which will give those designing a program a more precise determination of what is involved.

This paper will first deal with the issues involved in setting up an alcoholism program. It will then explore the program model options available, and finally will outline in detail a proposed workable program model for a regional Indian alcoholism program operated under the auspices of the Southeast Alaska Regional Health Corporation.

II. ISSUES TO BE EXAMINED

A. Definition

The first issue to be examined is that of definition - just what exactly do we mean when we use the term, an "alcoholism program"? What population are we trying to reach - the alcoholic, the family of the alcoholic, the alcohol abuser, the youth, the community at large? Joy Leland, in her book, Firewater Myths devotes a whole chapter to various definitions of alcoholism.[1]

The best operational definition of an alcoholism program that I have seen is the one used by the Joint Commission On Accreditation of Hospitals (JCAH) Accreditation Manual For Alcoholism Programs:

> "The primary functions of any alcoholism program are to identify, evaluate, and treat persons who experience problems related to alcohol use."[2]

This definition is person and not community oriented. It does not make a distinction between alcoholism (the disease) and alcohol abuse. If any individual experiences a "problem" related to drinking alcohol, be it medical (alcohol withdrawal, gastrointestinal, etc.), personal (psychological disturbances), or social (family, job, community), then some type of service should be provided within the framework of the alcoholism program.

What the definition does not take into account, but which the Accreditation Manual lists at the end as optional, are services entitled education:

> "The education service shall be designed to convey on a regular and planned basis a philosophy that increases community understanding of the nature of the use and abuse of alcohol, its treatment and prevention, and the human, legal rights of the population at risk, as well as to inform the public of existing alcoholism resources and to gain public support for the development of additional resources".[3]

While the Accreditation Manual does not see community education as an integral part of an alcoholism program, the operational reality in Southeast is that all communities that I have visited have or want this component to be included in their alcoholism program. In some communities there are already frequent contacts with the schools for alcohol education and community alcohol education film nights.

Since the Accreditation Manual standards are those by which the State Office of Alcoholism will be eventually reviewing all programs operating in the State, I would recommend that their definition be accepted with the inclusion of education as an integral part of the definition. This would leave us with the following operational definition:

> AN ALCOHOLISM PROGRAM IS ONE THAT IDENTIFIES, EVALUATES, AND TREATS PERSONS WHO EXPERIENCE PROBLEMS RELATED TO ALCOHOL USE, AND PROVIDES ALCOHOL EDUCATION ON A REGULAR PLANNED BASIS TO ALL SEGMENTS OF THE COMMUNITY.

The program to be designed, then, must meet all aspects of this definition.

B. Numbers

The second issue that must be examined is that of numbers - the number of individuals that would be served by the program as defined by the above definition. There has been a tendency in the alcoholism field not to define potential numbers of clients, and to make the general vague assumption that there are plenty of clients to support any program. I have identified three possible ways of estimating the potential number of clients for a SE alcoholism program, all of which have limited validity, but are the best tools available for estimates in the field.

1) One possible way to estimate client population would be to take an arbitrary percentage of the total SE Indian population and define those people as in need of the above services from an alcoholism program. The percentage that you would use would be based on a reliable published estimate. One problem with this method is determining a current valid Indian population figure for Southeast. Estimates range from 7,625 - 12,262 depending upon which agency's set of figures that you use.[4] The other problem is determining a valid percentage estimate. The one most commonly used in Alaska is 9.2% derived from a study done in 1973 for the State of Alaska.[5] Table 1 in Appendix One shows the various SE population estimates, their sources, and the resulting 9.2% estimate of alcoholics (Not problem drinkers or alcohol abusers). Estimates using this formula range from 700-1000 Indian alcoholics in SE Alaska.

2) A second way to estimate client population would be to use the Parker Marden Formula to estimate the number of problem Indian drinkers in SE Alaska. The Parker Marden Formula was devised for use by Dr. Parker Marden, Associate Professor of Sociology, Lawrence University, and uses population census data to determine problem drinkersrather than just alcoholics.[6] This formula, although having some very real problems, is now used in place of the old Jellinec formula (which estimated the number of alcoholics by the number of individuals dying from cirrhosis of the liver) and is the only statistically reliable formula available for estimating the alcohol abuse population. The formula uses census data broken down by sex, age, and occupation.

I had problems in obtaining the necessary Indian population census data for use in the formula, and arrived at an approximation by using the formula for

all SE residents and taking a calculated percentage of that figure to be Indian problem drinkers. Table 2 in Appendix One shows the breakdown for the entire SE population which estimates a total of 2,683 problem drinkers in SE Alaska.[7] Using census data again, Table 3 in Appendix One shows that 18% of the total SE population were native; therefore 18% of the estimated number of problem drinkers or 483 individuals could be thought to be native alcohol problem drinkers.[8]

Two things must definitely be kept in mind when looking at these figures:

a) It has been noted that the 1970 census not only undercounted the Alaskan native population, but it also incorrectly listed a number of Alaskan natives as white.[9]

b) According to the information in Table 1, a more accurate total Indian population count would be around 11,000 rather than 7,625 individuals. There has also been an increase in the non-Indian population in SE Alaska which would increase the number of estimated problem drinkers.

Reliable use of the Parker Marden formula will increase when the results of the 1980 census are tabulated. Until that time, however, these figures should be used as base line estimates only.

3) The third way to estimate client population would be to look at utilization of already existing alcoholism treatment programs. Table Four in Appendix One shows that of almost 1400 clients during FY76 in SE Alaska (the latest statistical information available), 635 or 45% were native.[10] While this is well over the estimate of Indian problem drinkers shown in the Parker Marden formula, these facts need to be viewed in the light that the data collection system instituted during FY76 by the State Office was

not fully in operation, and that the client figure of 1400 is probably much higher. As this system is refined, the information will become more helpful.

Data from the above four tables show that there are approximately 500-1000 Indian alcoholics/problem drinkers in SE Alaska. As has been pointed out in the analysis, there are problems with the reliability of all the data being examined. However, until more reliable estimates are made (i.e. a more accurate population count, 1980 census data, and the refinement of the State data collection system), I think it would be fair to use the above figures as "ball park" estimates. It therefore facilitates any program planning that will be done.

C. Structure of Program

The most appropriate structure for an Indian alcoholism program will be dealt with in more detail under program model options. The issue that must be dealt with is which model will most successfully treat Indian clients who "experience problems related to alcohol use" and which will most successfully provide "alcohol education on a regular planned basis to all segments of the Indian community".

Again, there is no conclusive factual data to support one structure over another. In terms of an all Indian approach, the program that has had the most experience has been the Seattle Indian Alcoholism program, in operation since 1972. In an analysis of 677 of their patient charts, the survey found that 35% remained sober for 3 months or less, 18% remained sober for 3-6 months, 16% remained sober for 6 months-1 year, 25% remained sober for 1-3 years, 5% for 3-6 years, and 1% for more than 6 years.[11] To determine whether the Seattle Indian Program was more successful than other Seattle

alcoholism programs dealing with Indian people, one would have to compare "success" rates with the other programs. This is not done in their study.

However, a 25% 1 year sobriety rate shows a degree of success that should be looked at more closely. I would recommend that the hypothesis that an all Indian program is more successful with Indian clients be looked at more closely for this region. Any initial research hypothesis is always based on personal opinion. It does seem to follow that a totally separate Indian program will be more successful with Indian people purely from the basis of trust and acceptance of the Indian client, a necessary ingredient in any helping relationship. An article written in Social Casework mentions that social service programs with Native Americans have largely been ineffective because of the traditional methods and techniques that are used and the fact that cultural stereotypes are still largely held by counselors working with Native Americans.[12] The Seattle Indian Program uses the concept "culturally sensitive providers" in describing the type of counselors they employ in their program. While I actually saw no definition of this term, from my personal interview with the Assistant Director as well as my general understanding of their program, this term means that individuals in the helping role (counselors) must not only know and understand Indian culture and values, but must also feel them - that is - they must be an integral part of their own lifestyle. Over 90% of the counselors employed with the Seattle program are of Indian heritage.

As was pointed out earlier, the information contained in the State Office data collection system is very incomplete at this time, and it would be impossible to factually determine current Indian success rates within the local SE programs. The fact that this information is not available should

not deter testing the all Indian program hypothesis. If the general consensus of opinion is strong enough to develop such a program, I would recommend the following:

1) Keep close contact with the Seattle program and review their ongoing statistics as their program develops;

2) Continue to monitor the State data collection system;

3) Design an all Indian program here in Southeast, but build into it an internal evaluation mechanism to monitor success or lack of success, and compare these rates with the success rates of the local programs;

4) If money is available, hire the Seattle Indian Alcoholism Program on a consultant basis to assist in the initial program development.

D. Local Hire

The hiring of local counselors is an important issue, one that has been overlooked in this region, but one that I think needs to be looked at quite carefully. The Seattle Indian Program feels that one of its main assets is its culturally sensitive providers. Their counselors, while all now residents of Seattle, are from various Indian tribes. They do not believe, however, that it takes an Alaskan native to counsel an Alaskan native client. The emphasis is on common Indian identity.

Both the ANCADA needs assessment done in 1975, and the SEARHC grant submitted to NIAAA in 1976 for Indian alcoholism counselors, made the point that the hiring of local counselors was a necessary component for an Indian alcoholism program in SE based on shared cultural history, communication, interpersonal relations, and "attitudes" towards outsiders.[13]

Since I have been with this project, I have observed as well as talked with several individuals who have worked as alcohol counselors or educators in their own communities (Yakutat, Hoonah, Kake, and Hydaburg). All of the individuals that I have talked with have spoken of problems with their role as alcohol counselors because of extended family and clan lines (for example, they can not effectively work with a close family member), and role identification (community members tend to identify the individual in line with past roles rather than their present role as counselor or alcohol educator). For Southeast, the best approach might be culturally sensitive providers but not from the community of employment. Again, this can not be factually documented. However, when designing the program, this issue should be looked at quite carefully. Perhaps local people can perform certain role functions and not others. My personal opinion is that local people can perform the majority of alcoholism services with the exception of outpatient services (i.e. counseling) which could be performed more appropriately by a "culturally sensitive" individual from another community.

III. PROGRAM MODEL OPTIONS AVAILABLE

Assuming that one has reached tentative conclusions on the above issues, a program can now be designed. I have identified five possible program model options. All five program options need to be reviewed taking the JCAH Accreditation Manual For Alcohol Program standards into account. The Joint Commission is a voluntary professional organization which has set standard policies for hospital, mental health facilities, and alcoholism programs. The purpose for setting national standards is to give programs a guideline for operation. Accreditation also provides for an objective evaluation of a program's services, a form of recognition that is respected by health professionals and consumers, and it may assist programs in becoming eligible for third party payments.[14] While the State at present is only requiring the larger urban programs to meet these standards, eventually all programs within the State will be required to meet similar standards. The JCAH Manual list seven essential components of service and two optional components. Although a program does not necessarily have to operate all seven components, it does have to show specifically how all essential components will be provided (i.e. direct service, contract, affiliation agreement, etc.).

A. Use What Already Is Available

This naturally would be the easiest model to adopt. There already exists in this region alcoholism services which are heavily utilized by Indian people. Table 4 in Appendix One shows the 1976 utilization statistics. An assumption could be made that what already exists is sufficient, and that there is no need to make any changes. This model would further make the assumption

that the services provided are not only adequate but are also "successful" in that Indian people utilizing the services have experienced a reduction in "problems related to alcohol use".

The facts to support this model are not available. As has already been mentioned, the data collection system of the State Office of Alcoholism is quite incomplete, and only rough trends can be shown. While the data indicates that approximately 45% of all clients seen in SE alcoholism programs were native, no breakdown on the type of services received, and whether these services did in fact make any changes are recorded. To adequately review and make a decision about use of this program model, one would have to wait for a more accurate statistical breakdown on Indian utilization and client success in the existing program structure.

B. Use What Is Available But Adapt For Indian Clients

This model would assume that there is validity in the idea that there needs to be certain program adaptations for Indian clients (such as hiring Indian counselors, use of cultural identity groups in treatment, etc.), but that these adaptations can be done within the present structure of alcoholism services. For example, for every program that serves Indian clients, an Indian (or "culturally sensitive provider) be hired to serve that population. In practice, this is fairly much the case in most Southeast programs. There are Indian counselors on staff in the programs of Yakutat, Juneau, Hoonah, Sitka, Ketchikan, and Metlakatla. To my knowledge, none of these programs run special Indian groups or make any other special program adaptations, although at a given time, the entire client group may in fact be all native.

An interesting point that would need further discussion and research on use of this program model option would be what are the unique treatment areas for Indian clients? Does it merely mean Indian identity or are there other areas involved (i.e. length of treatment, specific interpersonal communication approaches, etc.) that need to be considered. This program model would also include expanding current operating program services to include regular services to outlying rural communities which is done on an infrequent basis now due to very limited travel funds.

This is a program model that should be studied more closely. It would be the responsibility of the Indian community to provide input to the local programs as to what is specifically needed for Indians in the way of alcoholism services. The major problem with this program model might be the tendency that the identified specific needs for Indian clients would be diffused to include the needs of all other community groups.

C. Form A Series Of Autonomous Local Programs

This model would contend that each community (both rural and urban) should offer services to the part of the client population living in that community. The services offered would not have to include all of the essential components listed by JCAH, although each community would have to document a minimum of management/support, aftercare, and one other essential component.[15] This model would be community oriented and would not emphasize Indian/non-Indian identity. A good example of this model is the recent emergence of the Hoonah program, another local autonomous program which serves a quite limited part of the SE population.

The main drawback to this model would be cost. In terms of the projected numbers of individuals to be served in the region (approximately 2,000 for the region), the cost to run and staff such community programs would be phenomenally high. The 1977 State Plan points out the need for a regional/district organization of services with the offering of basic counseling and education services in rural communities and sophisticated treatment facilities in the regional centers.[16] There is definitely a need to regionalize and subregionalize services, but it would be impossible to offer a network of autonomous local services.

D. Separate Indian Regional Alcoholism Program

This model would assume that the present structure is not applicable for Indian people, and would propose to set up a totally separate Indian alcoholism program. It would be regional in program and administration, and its goal would be to serve the estimated Indian client population. The program would be a separate non-profit organization with a Board of Directors (much like the Seattle Indian Alcoholism Program) but regionalized, and thus would be eligible for State and Federal grants. All essential components of service would be offered. Some components such as outpatient and aftercare would be offered with a direct service staff of regional and community counselors, and other components (such as medical detox and inpatient treatment) would be contracted throughout the region.

Again, I must emphasize that there is no conclusive evidence that this model is any more successful than the first two models. Also, given the proliferation of already existing non-profit Indian organizations, adding another organizational structure would seem to only confuse rather than to aid funding and implementing such a program

E. Regional Indian Alcoholism Program Under SEARHC

This is the program model option that I have chosen. This model would build on an already existing structure and would emphasize all components of service as well as Indian identity. The Health Corporation has the potential to contract the 30 day rehabilitation program at Mt. Edgecumbe Hospital, and already has contracts for outreach workers and health aides with Indian Health Service. All that needs to be done is to identify what already exists within SEARHC as potential alcoholism services, publicly identify these services as a regional Indian alcoholism program, locate funding for a regional coordinator (using the RTA position for the first year), continue funding for outreach workers and structure these positions to offer outreach and aftercare services, and find training monies for all staff.

I would like to emphasize that all the program model options have both good and bad points. The lack of reliable data in the region forces one to make a choice more on personal opinion than factual data. As has already been pointed out on page 7, designing an Indian alcoholism program has merit. It is essential, though, that there be a consensus of opinion by the SEARHC Board of Directors that this is the program model option that they wish to implement.

IV. SEARHC INDIAN ALCOHOLISM PROGRAM

The fifth program model will be examined in greater detail analyzing each component of service as defined by the JCAH Accreditation Standards. JCAH Standards have been documented for nine separate components of service (Management/Support, Emergency, Inpatient, Intermediate, Outpatient, Outreach, Aftercare, and Consultation and Education). In this section, I will examine each component according to the JCAH standard, and show how that component can be provided in a comprehensive Indian Alcoholism Program under the Health Corporation utilizing already existing Health Corporation programs. The program would be an evolving process which should take approximately three years to be fully operational (See Time Frame in Appendix Two). The first year would see the initiation of three components of service (Management/Support, Emergency Care and Outreach). The second year would see the initiation of the Inpatient, Outpatient, and Aftercare components. The third year would concentrate on the Intermediate and Education components. While Education is shown as not being fully operational until the third year, education services would be initiated during the first year on a limited basis and increased each year. As was mentioned in the first section of this paper, the provision of education services will be a essential component of this regional alcoholism program.

Appendix Three shows a projected three year budget for the development of the program. The budget is broken down by component of service and by fiscal year, and includes contract money already secured by the Health Corporation. In this projection the total budget for FY78 would be $143,000; FY79 budget is estimated at $297,800; and FY80 budget is estimated at $356,000. Appendix Three also includes budget justification sheets for each fiscal year explaining how these figures were computed.

For FY78, the budget calls for two additional staff (Regional Alcoholism Coordinator and Administrative Assistant), monies for one consultant and part time detox supervisors, and monies for health aide and outreach training. FY79 includes monies for hiring one additional staff person (Outpatient/Education Coordinator), and projects contracting the Mt. Edgecumbe Hospital Alcoholism Therapy Services Unit. FY80 includes monies for hiring two Outpatient Counselors. Job descriptions for the four permanent direct service staff are attached in Appendix Four. For the first year of operation only $32,000 additional monies would be needed to operationalize the program.

A. Management/Support

The JCAH standards for this section involve specific requirements for the governing body of an alcoholism program, patient rights, planning, fiscal managment, the physical environment of the program, personnel, evaluation, patient records, medication control, referrals and research.[17] Setting up adequate management support services is the key to having a well run alcoholism program. The responsibility for meeting the above standards would fall to the Regional Alcoholism Coordinator (see job description in Appendix Four). This position would be responsible for setting up and maintaining strict confidentiality of case files, writing and updating an alcoholism program plan, writing yearly goals and objectives, supervising an appropriate fiscal management procedure, providing information and technical assistance to local communities and alcoholism programs, working with other agencies providing alcoholism services, setting up training programs, and evaluating the program on a regular planned basis.

The position for the first year would be partially funded by the RTA program, but upgraded from a GS-9 to a GS-11. As the RTA program is in its third year of funding, monies for the position for FY79 may have to be sought elsewhere (hopefully from the Indian Health Service). The Regional Alcoholism Coordinator would spend FY78 setting up and operating the first three components of the program (Management/Support, Emergency, Outreach), add three more components by FY79 (Inpatient, Outpatient, and Aftercare), and operationalize the last two components (Intermediate and Education) by FY80. When setting up the program, it should be remembered that to operate a comprehensive alcoholism program, it is not necessary to demonstrate that the program directly operates all components. Signed affiliation agreements or contracts with other agencies will be sufficient.

B. Emergency Care

According to JCAH standards, the emergency care system shall provide 24 hour service to all persons and their families with problems related to alcohol use and abuse including: 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 (non medical detox); 3) evaluation of medical, psychological and social needs leading to the development of a plan for continuing care; 4) effective transportation services.[18]

I think that it can be easily shown that the health aides are already providing services identified under #1 & #4, and could be trained to provide part of the services required under #2 & #3. A supervised non medical detox is an essential part of a comprehensive alcoholism program. It is being done now on an informal basis in some of the communities. For example, a local minister

in Hoonah uses a spare room in his home for this purpose, and the alcoholism program in Yakutat has a spare room in their office staffed by volunteers for detox purposes. I don't think that the health aides would have to be involved in the actual supervision of those individuals needing detox, but could be trained to supervise individuals assigned this responsibility. One way would be to identify volunteers in each community (perhaps AA members, extended family members of the client) who would take on this responsibility.

The best way would be to pay individuals a small sum ($15-25) for a 12 hour shift (this is what is done at Bartlett Hospital). These part time workers would be hired to sit and supervise the individual, provide appropriate food and medication specified by the health aide, and be responsible to call the health aide if an emergency (medical or otherwise) arises. Monies for these workers as well as training for the health aides have been included in the projected budget.

I don't think that it would be realistic or appropriate to assign full responsibility of #3 to the health aides. Comprising a medical, social, and psychological evaluation and an initial treatment plan would for the first year be the responsibility of the Regional Alcoholism Coordinator and later by the Outpatient/Education Coordinator (see job description in Appendix Four). For the coordinator to write the plan, a release of information from the individual will be necessary, and the health aide can be helpful in obtaining the required releases. The health aide will also be responsible for arranging transportation to further treatment, and for sending to the regional alcoholism coordinator, any medical information known on the client from previous contacts, after the necessary releases of information are obtained. The Coordinator would then write a brief synopsis and include it in the client's file.

A confidential case file for each individual that is provided a direct service under the alcoholism program must be set up and maintained in the regional office. Information from these files would not be released without the prior consent of the patient. However, with that consent, the information would be forwarded to requesting appropriate treatment facilities that the program has signed affiliation agreements with.

For communities that don't have health aides (urban communities), affiliation agreements would have to be signed with local alcoholism programs to provide emergency services. This would be an area that the Regional Alcoholism Coordinator should work on to strengthen during the initial development of the program, because, to my knowledge supervised non medical detox is almost non-existent in the larger communities, and a service that local alcoholism programs don't normally provide. However, by utilizing the health aide system in the rural communities for FY78, and working at the same time to devise a workable plan for offering similar services in the larger communities by FY79, this should be sufficient to meet initial compliance of JCAH standards.

C. Outreach

The JCAH manual states that the outreach component shall focus on identification of individuals and families having problems related to the use of alcohol, focus on the procurement of such services, and alert all human service agencies who serve this population to the importance of early identification.[19] The objectives of this component could be carried out quite easily by utilizing the outreach worker positions and the regional alcoholism coordinator position. The outreach workers would be involved in the identification of individuals in the rural communities and would make the initial contacts and

initial referrals. The regional coordinator position would be involved in "maintaining liason and interaction with all relevant community organizations", and alerting agencies to the importance of early detection.

Outreach is basically letting the community (region) know that services do exist, and how and where those services can be procured. This could be done on the regional level by the regional alcoholism coordinator through the newsletter, and through public presentations. It would also be done on the community level by the individuals who are the first point of contact with individuals in need of service (i.e. the health aides, outreach workers, and other community service personnel). As with the emergency component, a plan for providing these services to the urban communities will have to be devised using affiliation agreements with existing urban programs as the Health Corporation does not anticipate having outreach worker positions in the larger communities until FY79.

The above three components would be initiated during FY78. Also, during FY78, the regional alcoholism coordinator would begin writing a plan of action for provision of the other five components. The second year would see the operationalizing of the Inpatient, Outpatient, and Aftercare components.

D. Inpatient Care

The JCAH manual states that the inpatient care component shall provide 24 hour supervised care under the direction of a physician in a hospital or other suitably equipped medical setting designed for the treatment of alcohol abuse and/or alcoholism.[20] This region is quite fortunate to already have an established 30 day Alcoholism Therapy Services Program at Mt. Edgecumbe Hospital that has been in operation now for approximately

two years. This program is a contracted Indian Health Services program, presently contracted to the Sitka Council On Alcoholism. The hospital program under the auspices of the Sitka Council has already made efforts at complying with the JCAH standards. The program, while in a hospital setting, may only meet Intermediate Care standards rather than Inpatient.

The Health Corporation has the potential to become the contractee for this program. I think that the key in winning this contract would be for the Health Corporation to demonstrate to the IHS that it has the capacity for operating a comprehensive alcoholism program. I would recommend that the Health Corporation look towards FY79 to bid on this contract. By that time the first three components will be in operation, and a plan for utilizing or operating the other components will be completed.

One thing that the Health Corporation might look at during the coming year would be the appropriate length of treatment for such a program. There is nothing in the JCAH standards that indicates a correct or appropriate length of treatment. The Seattle Indian Alcoholism program uses 90 days; Alcoholism Therapy Services uses 30 days. It might be helpful to evaluate individuals that have gone through treatment programs with different length of treatment days by the number of sober days after treatment to determine which length of treatment is more successful. As far as I know, there is no treatment program in Alaska that uses 90 days, but that does not mean that this should be discounted if it can be proven that it <u>is</u> more successful. Once this information is collected, it could then be included in the contract negotiations with IHS.

E. Outpatient Care

Outpatient care according to JCAH shall provide alcoholism treatment services on a scheduled and non-scheduled basis in a non-residential setting to alcoholic person's and families.[29] This component is presently being provided in the urban communities by the already existing alcoholism programs. The surrounding communities are served by traveling service workers (T&H Social Service, Mental Health Workers, State Social Workers, Public Health Social Workers) on a fairly frequent basis, and counseling is offered to those families requesting it. The standards set up by JCAH for outpatient care require that the program providing this component perform a social/ psychological evaluation and a written individualized treatment plan for each individual under treatment. It also maintains that the staff be trained to perform these services.

I think the easiest way for the Health Corporation to provide documented outpatient services would be to sign an agreement with Tlingit and Haida Social Services to initially provide this component. While the focus of the T&H social services unit is not strictly alcohol counseling, the majority of individuals seen there have alcohol-related problems, and the services staff travel on a regular basis to most of the communities. Copies of reports of these contacts (with the individual's permission) could be kept in the regional file.

Ideally, when funds were available, having direct services staff under the auspices of the Health Corporation would be the best way to administer this component. Funds for an Outpatient/Education Coordinator and 2 Outpatient counselors have been included in the projected budget. The Health Corporation

could possible think of establishing regional offices in Juneau and Ketchikan with locally based community counselors or counselors that travel from the regional office. As the Health Corporation will be able to document that a systematic plan for providing all necessary components has been drawn up, they will be eligible to apply for funds for these positions. Ideally, these positions could be funded by the IHS, but the next best alternative would be to apply to the State for funding.

F. Aftercare

The JCAH Manual states that the aftercare component will emphasize continued contact for those individuals who have progressed sufficiently through inpatient and outpatient treatment services, the continued contact being mainly for support.[22] This component could again be accomplished through the outreach worker staff. It involves mainly regular contact (and documenting that contact) with individuals who have received treatment either in an inpatient program or outpatient program, and documenting that the individual is still maintaining sobriety and not in need of further treatment services. Operation of this component is essential in determining success of the alcoholism program. Aftercare is the one component that has been lacking in many of the alcoholism programs in this region, mainly due to funding problems.

The Health Corporation has an already established framework to provide this component. What would be needed to operationalize this component would be to supply the outreach workers with aftercare contact form sheets which would be mailed in on a regular basis for all individuals identified in the community as having completed treatment for a period of 2-5 years.

G. Intermediate Care

The JCAH manual states that intermediate care shall be designed to organize a therapeutic environment in which an individual may receive diagnostic services, counseling, vocational/rehabilitation or work therapy.[23] Intermediate care services now being provided in this region are through a series of halfway houses (Gastineau Manor, Juneau, Victory House, Ketchikan, Aurora's Watch, Sitka, and Hill Street Cottage, Hoonah). Tlingit and Haida Social Services pays for an individual's stay at one of these facilities under certain conditions (i.e., a person returning from treatment, a person making an effort to stay off alcohol and find work). All of the above intermediate care facilities are non-profit community organizations receiving funds from the State. All have a high percentage of Indian residents.

The Health Corporation, if it felt it was feasible and necessary could open a halfway house facility as a component to the hospital treatment program using 3rd party monies such as T&H Social Services. However, this is not necessary if the Health Corporation feels that the services being provided at the present facilities are adequate to the needs of Indian clients. A formalized referral and followup system would only then have to be set up through the regional alcohol coordinator's office to keep track of where clients are. As was pointed out under the Inpatient section, the hospital program may only meet Intermediate Care standards and not Inpatient standards. If this is the case, the Health Corporation would then be involved in directly providing Intermediate care services.

I would recommend that the Health Corporation utilize the already existing halfway house structure for the first year, evaluate if this structure is adequate, and if it is not, to plan setting up a halfway house facility by FY81.

Setting up a separate halfway house program is a lot of work as it involves finding an appropriate structure that will meet building and fire codes, getting 3rd party approval for clients, hiring and maintaining staff, and housing enough clients to make the operation break even. In short, it can be a big headache and should not be undertaken lightly. As far as I can determine, at this point, the halfway houses presently in operation are adequate for this region, and the hospital program is well run.

H. Consultation/Education. The JCAH manual states that the consultation service shall be designed to provide to individuals and groups the skills necessary for program management and treatment.[24] This is an optional component and one that is very similar to the primary purpose of the RTA position. As I have already recommended that the RTA position be utilized as a regional alcoholism coordinator concentrating on administration rather than technical assistance, I would not recommend that this component be initiated formally as a part of the program. To formalize this component, a written plan would have to be drawn up and an individual on staff would have to be designated specifically to provide this service. I am sure that there will be quite a lot of informal consultation with local programs and communities done by the regional alcoholism coordinator, and this should be written into the job description of that position. Other than that, I would not recommend operationalizing this component.

As was mentioned at the outset, the education component is considered to be an essential part of a comprehensive SE Indian alcoholism program. The education component must be designed to convey on a regular and planned basis information that increases community understanding on the nature of alcohol use and abuse, treatment and prevention, the human and legal rights of the risk

population, and the resources available.[25] There are two levels that the education component must simultaneously address - the education system through the local school districts, and the community at large.

ANCADA is already working on a plan to train the RTA's to give teacher workshops on the use of the Seattle school disctict alcohol education curriculum entitled "Here's Looking At You". This curriculum is designed to be used from kintergarden to 12th grade and provides information as well as suggestions on presenting the curriculum in the classroom. A letter from Diane Le Resche, State Department of Education, was mailed to all school districts in April 1977 explaining the curriculum and where the curriculum could be obtained. By training teachers in the region this next year to use the curriculum, one would easily be able to measure how many school district's actually have begun using the curriculum.

Community education sessions have been taking place in the region but on an informal and sporadic basis. Funds would be needed to hold community education workshops in the region. These workshops would be mainly a listing of all the available resources and a presentation of 1 or 2 sample community education presentations with emphasis on group role playing participation. It has been my feeling over the past several months that the main problem with community education services to date has been the individual's uncomfortableness in speaking to groups. The Outpatient/Education Coordinator would be responsible for providing this training, and for maintaining a resource bank of educational materials for the region.

V. CONCLUSIONS

This paper has been an effort to show how a comprehensive regional Indian alcoholism program can be operational under the already existing structure of the Southeast Alaska Regional Health Corporation. I have tried to identify some of the issues that need to be resolved prior to initiation of such a program, the program options available, and finally a detailed explanation of one recommended program option using the JCAH standards as a guideline. In this presentation, I have shown that several of the components now already exist within the Health Corporation. What needs to be done is to begin tying together what already exists. Although the program will operate under the SEARHC organizational structure, it is absolutely essential that the alcoholism service components be seen as one identifiable program under SEARHC not only to the community and potential clients, but to the agencies that the program will be working with.

This tying together of already existing components also makes it easier to identify gaps of service. I think one of the problems in the past has been that services have been so fragmentary leading to a false impression that nothing has been offered. Also, publicly identifying a comprehensive program will make it easier for the program to apply for and receive funds from other sources. Any funding body needs to see a plan of action, including goals and objectives. By being able to show that the program has recognized the need to provide services in each of the components and has set up a time frame to accomplish this, this will give the potential funding body (be it NIAA, State Office of Alcoholism, etc.), a clear picture of the program's intentions.

One of the most essential points of the JCAH manual is documentation of what a program is doing. This paper is just the first step, giving hints for an organizational start up. The next phase would be to write program goals and objectives and a long range plan.

I can not overemphasize that before a regional alcoholism program can be initiated that it is absolutely essential that SEARHC re-examine the issues and program model options presented in this paper. What has been presented has been one individual's recommendations. Whatever program model adopted must reflect the policies and commitment of the SEARHC Board of Directors. Without that, any attempt to initiate any program will be a failure.

APPENDIX ONE

TABLES

TABLE ONE

Estimated Number of Indian Alcoholics
In SE Alaska*

Population Source	Estimated SE Native Pop.	Estimated Number Alcoholics (9.2%)
1970 Census**	7,625	701
ISEGR***	8,277	761
ANCSA****	9,902	911
BIA*****	12,262	1,128
BIA******	11,303	1,040

* Estimated percent taken from Allocation of Adult Alcoholics in Alaska By Geographic, Sex, and Racial Indices

** 1970 Census of Population, Volume 1, Part 3, Table 34

*** From Division of Economic and Social Development, Tlingit and Haida

**** From Division of Economic and Social Development, Tlingit and Haida

***** From Division of Economic and Social Development, Tlingit and Haida

****** From Staff Estimates of Native Alaskan Population, Labor Force, Employment and Unemployment By Agency With Area (State) Totals For Years 1966-1976, Bureau of Indian Affairs

TABLE TWO

Estimated Number of Problem Drinkers in SE Alaska*
Using Parker Marden Formula

Age	Male	Female	Total
0-19			
20-29	791.62	62.52	854.14
30-39	525.13	210.07	735.20
40-49	474.50	156.47	630.97
50-59	268.74	34.13	302.87
60-69	137.93	11.38	149.31
70+	8.64	2.14	10.78
	2,206.56	476.71	2,683.27

* Population figures from 1970 Census statistics; Computation Worksheets On File in RTA office

TABLE THREE

Estimated Percent: Native Population
Of Total SE Population Using 1970 Census Data

District	Total Pop.	Native Pop.	% Native of Total Pop.
Angoon	503	371	
Haines	1,504	315	
Juneau	13,556	1,477	
Ketchikan	10,041	1,179	
Otr. Ketch.	1,676	820	
Pr. Wales	2,106	567	
Sitka	6,109	1,169	
Sgw./Yak.	2,157	752	
Wrg./Ptrs.	4,913	975	
	42,565	7,625	.18%

TABLE FOUR

Native Utilization of SE Alaska
Alcoholism Programs*

Program	Total Native	Total Client	% Native
Juneau	152	452	
Ketchikan	101	365	
Sitka	167	279	
Petersburg	107	169	
Wrangell	5	24	
Yakutat	103	109	
Total	635	1,398	45%

* From 1976 State Office of Alcoholism Annual Report

APPENDIX TWO

TIME FRAME

TIME FRAME
SE Regional Indian Alcoholism Program

FY78	FY79	FY80
ESTABLISH: 1. Management/Support a. Regional Coordinator & AA hired b. Administrative & Case files c. Fiscal management d. Program plan, goals and obj. e. Referral proc. & affil. agrmt. f. Evaluation tools 2. Emergency a. Detox policy and prcdrs. b. Training for health aides c. Affil. agrmt. with urban areas 3. Outreach a. Identif. of alcoh. resources b. Liason with comm. organizations c. Referral policy and proc. d. Training for outreach workers e. Affil agrmt. with urban areas	ESTABLISH: 1. Inpatient a. IHS contract: Alcoholism Therapy Services 2. Outpatient a. Outpatient/Educ. Coord. hired b. Affil. agrmt. with T&H Soc. Ser. c. Grant to IHS or SOA for Outpatient Couns. positions 3. Aftercare a. Training for outreach workers b. Affil. agrmt. with urban areas	ESTABLISH: 1. Intermediate a. Affil. agrmt with Halfway Houses 2. Education a. Reg. Alcoh. Wrkshps. b. Reg. Tchr. Wrkshps. c. Resource Bank 3. Outpatient a. Outpatient Counselors hired

APPENDIX THREE

BUDGET

PROJECTED BUDGET
Regional Indian Alcoholism Program

FY78	Funds Available	New Funds	Total
Management/Support	43,500	10,600	54,100
Emergency Care	14,500	16,000	30,500
Outreach	53,000	5,400	58,400
Total FY78	111,000	32,000	143,000

FY79			
Management/Support		62,000	62,000
Emergency Care	20,000	21,200	41,200
Outreach/Aftercare	80,000	8,600	88,600
Inpatient	84,000		84,000
Outpatient		22,000	22,000
Total FY79	184,000	113,800	297,800

FY80			
Management/Support		72,000	72,000
Emergency Care	21,000	21,200	42,200
Outreach/Aftercare	84,000	8,600	92,600
Inpatient	88,200		88,200
Outpatient/Education		61,000	61,000
Intermediate	-	-	-
Total FY80	193,200	162,800	356,000

PROJECTED BUDGET
FY78
Regional Indian Alcoholism Program

	Funds Available	New Funds	Total
Management/Support			
1. Regional Alcoh. Coord. (Salary+Frnge: GS11)	22,000	3,000	25,000
2. Administrative Asst. (Salary+Frnge: GS5)	10,000	4,600	14,600
3. Consultant		3,000	3,000
4. Admin. Costs (Travel, Fac. Comm., Supplies, Other)	11,500		11,500
Total	43,500	10,600	54,100
Emergency			
1. Health Aides(1/8 time)	14,500		14,500
2. Detox Supervisors		12,000	12,000
3. Health Aide Trning		4,000	4,000
Total	14,500	16,000	30,500
Outreach			
1. Outreach Workers (1/2 time)	53,000		53,000
2. Outreach Training		5,400	5,400
Total	53,000	5,400	58,400

BUDGET JUSTIFICATION
FY78

1) Regional Alcoholism Coordinator. This position will be mostly covered by the ANCADA grant. As the position will be administrative rather than technical assistance, it is my feeling that this position should be filled at a GS-11/12 salary range. Possibly ANCADA will be able to budget for those funds.

2) Administrative Assistant. This position could be partially funded under the T&H Manpower CETA Title VI program. As the maximum salary for these positions is $10,000, I would recommend that additional monies be found to upgrade this position to a GS5/7 level as the duties require more responsibility than just clerical.

3) Consultant. It is my feeling that hiring a consultant from the Seattle Indian Alcoholism Program during the first year of operation would be highly valuable as the SIAP has been in operation since 1972, and has had to go through many of the organization problems that will face this program. Monies for this position were budgeted as follows:

4 one week program visits ($100 day program consult. x 5 days + $200 round trip air fare: Seattle = $700 per trip x 4 visits = $2800.

4) Administrative Cost. The major administrative cost for this program have already been figured in the ANCADA grant (this includes travel, facilities cost, communications, office supplies, etc.). What was not figured would be the additional office space needed for two individuals during the first year. However, what has already been budgeted will most probably be sufficient.

5) Health Aides. The Health Corporation presently has a contract with IHS for 10 full time aides, 4 1/2 half time aides, and 13 alternates amounting to $116,000. It is estimated that approximately 1/8 of the health aides time would be spent on the provision of detox services.

6) Detox Supervisors. Monies for these positions have been budgeted as follows:

$50 day x 3 days x 4 detox clients x 20 communities = $12,000.

It is estimated that each community on the average will detox 4 clients per year. Each client will be detoxed an average of 3 days. The part time detox supervisors will be paid $25 for a 12 hour shift.

7) Health Aide Training. Training monies will be needed for one 3 day in-service training workshop for the health aides on detox supervision. Monies for this training have been computed for 10 health aides to attend a 3 day workshop (1 day travel) in Sitka:

$2,000 (Transp. 10 indiv.) + $2,000 (Per Diem: 4days) = $4,000

The training will be provided either by the Regional Alcoholism Coordinator or the SEARHC Field Trainer. Monies are needed only for travel and per diem of health aides only.

8) Outreach Workers. The Health Corporation has a contract with IHS for 6 Outreach Workers and a contract with T&H Manpower for 6 more Outreach Worker positions amounting to approximately $106,000. It is estimated that approximately 1/2 of the outreach worker's time will be spent on the provision of alcoholism services.

9) Outreach Worker Training. Training monies would be needed for one 3 day (1 day travel) training workshop on the provision of outreach and aftercare services. Training costs have been computed as follows:

$3,000 (Transp. 12 indiv.) + $2400 (Per Diem) = $5400.

PROJECTED BUDGET
FY79
Regional Indian Alcoholism Program

	Funds Available	New Funds	Total
Management/Support			
1. Regional Alcoh. Coord. (Salary+Frnge:GS12)		32,000	32,000
2. Administrative Asst. (Salary+Frnge:GS6)		17,000	17,000
3. Admin. Costs		13,000	13,000
Total		62,000	62,000
Emergency			
1. Health Aides(1/8 time)	20,000		20,000
2. Detox Supervisors		12,000	12,000
3. Health Aide Trning		9,200	9,200
Total	20,000	21,200	41,200
Outreach/Aftercare			
1. Outreach Wrkrs(1/2 time)	80,000		80,000
2. Outreach Training		8,600	8,600
Total	80,000	8,600	88,600
Inpatient			
1. ATS Contract	84,000		84,000
Total	84,000		84,000
Outpatient			
1. Outpnt/Educ. Coord.		22,00	22,000
Total		22,000	22,000

BUDGET JUSTIFICATION
FY79

1) Regional Alcoholism Coordinator. This position would be upgraded to a GS-12 and would remain at that level.

2) Administrative Assistant. This position would be upgraded to a GS-6 during the second year of operation.

3) Administrative Costs. Administrative costs would be increased by 12% to include administrative overhead for 3 positions.

4) Health Aides. The Health Corporation anticipates hat they will have 16 full time health aides by this fiscal year with an estimated total contract of $160,000. Health aides time in the provision of alcoholism services will remain at 1/8.

5) Detox Supervisors. This amount will remain the same pending evaluation as to how much is expended during FY78.

6) Health Aide Training. Continuing training monies for one 3 day training for 16 health aides is computed as follows:

Trans. (16 indiv.)	+ Per Diem (4 days)	
6,000	+ 3,200	= 9,200

7) Outreach Workers. The Health Corporation anticipates that they will have approximately 6 more outreach worker positions this fiscal year with a total estimated budget of approximately $160,000. The outreach worker's time in the provision of alcoholism services will remain at 1/2.

8) Outreach Training. Continuing training monies would be needed for one 3 day training workshop on the provision of outreach and aftercare services.

Trans. (18 indiv.)	+ Per Diem (4 days)	
5,000	+ 3,600	= 8,600

9) ATS Contract. The Alcoholism Therapy Services contract with IHS is presently being contracted to Sitka Alcoholism Council for approximately $84,000. This amount includes approximately 3 1/2 staff positions.

10) Outpatient/Education Coordinator. This would be a new position which would work out of the regional office, and would be responsible for coordinating services for both the outpatient and education components.

PROJECTED BUDGET
FY80
Regional Indian Alcoholism Program

	Funds Available	New Funds	Total
Management/Support			
1. Regional Alcoh. Coord. (Salary+Frnge: GS12)		33,000	33,000
2. Administrative Asst. (Salary+Frnge: GS7)		19,000	19,000
3. Administrative Costs		20,000	20,000
Total		72,000	72,000
Emergency			
1. Health Aides(1/8 Time)	21,000		21,000
2. Detox Supervisers		12,000	12,000
3. Health Aide Trning		9,200	9,200
Total	21,000	21,200	42,200
Outreach/Aftercare			
1. Outreach Workers	84,000		84,000
2. Outreach Trning		8,600	8,600
Total	84,000	8,600	92,600
Inpatient			
1. ATS Contract	88,200		88,200
Total	88,200		88,200
Outpatient/Education			
1. Outpnt/Educ. Coord. (Salary+Frnge:GS11)		25,000	25,000
2. Outpnt. Counselors (Slary+Frnge:GS7)		36,000	36,000
Total		61,000	61,000

BUDGET JUSTIFICATION
FY80

1. Regional Alcoholism Coordinator. This position would remain at GS12, Step One.

2. Administrative Assistant. This position would be upgraded to a GS7.

3. Administrative Costs. Administrative costs would be increased to $20,000 and include administrative overhead for 5 positions.

4. Health Aides. The Health Corporation anticipates continuing 16 full time health aides. An increase of a minimum 5% salary increase is projected with the health aides continuing at 1/8 time.

5. Detox Supervisers. Same

6. Health Aide Training. Same

7. Outreach Workers. The Health Corporation anticipates maintaining 18 outreach worker positions. Increase is for a minimum 5% salary increase.

8. Outreach Training. Same

9. ATS Contract. 5% increase.

10. Outpatient/Education Coordinator. This position would be upgraded to a GS11

11. Outpatient Counselors. Monies are for two outpatient counselors beginning at GS7.

APPENDIX FOUR

JOB DESCRIPTIONS

TITLE: Regional Alcoholism Coordinator

SALARY RANGE: $22,000-26,000 (GS11/12)

BASIC FUNCTION: To act as a program coordinator for a SE Regional Indian Alcoholism Program.

SPECIFIC DUTIES:

1) To set up necessary management support systems including administrative and client files, referral procedures, fiscal management policies, and evaluation mechanisms.

2) To write an annual program plan including goals and objectives under supervision of SEARHC Board of Directors.

3) To provide information and technical assistance to communities and local alcoholism programs including program development, grant application procedures, and fiscal management policies.

4) To act as liason with community and regional service agencies in providing coordinated alcoholism services.

5) To negotiate and sign affiliation agreements with agencies providing services not covered in regional alcoholism program.

6) To plan and set up alcoholism training programs for SEARHC staff and community groups

7) To seek supplemental sources of funding for comprehensive alcoholism program delivery.

REQUIRED KNOWLEDGE AND SKILLS:

1) Good administrative background including knowledge and experience in office procedures, accounting and grant managment. At least 4 years administrative work experience.

2) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values. Preferably 2-3 years direct work experience in an alcoholism program.

3) Ability to set up workable program plan, goals and objectives, meet time frame, make administrative decisions, and delegate work responsibility.

4) Ability to set up appropriate training programs and provide in-service training to SEARHC staff.

TITLE: Administrative Assistant

SALARY RANGE: $12,500-$15,500 (GS5/7)

BASIC FUNCTION: To provide administrative backup to the Regional Alcoholism Coordinator

SPECIFIC DUTIES:

1) To maintain administrative files and confidential patient case files.

2) To set up and maintain in conjunction with the Health Corporation Comptroller appropriate accounting procedures for alcoholism program

3) To assist in the draft preparation of reports and correspondance of the Regional Alcoholism Coordinator

4) To type all necessary reports as assigned by the Regional Alcoholism Coordinator.

5) To assist in the preparation of regional alcoholism workshops including travel arrangments, preparation of training materials, and registration.

6) To prepare monthly statistical reports on program operation.

7) To purchase all supplies for program.

REQUIRED KNOWLEDGE AND SKILLS:

1) Minimum of 3 years general office experience including one year administrative and accounting experience.

2) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values. Preferably 1 year direct work experience in an alcoholism program.

3) Ability to perform a number of varied responsible work tasks under prescribed time frames.

4) Ability to compose draft correspondance, minutes and reports.

TITLE: Outpatient/Education Coordinator

SALARY RANGE: $19,000- $23,000 (GS9/11)

BASIC FUNCTION: To supervise regional outpatient staff and to direct a comprehensive education program in.SE Alaska

SPECIFIC DUTIES:

1) To supervise regional outpatient staff.

2) To be responsible for updating regional client files, for writing social/psychological evaluations, and for maintaining confidentiality of files.

3) To maintain client tracking system.

4) To maintain resource bank of educational materials for use in region.

5) To set up and provide regional community education workshops.

6) To provide teacher workshops on utilization of Seattle alcohol education curriculum.

REQUIRED KNOWLEDGE AND SKILLS:

1) Minimum of two years supervisory experience preferably in alcoholism program.

2) Preferably at least one year work experience as an instructor or trainer.

3) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values.

4) Ability to write appropriate training materials for region.

TITLE: Regional Outpatient Counselor

SALARY RANGE: $16,000 - $19,000 (GS7/9)

BASIC FUNCTION: To provide outpatient counseling services.

SPECIFIC DUTIES:

1) To provide individual and group counseling to individuals with alcohol abuse problems and to their families.

2) To utilize the cottage program group technique.

3) To travel to surrounding rural communities on a regular basis to offer outpatient services.

4) To consult with health aide and outreach worker staff.

5) To make appropriate referrals.

6) To write treatment plans and progress notes.

REQUIRED KNOWLEDGE AND SKILLS:

1) Minimum 3 years counseling background (at least one year in alcoholism program).

2) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values.

3) Ability to work closely with native client groups.

FOOTNOTES

1. Leland, Joy. Firewater Myths (Rutgers Center of Alcohol Studies: 1976), pp. 10-15.

2. Accreditation Manual For Alcoholism Programs (Joint Commission On Accreditation of Hospitals:1974), p. 3.

3. JCAH, p. 71.

4. Unpublished Report from Tlingit and Haida Division of Social and Economic Development 1977; and Staff estimates of Native Alaskan Population Labor Force For Years 1966-1976(Bureau of Indian Affairs), p. 70.

5. Allocation of Adult Alcoholics In Alaska By Geographic, Sex & Racial Indices (Alaska Center For Research, Planning & Evaluation:July 1973); and 1977 Annual Update To Alaska State Plan, p. 13

6. A Procedure For Estimating the Potential Clientele of Alcoholism Service Programs (Division of Special Treatment and Rehabilitation Programs, NIAAA .

7. Census of the Population: 1970 (Bureau of the Census), Table 35.

8. Census of the Population: 1970 (Bureau of the Census), Table 34.

9. 2(c) Report: Federal Programs and Alaska Natives Introduction and Summary, Task 1, Part B, Section 1, p. 71.

10. State Office of Alcoholism Annual Report 1976.

11. Turner, Fain, and Kauffman. Analysis of an Indian Alcoholism Program, A Case Study. (Unpublished Paper of Seattle Indian Alcoholism Program).

12. Lewis and Ho. "Social Work With Native Americans". Social Casework (September 1975), pp. 379-389.

13. American Indian Alcohol Project Grant(Southeast Alaska Regional Health Corporation Grant to NIAAA), Problem Statement.

14. JCAH, p. vii.

15. JCAH, p. xii.

16. 1977 Annual Update to Alaska State Plan, p.3.

17. JCAH, pp. 9-23.

18. JCAH, pp. 35-40.

19. JCAH, pp. 53-58.

20. JCAH, pp. 41-44.

21. JCAH, pp. 53-58.

22. JCAH, pp. 63-68.

23. JCAH, pp. 47-52.

24. JCAH, pp. 69-70.

25. JCAH, pp. 71-73.